



Points of Origin, PLLC  
18810 NE 18<sup>th</sup> Street  
Vancouver, WA 98684

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**PEDIATRIC INTAKE FORM**  
*(please feel free to attach any additional information)*

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address \_\_\_\_\_ Age \_\_\_\_  
City, State, Zip \_\_\_\_\_  M  F Ht \_\_\_\_ Wt \_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
School and Grade \_\_\_\_\_ Email address \_\_\_\_\_  
Emergency Contact Person and Phone # \_\_\_\_\_  
Referred by \_\_\_\_\_

Reason (s) for Visit Today \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long has your child had this condition? \_\_\_\_\_  
What seemed to be the initial cause? \_\_\_\_\_  
What seems to make it better / worse? \_\_\_\_\_  
What do you feel needs to happen to relieve this condition? \_\_\_\_\_  
Any additional health concerns \_\_\_\_\_  
\_\_\_\_\_

Is your child under the care of a physician now?  Yes  No If yes, for what diagnosis? \_\_\_\_\_  
Who is your child's primary care physician? \_\_\_\_\_  
Physician's Phone# \_\_\_\_\_ (we will not contact without your permission)  
Other current therapies \_\_\_\_\_  
Other therapies tried in the past \_\_\_\_\_

Any Pets? Y / N    Type of Pets & general health \_\_\_\_\_

- Family Medical History** (indicate which: **Grandparents, Parents, Siblings, or your Children**):
- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Allergies        | <input type="checkbox"/> Alzheimer's   | <input type="checkbox"/> Gall Bladder issues | <input type="checkbox"/> Kidney stones       |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Cancer        | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Obesity             |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Seizures            | <input type="checkbox"/> Inherited Disorders |
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Depression          |



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Your Child's Past Medical History:

- Abdominal Pain
- Asthma
- Allergies
- Appendicitis
- Birth Trauma
- Cancer
- Chicken Pox
- Diabetes
- Ear infections
- Epilepsy
- Febrile Seizures
- Gastrointestinal Disorder
- Heart Disease
- Headaches/Migraines
- Joint Problems
- Kidney Problems
- Sinus problems
- Skin problems
- Vaccine Reaction
- Viral illnesses

Surgery (list/date):  
\_\_\_\_\_  
\_\_\_\_\_

Hospitalization (list/date):  
\_\_\_\_\_  
\_\_\_\_\_

Major Trauma  
(Car accident, fall, abuse, head injury, etc.)  
\_\_\_\_\_  
\_\_\_\_\_

Other (Specify) \_\_\_\_\_  
\_\_\_\_\_

Eating Habits: Appetite  Low  Moderate  High  Coffee  Soft Drinks  Sugar  Salty food  
Thirsty a lot?  Yes  No Average # of glasses of water per day \_\_\_\_\_

Typical Daily Menu:

Breakfast (approx time _____)	Lunch (approx time _____)	Dinner (approx time _____)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Snacks: \_\_\_\_\_

Prescription Medications currently taking (indicate dosage, how many times per day):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Vitamins/Supplements currently taking (indicate dosage, how many times per day):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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- Lifestyle:  Preschool  School  
 Daycare  Hobbies \_\_\_\_\_  
 Sports Type \_\_\_\_\_ Frequency \_\_\_\_\_  
 Other \_\_\_\_\_

General Symptoms:

- |  |   |  |  |  |
|--|---|--|--|--|
| <input type="checkbox"/> Poor appetite       | <input type="checkbox"/> Poor Sleep       | <input type="checkbox"/> Bodily Heaviness    | <input type="checkbox"/> Chills                        | <input type="checkbox"/> Bleed or Bruising |
| <input type="checkbox"/> Heavy appetite      | <input type="checkbox"/> Heavy Sleep      | <input type="checkbox"/> Cold hands or feet  | <input type="checkbox"/> Night Sweat                   | <input type="checkbox"/> Peculiar taste    |
| <input type="checkbox"/> Like cold drinks    | <input type="checkbox"/> Dream disturbed  | <input type="checkbox"/> Poor circulation    | <input type="checkbox"/> Sweat easily (describe) _____ |  |
| <input type="checkbox"/> Like hot drinks     | <input type="checkbox"/> Fatigue          | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> muscle cramps _____           |  |
| <input type="checkbox"/> Recent wt loss/gain | <input type="checkbox"/> Lack of strength | <input type="checkbox"/> Fever               | <input type="checkbox"/> vertigo/dizzy _____           |  |

