Infant-Toddler Intake Form **Please circle all answers in BOLD**

History of Present Illness

Name/Preferred _____

Parents Names _____

Date_____/_____/_____ Age _____ DOB _____/_____/_____

Email address _____

Preferred Phone (____) _____-_____

History of Present Illness

Please list main health concerns in the order of importance _____

_____

Do these health concerns interfere with **Feeding/Sleep/Play/Daily Routine/Other** _____

Describe _____

Are the symptoms getting progressively worse? **Yes/No**

Do the symptoms worsen at certain times of the year? **Yes/No** If yes, when?

_____

Is there anything else you would like to share? _____

Birth **(Parent please circle as appropriate)**

Is there any history of maternal complications in pregnancy? **Yes/No** Describe _____

_____

Is there any history of birth complications such as prematurity, or congenital birth defects? **Yes/No** If yes, please describe _____

Birth Weight _____ Length _____

Was birth **Full-Term/Pre-Term/Post Dates/Vaginal Delivery/C Section/Forceps** Feedings was with **Breastmilk/Formula/Unsure** Describe any difficulties, and how often if still breastfeeding _____

_____

Weaned at age _____

Were vaccines/vitamin K given at birth **Yes/No** Please explain _____

Sleep

How many hours of sleep at night on average does the infant/toddler sleep? _____ Are parents resting when needed? **Yes/No** If no, is help at home available? **Yes/No**

Past Medical History

Circle here if **No history of chronic illnesses** Has there been any medical diagnosis of your infant/toddler's complaint? **Yes/No** If yes, list the diagnosis and who diagnosed this problem

_____

In the past the infant/toddler has had **Acupuncture/Chiropractor/Diet/Emergency Room/Exercise Medications/Naturopathy/Routine Medical Care/Supplements/Surgery/Other**

_____

How did this work?_____ What do you think is wrong?_____

Please list any medical history/serious illnesses/hospitalizations/injuries?_____

_____

_____

Health Maintenance

Date of last wellness exam ___/___/___ **Normal/Abnormal**

Is your infant/toddler is vaccinated? **Yes/No** If yes, are they up to date? **Yes/No**

Does your infant/toddler get an annual flu vaccine? **Yes/No**

Explain _____

Family History

List mother's medical history_____

List father's medical history _____

Please list any other pertinent family history _____

Allergies

Please list all allergies to medications, food or the environment_____

_____

_____

Medications & Supplements

Please list any medications, supplements or herbs your infant/toddler currently takes and for what conditions _____

_____

Social History

Is your infant/toddler exposed to second hand smoke, illicit drugs or alcohol in the home? **Yes/No I**f yes, please describe _____

How many hours of television does your infant/toddler watch per day? _____ What types of television does your infant/toddler watch? _____ Does your infant/toddler listen to **Music/Radio/Audiobooks/Podcasts** How many hours per day _____

Are there guns present in home? **Yes/No** Are they **Secured/Unsecured**

Spirituality

Do you have a family religious preference? If yes which one? _____

Relationships

The infant/toddler lives at home with **Both Parents/Mother/Father/Grandparent/Step Parent/Guardian Other**_____ Does your infant/toddler have siblings at home **Yes/No** If yes, names and ages _____

Does your infant/toddler get along with siblings **Yes/No** If no, describe _____

Home Life

Does your family feel safe at home? **Yes/No** If no, why? _____

Is there any other place that your family feels they are unsafe? **Yes/No** If yes, where and why?

Is your family **Homeless/Near Homeless** What type of structure does your family live in? **Owned home/Rented home/Rented Apartment/Cabin/RV/Car/Tent/None of the above/Other**_____

Mobility/Exercise Please circle all answers

Is your infant/toddler **Rolling Over/Sitting Up/Crawling/Walking/Running**
Are you concerned about their mobility **Yes/No** If yes, why _____

Toxic Exposure

Has your infant/toddler, to your knowledge, been exposed to toxic metals? **Yes/No** If yes, which one(s)? **Lead/Arsenic/Aluminum/Cadmium/Mercury**
Do you have **Running Water/Toilets/ Well water/City water/Electricity** If well water how many years? _____ In what state(s) was the well located? _____
Has the well water been tested for arsenic **Yes/No** Have you ever lived in a basement for many years? **Yes/No** If yes, was this in an area of radon? If yes, in what states _____
Do odors affect your infant/toddler? **Yes/No** If yes, which ones? _____

