The Natural Health Medical Clinic Dr John Ruhland – 206-723-4891

PEDIATRIC/ADOLESCENT PATIENT CONFIDENTIAL INFORMATION

Today's Date _____, _____

Name _____ Date of Birth _____ Age ____
Home phone _____ Email Address _____
Address _____ City _____ State ___ Zip _____
Parent A's Name _____ Daytime Phone _____
Parent B's Name _____ Daytime Phone _____
Social Security #_____
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
□ Anti-inflammatory
□ Aspirin/Tylenol
□ Decongestants
□ Laxatives
□ Thyroid
□ Other
_____
_____

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
□ 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

Please identify any family members who have had any of the following:

Abbreviations: Self (Self), Parent A (PA), Parent B (PB), Sibling (Sib), Grandparent (G), Your Children (C)

	Self	PA	PB	Sib	G	C
Smoking	□	□	□	□	□	□
Alcoholism	□	□	□	□	□	□
Allergies	□	□	□	□	□	□
Anemia	□	□	□	□	□	□
Arthritis	□	□	□	□	□	□
Asthma	□	□	□	□	□	□
Birth Defects	□	□	□	□	□	□
Cancer	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□
Ear Infections	□	□	□	□	□	□
Epilepsy/Seizures	□	□	□	□	□	□
Hearing Loss	□	□	□	□	□	□
Heart Disease	□	□	□	□	□	□

	Self	PA	PB	Sib	G	C
High Blood Pressure	□	□	□	□	□	□
Hypoglycemia	□	□	□	□	□	□
Kidney Disease	□	□	□	□	□	□
Memory Loss	□	□	□	□	□	□
Mental Illness	□	□	□	□	□	□
Pneumonia	□	□	□	□	□	□
Strep Throat	□	□	□	□	□	□
Stroke	□	□	□	□	□	□
Thyroid Disorder	□	□	□	□	□	□
Tuberculosis	□	□	□	□	□	□
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

Parent A's Occupation _____ □ Full Time □ Part Time

Parent B'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?

_____