Date: ___________ Sex: M F Age: ________ Birth date: ________________

Patient's Name: ____
First Name Middle Initial Last Name

Address: ______________________________ Phone (Home): ________________

City: ______________________________ State: __________ Zip: ____________

Name of Parent(s): ____

In Case of Emergency: Name: ______________________________ Phone: ________________

What other healthcare is your child currently receiving? ______________________________

______________________________ Date of last Physical Exam: __________

A note to our patients: Naturopathic, holistic and preventative healthcare are only possible when the physician has a complete picture pf the patient mentally, physically and emotionally. Please complete the questionnaire as thoroughly as possible. Thank You.

Present Health Concerns: In your opinion, what are your child's most important health concerns (in order of importance)? Also please indicate the problem that motivated you to bring your child in today.

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

Your Child's Health History: General health is Good Fair Poor

Childhood Illnesses: Mumps Pertussis Measles Rheumatic Fever Chicken Pox Diptheria German Measles Pneumonia Mononucleosis Ear Infections Tonsillitis Other: ______________

Surgeries (Year/Type): ______________________________

Serious Illness or Injury (Year/Cause): ______________________________

Hospitalizations (Year/Reason): ______________________________

Medications: Please list all supplements, prescriptions, and non-prescription drugs and their dosage. (pills, liquids, ointments, suppositories, etc.)

1. ______________________ 5. ______________________
2. ______________________ 6. ______________________
3. ______________________ 7. ______________________
4. ______________________ 8. ______________________

Allergies: (List any allergies and their adverse effects (inhalants, food, drugs, chemicals etc.)

____

Immunizations: (Please give dates and adverse reactions for the following)

DPT ______________ MMR ______________ Polio ______________

TB Test ______________ HIB ______________ Hep B ______________

______________ Other ______________________________

Review of Systems: Please C. -For a condition the child has now P-A con... the child had in the past. N-Never had

Weight:	______			Cradle Cap	Y	P	N	High Fever:	Y	P	N
Height:	______			Depression:	Y	P	N	Hyperactivity:	Y	P	N
Acne:	Y	P	N	Diarrhea:	Y	P	N	Insomnia:	Y	P	N
Allergies:	Y	P	N	Ear Aches:	Y	P	N	Jaundice:	Y	P	N
Anemia:	Y	P	N	Eczema:	Y	P	N	Learning Disorder:	Y	P	N
Asthma:	Y	P	N	Epilepsy/Seizures:	Y	P	N	Moodiness:	Y	P	N
Bed Wetting:	Y	P	N	Fatigue:	Y	P	N	Stuffy Nose:	Y	P	N
Birth Defects:	Y	P	N	Frequent Infections:	Y	P	N	Thrush:	Y	P	N
Colic:	Y	P	N	Frequent Colds:	Y	P	N	Vomiting Spells:	Y	P	N
Constipation:	Y	P	N	Headaches:	Y	P	N	Other: ______			
Cough/Wheeze:	Y	P	N	Heart Murmur:	Y	P	N	______			

Prenatal/Birth/Feeding History: **Mother's health during pregnancy: Age:** ______ **Bleeding:** Y N

Nausea: Y N **Illness:** Y N **Toxemia:** Y N **Trauma/Injury:** Y N **Stress:** Y N **High Blood Pressure:** Y N

X-Rays: Y N **Medications:** Y N **Alcohol Consumption:** Y N **Drugs:** Y N **Smoking:** Y N

Other: ______

Term: Full Premature Late **Birth Weight:** ______ **Pregnancy was:** Easy Difficult

Place of Birth: Hospital ______ Clinic ______ Home or Other ______

Feeding: Brest Fed: Y N **How Long?** ______ **Formula Fed:** Y N **What Type?** ______

Age solid foods begun? ______ **What Kinds of Foods?** ______

Food Allergy/Intolerance: ______

Favorite Foods: ______

Social History: **Parents:** Married Separated Divorced

Mother's Occupation: ______ Full time Part time

Father's Occupation: ______ Full time Part time

Other Guardian: ______ Relationship: ______

Others Residing in Home: ______ Relationship: ______

Daycare: ______ At what ages: ______ Hrs. per day ______ Days per week: ______

Preschool: ______ At what ages: ______ Hrs. per day ______ Days per week: ______

School: ______ At what age: ______ Hrs. per day ______ Days per week: ______

Siblings:	Name	Sex	Age	Health Concerns
1				
2				
3				
4				

Interaction with relatives: Who? ______

How often? ______

Do you have any other health concerns you would like to discuss? ______

______

______

Diet: Any diet restriction regimen? ______________________________

____

Is your child satisfied with their diet as it is now? Y N Do they eat three meals daily? Y N

Do they crave Starches: Y N Sweets: Y N Salt: Y N Fats: Y N

Please write down two samples of each meal that your child eats nearly everyday. Include what they drink with their meals, desserts and snacks:

Breakfast: 1. ______________ 2. ______________

Morning Snack: 1. ______________ 2. ______________

Lunch: 1. ______________ 2. ______________

Afternoon Snack: 1. ______________ 2. ______________

Dinner: 1. ______________ 2. ______________

Late Snack/Dessert: 1. ______________ 2. ______________

What type of water do they drink: Tap Filtered Distilled Well How many glasses per day? ____

Do they drink soft drinks? Y N How many per day/week? _______ Other beverages ____________

____________ Do they salt your food? Y N If so, how much? Light Moderate Heavy

Do they use artificial sweeteners? Y N What kind? ____________ How much? ________

Describe their appetite in the: Morning ____________ Noon ____________ Evening ____________

Sleep: Do they sleep well? Y N Wake Rested? Y N Average Hours of Sleep (per 24 Hrs.) ______

Exercise: Do they Exercise Regularly? Y N What Type? ______________________

______________ How Long? ______________ How Often? ______________

Family History:	Father	Mother	Brothers	Sisters
Age (If Living)				
Heath G-Good, P-Poor				
Age (At Death)				
Cause of Death				

Please identify known conditions within your family and list the family member's relationship to the child:

Cancer: Y N ______________

Diabetes: Y N ______________

Stroke: Y N ______________

Hives: Y N ______________

Asthma: Y N ______________

Hay Fever: Y N ______________

Alcoholism: Y N ______________

Mental Illness: Y N ______________

Heart Disease: Y N ______________

Glaucoma: Y N ______________

Kidney Disease: Y N ______________

Tuberculosis: Y N ______________

Physical Abuse: Y N ______________

Emotional Abuse: Y N ______________

High Blood Pressure: Y N ______________ Other: ______________

Does the child have any of the above? Y N If yes, please list: ______________________

____