Head, Eyes, Ears, Nose, Throat

- |   |  |  |  |                                     |
|---|--|--|--|-------------------------------------|
| <input type="checkbox"/> Glasses        | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Sores on lips or tongue | <input type="checkbox"/> Recurrent sore throat | <input type="checkbox"/> Headache   |
| <input type="checkbox"/> Eye strain     | <input type="checkbox"/> Glaucoma        | <input type="checkbox"/> Dry mouth               | <input type="checkbox"/> Swollen glands        | <input type="checkbox"/> Migraines  |
| <input type="checkbox"/> Eye pain       | <input type="checkbox"/> Cataracts       | <input type="checkbox"/> Excessive saliva        | <input type="checkbox"/> Lumps in throat       | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Red eyes       | <input type="checkbox"/> Teeth problems  | <input type="checkbox"/> Sinus problems          | <input type="checkbox"/> Enlarged thyroid      | Other head or neck problem<br>_____ |
| <input type="checkbox"/> Itchy eyes     | <input type="checkbox"/> Grinding teeth  | <input type="checkbox"/> Excessive phlegm        | <input type="checkbox"/> Nose bleeds           |                                     |
| <input type="checkbox"/> Spots in eyes  | <input type="checkbox"/> TMJ             | Color of phlegm _____                            | <input type="checkbox"/> Ringing in ears       | _____                               |
| <input type="checkbox"/> Poor vision    | <input type="checkbox"/> Facial pain     |  | <input type="checkbox"/> Poor hearing          | _____                               |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Gum problems    |  | <input type="checkbox"/> Earaches              | _____                               |

Respiratory:

- Difficulty breathing when lying down  Tight chest  Cough  wet or  dry?  Coughing blood  
 Asthma  thick or  thin?  Pneumonia  
 Shortness of breath Color of phlegm \_\_\_\_\_

Cardiovascular:

- |   |   |   |                                       |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain           | <input type="checkbox"/> Tachycardia  |
| <input type="checkbox"/> Congenital Problem   | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Heart Murmur       |   |                                       |

Gastrointestinal:

- |   |   |                                       |   |  |
|---|---|---------------------------------------|---|--|
| <input type="checkbox"/> Nausea                         | <input type="checkbox"/> Vomiting                   | <input type="checkbox"/> Gas          | <input type="checkbox"/> Strange Tastes | Bowel Movement Frequency:<br>_____ / _____ day or week<br>(circle one) |
| <input type="checkbox"/> Acid Regurgitation / Heartburn | <input type="checkbox"/> Hiccups                    |                                       |   |  |
| <input type="checkbox"/> Diarrhea                       | <input type="checkbox"/> Constipation               | <input type="checkbox"/> Laxative use |   |  |
| <input type="checkbox"/> Intestinal pain/cramping       | <input type="checkbox"/> Parasites (current / past) |                                       |   |  |



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Musculoskeletal:

- Neck/shoulder pain       Upper back pain       Joint pain       Limited range of motion  
 Muscle pain       Lower back pain       Rib pain       Limited use

Other (describe) \_\_\_\_\_  
 \_\_\_\_\_

Skin and Hair:

- Rashes       Eczema       Dandruff       Change in hair/skin texture      Other skin conditions  
 Hives       Psoriasis       Itching       Fungal infections      \_\_\_\_\_  
 Ulcerations       Acne       Hair loss      \_\_\_\_\_

Neuropsychological:

- Seizures       Poor memory       Irritability       Considered      Other (specify)\_\_\_\_  
 Numbness       Depression       Easily stressed      suicide      \_\_\_\_\_  
 Tics       Anxiety       Abuse survivor       seeing therapist      \_\_\_\_\_

Genito-urinary:

- Painful urination       Blood in urine       Congenital Kidney Problem  
 Frequent urination       Unable to hold urine       Bedwetting  
 Urgent urination       Incomplete voiding       Wake to urinate       Kidney stones

Gynecology:

- Age at first period      Duration of flow      Vaginal discharge       Breast lumps       Vaginal sores  
 \_\_\_\_\_ years old      \_\_\_\_\_ days      (color) \_\_\_\_\_       PMS       Vaginal odor  
 Length of cycle \_\_\_\_\_ days (time between periods)       Irregular cycle       Painful periods  
 Date of LMP (last menstrual period) \_\_\_\_\_       Mood Disturbance       Clots

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*Anything else?: Please provide further information about current or past health concerns in the space below.*

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