Naturally Unbridled Wellness Pediatric Client Intake

Name: _____ Today's Date: _____

Birthdate: _____ Age: _____ Male ☐ Female ☐

FULL Address: _____ City: _____ State: ____ Zip: _____

Parent Phone: _____ Parent Email: _____

Parent/Guardian Name : _____ Relationship to Child: _____

Referred by: _____

YOUR TOP TWO HEALTH CHALLENGES

#1: _____

#2: _____

What are you trying to accomplish with our services?

___ Better Sleep
___ Improved Mood
___Better Focus/Attention
___Digestive Relief
___Frequent Illness
___Eczema/Rash
___Other:

___Balanced Energy
☐ Autism Support
___Food Sensitivities
___Emotional Regulation
___Mycotoxin Exposure
___Lyme Disease or Other Infection
___Healthy Diet and Lifestyle

Current Weight: _____ Current Height/Length: _____

Does your child's doctor have concerns regarding their growth curve? Yes ☐ No ☐

If yes, please describe? _____

Who is your Chiropractor: _____

How many OUNCES of WATER does your child drink in an average day? _____

Pharmaceuticals (prescription or over-the-counter) taken in last two months:

Vitamins/ Supplements taken in last two months:

Has your child received any of the COVID vaccines? Yes ☐ No ☐

If yes, how many? _____

Please include vaccination history (list or attach to form):

Please list any major illness, injuries or hospitalizations:

Please list locations of birthmarks, if present:

Has your child ever been diagnosed with any genetic condition, chromosomal difference, or congenital anomaly? *(Such as cleft lip/palate, heart defect, or other midline differences)* **Yes** ☐ **No** ☐

If yes, please describe:

As an infant, how was your child fed? Breastfed ☐ Formula-Fed ☐ Both ☐

For how long? _____

List formula type(s) here: _____

Pregnancy & Birth History

This section helps us understand possible influences from your child's prenatal development and birth.

☐ My child was adopted ☐ My child was born via surrogacy

During pregnancy, did your child's mother experience:

☐ High stress ☐ Illness or infection (e.g. COVID, flu, UTI)
☐ Hyperemesis gravidarum ☐ Physical trauma or injury
☐ Medical complications (e.g. preeclampsia, gestational diabetes)

Medication use during pregnancy (list):

Supplement use during pregnancy (list):

Birth Type:

☐ Vaginal
☐ C-section -- ☐ planned ☐ emergency
☐ Assisted -- ☐ vacuum ☐ forceps

Labor Length: _____ hours

Any birth complications?

☐ Yes ☐ No
If yes, please explain: _____

Was your child:

☐ Full term ☐ Premature (How many weeks early? _____) ☐ Post-term

Birth Weight: _____
Apgar Score (if known): _____

Immediate Postpartum (baby):

☐ Needed NICU care ☐ Needed oxygen or resuscitation
☐ Breastfed within first hour ☐ Skin-to-skin contact
☐ Trouble latching or feeding

How was your childs' mother's emotional experience with birth?

Check All That Apply

Digestive

- [ ] Bowel Movements 1-2x/day
- [ ] Diarrhea once a month or more
- [ ] Constipation
- [ ] Difficulty potty training
- [ ] Frequent urination
- [ ] Very stinky gas/stool
- [ ] Stomach aches
- [ ] Undigested food in stool
- [ ] Burping/Reflux/Spit Up
- [ ] IBS or inconsistent bowels
- [ ] Gassy
- [ ] History of antibiotic use

Details:

Sleep

- [ ] Fall asleep easily
- [ ] Difficulty falling asleep
- [ ] Night waking
- [ ] Nightmares/Night terrors
- [ ] Wakes fussy or irritable
- [ ] Wakes with large appetite
- [ ] Uses melatonin or sleep aid
- [ ] Restless sleep, tossing and turning
- [ ] Mouth breathing and/or snoring
- [ ] Bedwetting
- [ ] Dark circles under eyes
- [ ] Inconsistent sleep

Details:

Energy

- [ ] Energy is good all day
- [ ] Afternoon crash
- [ ] Has bursts of hyper energy
- [ ] Takes naps during the day
- [ ] Often fatigued or needs rest
- [ ] Body temperature runs hot
- [ ] Often restless, difficulty sitting still
- [ ] Energy best in the morning
- [ ] Never stops running, playing, doing
- [ ] Higher energy when tired
- [ ] Night owl
- [ ] Needs breaks with physical play

Details:

Emotional

- [ ] Frequent meltdowns/tantrums
- [ ] Worry/fear
- [ ] “Clingy” behavior
- [ ] Easily frustrated/angry
- [ ] Sensitive to sensory input
- [ ] Quick to tears
- [ ] Aggression (hitting, biting, etc.)
- [ ] History of trauma/PTSD
- [ ] Fussy as an infant
- [ ] Difficulty with transitions
- [ ] Tummy aches with stress
- [ ] Overly emotional
- [ ] High pain tolerance

Details:

Diet and Lifestyle

- ☐ Screen time 1+ hour per day
- ☐ Attends school/daycare
- ☐ Pets at home
- ☐ Regular bedtime routine
- ☐ Lives in separate households
- ☐ 1+ hours outside time daily
- ☐ Views screens during meals
- ☐ Known food intolerance/allergies (describe below)

- ☐ Eats mostly home cooked meals
- ☐ Eats school/daycare provided meals
- ☐ Prefers processed foods
- ☐ Sensory aversions to foods
- ☐ Difficulty sitting still for meals
- ☐ Little interest in food
- ☐ Always hungry

Describe:

Are you looking for natural symptom support or do you want to get to the root cause of the issue?

☐ **Natural symptom support** ☐ **Get to the root cause**

How long do you think it will take to reach your wellness goals? _____

How willing are you to make lifestyle changes to improve your situation?

◯ Not Willing ◯ Slightly Willing ◯ Willing ◯ Very Willing

You may include any other information that you feel may be helpful to us:

If you are under 18 years old a guardian must sign this form. Thank you.

I understand that Patti Bartsch, Ph.D. and the staff at Naturally Unbridled Wellness LLC are not medical professionals; therefore, they do not diagnose, treat, cure, or prescribe for any disease or condition. Their comments are not a replacement for qualified medical care. I have stated any medical conditions that apply to me and I take it upon myself to keep the practitioners and my healthcare providers up to date on health changes. It is my responsibility to evaluate all supplements and remedies for allergies and contraindications.

_____ _____

PARENT/GUARDIAN signature date

If you are currently breastfeeding, please fill out the additional "Currently Breastfed Infants" Questionnaire.