The Natural Health Medical Clinic

PEDIATRIC/ADOLESCENT PATIENT CONFIDENTIAL INFORMATION

Name ____________________________ Date of Birth __________ Age ____ Today's Date ___________, 2012
Home phone _________________ Email Address __________________________
Address ____ City _______________ State ___ Zip _______
Mother's Name _________________________________ Father's Name ____________________________________
Mother's Daytime Phone ___________________________ Father's Daytime Phone __________________________
Social Security #______________________ Sex: □ M □ F
How did you learn about our clinic? ____
Where you referred by a doctor or clinic? ____

MAJOR CONCERNS

List the main problems that your child is having and for how long / the reason for this appointment:

1. ____
2. ____
3. ____

Major stressors just prior to symptoms ____
Has your child previously had similar symptoms? □ Yes □ No When? Date: __________
Names of doctors recently consulted ____ Dates____________
Date of last thorough check up_____________ What do you think is wrong with your child?

____

Are you willing to change living habits (environmental, diet) to improve your child's health? □Yes □No

PAST MEDICAL HISTORY

Serious Illnesses ____
Surgeries ____
Major Accidents ____
Hospitalizations ____
Medications & Supplements ____
Allergies to medications, inhalants, foods ____
Immunizations ____
Major Childhood Illnesses____________________________________ Scars _____________________________

List chemicals, fumes, dusts, pets, radiation, etc to which your child is repeatedly exposed:

____

How many hours does your child sleep at night? ___ Does your child awaken refreshed? Yes No
Child's energy level? (1= lowest, 10= the most energy you can imagine) 1 2 3 4 5 6 7 8 9 10

Check any medications your child takes:

□ Antibiotics/Antifungal □ Decongestants □ Other
□ Anti-inflammatory □ Laxatives _________________________
□ Aspirin/Tylenol □ Thyroid

Check if your child eats, drinks or uses:

- □ Alcohol
- □ Artificial Sweeteners
- □ Candy
- □ Carbonated Beverages
- □ Chlorinated Water
- □ Dairy Products
- □ Eat at fast food restaurants regularly
- □ Filtered Water
- □ Fluoridated Water
- □ Fried Foods
- □ Luncheon Meats
- □ Margarine
- □ Refined (White) Flour
- □ Special Diet (be specific) ____________________ ____________________
- □ Sugar Products

Foods your child craves: ____

Foods your child has aversion to: ____

Is child chilly or warm (wears more or less clothes than average): □ Chilly □ Warm

FAMILY HISTORY

Identify any family members who have had any of the following:

[Abbreviations: Mother (M) Father (F) Brother (B) Sister (S) Grandparent (G) Your Children (C) Self (S)]

	M	F	B	S	G	C	S
Smoking	□	□	□	□	□	□	□
Alcoholism	□	□	□	□	□	□	□
Allergies	□	□	□	□	□	□	□
Anemia	□	□	□	□	□	□	□
Arthritis	□	□	□	□	□	□	□
Asthma	□	□	□	□	□	□	□
Birth Defects	□	□	□	□	□	□	□
Cancer	□	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□	□
Ear Infections	□	□	□	□	□	□	□
Epilepsy/Seizures	□	□	□	□	□	□	□
Hearing Loss	□	□	□	□	□	□	□
Heart Disease	□	□	□	□	□	□	□

	M	F	B	S	G	C	S
High Blood Pressure	□	□	□	□	□	□	□
Hypoglycemia	□	□	□	□	□	□	□
Kidney Disease	□	□	□	□	□	□	□
Memory Loss	□	□	□	□	□	□	□
Mental Illness	□	□	□	□	□	□	□
Pneumonia	□	□	□	□	□	□	□
Strep Throat	□	□	□	□	□	□	□
Stroke	□	□	□	□	□	□	□
Thyroid Disorder	□	□	□	□	□	□	□
Tuberculosis	□	□	□	□	□	□	□
Other ____________	□	□	□	□	□	□	□
Other ____________	□	□	□	□	□	□	□
Other ____________	□	□	□	□	□	□	□

Age and cause of parents' death ____

MOTHER'S HEALTH DURING THE PREGNANCY WITH THIS INFANT/CHILD/ADOLESCENT

Check and Describe in the spaces provided

- □ Age
- □ Alcohol Consumption
- □ Bleeding
- □ Drugs
- □ High Blood Pressure
- □ Illness
- □ Medications
- □ Nausea
- □ Other
- □ Smoking
- □ Stress
- □ Toxemia
- □ Trauma/Injury
- □ X-Rays

TERM:

□ Full □ Premature □ Late ____ Birth Weight ____ Birth Length ____

Pregnancy / Birth was: □ Easy □ Difficult ____

Place of Birth: □ Hospital □ Home □ Clinic □ Other _____

FEEDING:

Breast Fed_____ for how long? _____ Formula (type) ________ for how long? _____

Age solid foods began: _______ Which foods____________________________________

Food Intolerances? ____

Favorite Foods____

DIET EATEN YESTERDAY

____

____

MENTAL / EMOTIONAL HEALTH HISTORY

What do you consider strong points in your child's health or life? ____
____
What is a typical day like for your child?
____
____

SOCIAL HISTORY

Parents: □ Married □ Separated □ Divorced
Mother's Occupation ____________________________ □ Full Time □ Part Time
Father's Occupation ____________________________ □ Full Time □ Part Time
Guardian _____________________________________ Relationship ____________________________
Others residing at home _______________________________ Relationship(s) ____________________________
Daycare hours per day, days per week ____
Siblings: Name Age Health Concerns

1. ____
2. ____
3. ____
4. ____
5. ____

REVIEW OF SYSTEMS

Has your child ever suffered from:

□ Acne / Eczema
□ Anxiety
□ Asthma
□ Bed-wetting
□ Bruise Easily
□ Chest Pain
□ Child Abuse
□ Colon Trouble
□ Constipation / Diarrhea
□ Cramps or Backache
□ Deafness
□ Depression
□ Difficult Breathing
□ Difficult Digestion
□ Dizziness
□ Ear Noises
□ Enlarged Thyroid
□ Excessive menstrual Flow
□ Failing Vision
□ Fatigue
□ Food Allergies
□ Foot Trouble
□ Frequent Colds
□ Frequent Urination
□ Gas / Bloating
□ Hay Fever
□ Head Injury
□ Headaches
□ Heart Murmur
□ Heart Pain
□ Hemorrhoids
□ Insomnia
□ Irregular Cycle
□ Irregular Heart-rate
□ Jaundice
□ Learning Disorder
□ Low Back Pain
□ Low Blood Pressure
□ Mercury Fillings (how many?) ___
□ Nausea
□ Neck Pain / Stiffness
□ Nosebleeds
□ Numbness
□ Pleurisy
□ Poor Circulation
□ Poor Posture
□ Rapid Heart-rate
□ Root Canals (how many?) ___
□ Sciatica
□ Scoliosis
□ Sinus Infections
□ Swollen Ankles
□ Swollen Joints
□ Ulcers
□ Varicose Veins
□ Vomiting Spells

Are there any other problems you would like to discuss?
____
____

List any fears your child has:
____

If there is one main thing we could help you with today, what should it be?
____