Constitution

If your infant/toddler has something in the morning to drink what would it normally be? **Cold liquid/Hot liquid/Room temperature liquid**
If your infant/toddler has something to drink during the day what would it normally be? **Cold liquid/Hot liquid/Room temperature liquid**
If your infant/toddler has something to drink what would it most often be?
Water/Juice/Pop/Other _____
In regards to temperature, do you feel your infant/toddler is **cold natured/hot natured/neutral temperature**

Digestion & Elimination

Is the family on a special diet? **Yes/No** If yes, **Standard American Diet/Ovo-lacto vegetarian/Vegetarian/Vegan/ Dairy restricted/Gluten Free/Diabetic/Paleo/ Autoimmune Paleo/Other**_____
Does your infant/toddler have any **sensitivities** to food? **Yes/No** Please list actual food allergies in the allergy section If yes, describe _____

Does your infant/toddler have symptoms immediately after eating? **Yes/No** If yes, describe

_____

Are these symptoms associated with any particular food or supplement(s)? **Yes/No** If yes, list the food and the symptoms _____

_____

Does your infant/toddler appear to have delayed symptoms after eating certain foods such as fatigue, muscle aches, sinus congestion, etc.? **Yes/No** If yes list the food and the symptoms

_____

_____

Are there certain foods that your infant/toddler strongly dislikes? **Yes/No** If yes, which foods?

_____

_____

Does your infant/toddler have any of the following currently or in the past
Constipation/Diarrhea/Food allergies/Food sensitivities/Gas/Bloody Stools/Black Stools
Describe the frequency of your infant/toddler's bowel movements **More than 3X/day/1 to 3X/day/4 to 6X/week/2 to 3X/week/1 or fewer X/week**
Describe the consistency of your infant/toddler's bowel movements **Soft and well-formed/Often float/Difficult to pass/Diarrhea/Thin, long or narrow/Small and hard/Loose but not watery/Alternate hard and loose/watery**
Describe the color of your infant/toddler's bowel movements **Medium brown consistently/Very dark or black/Greenish color/Blood is visible/Varies a lot Dark brown consistently/Yellow, light brown/Greasy, shiny appearance**
Does your infant/toddler have intestinal gas? **Yes/No** If yes, **Daily/Occasionally/Excessive/ Present with pain/Foul smelling/Little odor**
Does your infant/toddler eat breakfast? **Yes/No** If so, what is a usual breakfast?_____

_____

What is a usual lunch? _____
What is a usual dinner? _____
What kinds of snacks does your infant/toddler typically eat? _____
What does your infant/toddler typically drink? _____
The healthiest foods my infant/toddler eats during the week are _____
The worst foods my infant/toddler eats during the week are_____
Does your family **Cook/Hunt/Fish/Garden**
Did you know if you are unable to hunt or fish you can have someone proxy hunt or fish for you **Yes/No** Did you know you can also be added to the kill list **Yes/No** Where do you get the rest of your food from? _____

Readiness to Change

Is there anything else you would like us to know? _____
If your infant/toddler/or breastfeeding mother needs to make major dietary changes, will family members be supportive? **Yes/No** Parents: Are you willing to change what you believe about health and the body to improve your infant/toddler's health? **Yes/No**

Goals

Please check the following things the parent feels are important goals:

- ☐ I want my infant/toddler to be in better moods
- ☐ I want to reduce my infant/toddler's risk of developing a chronic disease
- ☐ I want to improve my infant/toddler's diet
- ☐ I want to improve my infant/toddler's skin
- ☐ I want my infant/toddler to have more energy
- ☐ I want my infant/toddler to sleep better
- ☐ I want my infant/toddler to have better digestion
- ☐ I want my infant/toddler to be able to eat more foods
- ☐ I want my infant/toddler to get rid of or improve allergies
- ☐ I want my infant/toddler to have a better immune system i.e. less colds and coughs
- ☐ I don't want my infant/toddler to be dependent on laxatives or stool softeners
- ☐ I want my infant/toddler to no longer use chronic medication
- ☐ Other:_____

Lastly, is it ok to leave a detailed message via phone or email? **Yes/No**
Kristen tries to make herself very available to her patients. Her personal cell is (907) 395-7565. If you contact Kristen via text on her personal cell phone please understand it is not secure. Kristen deletes texts and voicemails very quickly in an attempt to decrease this risk. Kristen will not answer medical qustions on social media. Please circle: **I understand and would like her cell number/I do not understand or do not agree, I will only contact Kristen through the office.**

Kristen Coletti Giesler NP-C, CFMP
Certified Family and Emergency Nurse Practitioner
Certified Functional Medicine Practitioner