



Marcus Porrino, ND  
Rebecca H. Porrino, ND  
710 West Napa Street, Suite 1  
Sonoma, CA 94576  
707-996-9355

### Pediatric Patient Health History Six Years of Age to Adolescence

Name: \_\_\_\_\_  
*Last First M.I.*

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:(circle one) F M

S.S.#: \_\_\_\_\_

Name and address of Dr's office/hospital/clinic where your child's health records are kept:

\_\_\_\_\_  
*Office/Hospital/Clinic Name Street/ P.O. Box*

\_\_\_\_\_  
*City State Zip Code*

Parent or Guardian: \_\_\_\_\_  
*Father Mother Guardian*

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: Please circle the preferred number to contact you:

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

E-mail: \_\_\_\_\_ S.S.#: \_\_\_\_\_

How did you find out about our clinic? \_\_\_\_\_

#### ALL RESPONSES WILL BE KEPT CONFIDENTIAL

What are your child's most important health problems? List in order of importance:

1) \_\_\_\_\_ 3) \_\_\_\_\_

2) \_\_\_\_\_ 4) \_\_\_\_\_

#### MEDICATIONS

**Now = medications currently being taken. Past =medications taken at one time or another**

	<b>Now</b>	<b>Past</b>		<b>Now</b>	<b>Past</b>
<i>Aspirin</i>	_____	_____	<i>Asthma Medications</i>	_____	_____
09/03/08					



Marcus Porrino, ND  
 Rebecca H. Porrino, ND  
 710 West Napa Street, Suite 1  
 Sonoma, CA 94576  
 707-996-9355

*Ibuprofen* \_\_\_\_\_ *Decongestants* \_\_\_\_\_  
*Inhalers* \_\_\_\_\_ *Topical Steroids* \_\_\_\_\_  
*Antibiotics* \_\_\_\_\_ *Other* \_\_\_\_\_  
*Anti-histamine* \_\_\_\_\_ \_\_\_\_\_

**MEDICAL HISTORY**

Does your child have any **allergies** to foods, drugs or other allergens in your environment (cats, mold, dust)? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, list ALL and explain.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Has your child ever had: (Check those that are applicable)**

\_\_\_\_\_ *Chicken pox*    \_\_\_\_\_ *Scarlet fever*    \_\_\_\_\_ *Bronchitis*    \_\_\_\_\_ *Asthma*  
 \_\_\_\_\_ *Measles*    \_\_\_\_\_ *Pneumonia*    \_\_\_\_\_ *Rubella*    \_\_\_\_\_ *Mumps*  
 \_\_\_\_\_ *Frequent Colds*    \_\_\_\_\_ *Eczema*    \_\_\_\_\_ *Croup*    \_\_\_\_\_ *Other* \_\_\_\_\_  
 \_\_\_\_\_ *Tonsillitis-How many times?*    \_\_\_\_\_ *Ear infections-How many?* \_\_\_\_\_

**X-RAYS AND SPECIAL STUDIES**

	When	Where	Results
_____ <i>Electroencephalogram:</i>			_____
_____ <i>Psychological Evaluation:</i>			_____
_____ <i>Hearing:</i>			_____
_____ <i>Speech/Language:</i>			_____

**INJURIES/SURGERIES/HOSPITALIZATIONS**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**IMMUNIZATIONS (Y or N)**

\_\_\_\_\_ *Measles*    \_\_\_\_\_ *Polio*    \_\_\_\_\_ *MMR*    \_\_\_\_\_ *Small Pox*    \_\_\_\_\_ *Hep B*  
 \_\_\_\_\_ *Mumps*    \_\_\_\_\_ *DPT*    \_\_\_\_\_ *Tetanus*    \_\_\_\_\_ *Influenza*    \_\_\_\_\_ *Other* \_\_\_\_\_

**Any adverse reactions to immunizations? (Please specify)**

\_\_\_\_\_  
 \_\_\_\_\_

**SYMPTOMS**

**Please circle:**    **Y=a condition your child has now**    **N=never had**    **P=has had in the past**

<i>Hives</i>	Y P N	<i>Burning of urine</i>	Y P N	<i>Bloody urine</i>	Y P N
<i>Eczema</i>	Y P N	<i>Frequent urination</i>	Y P N	<i>Cries easily</i>	Y P N
<i>Bleeding gums</i>	Y P N	<i>Heart Murmur</i>	Y P N	<i>Nervous</i>	Y P N
<i>Nose bleeds</i>	Y P N	<i>Vomiting spells</i>	Y P N	<i>Sleep problems</i>	Y P N
<i>Acne</i>	Y P N	<i>Anemia</i>	Y P N	<i>Night sweats</i>	Y P N
<i>High fever</i>	Y P N	<i>Stomach aches</i>	Y P N	<i>Sensitive to light</i>	Y P N



Marcus Porrino, ND  
 Rebecca H. Porrino, ND  
 710 West Napa Street, Suite 1  
 Sonoma, CA 94576  
 707-996-9355

<i>Chronic rash</i>	<i>Y P N</i>	<i>Jaundice</i>	<i>Y P N</i>	<i>Body/Breath odor</i>	<i>Y P N</i>
<i>Hearing loss</i>	<i>Y P N</i>	<i>Easy bruising</i>	<i>Y P N</i>	<i>motion/car sick</i>	<i>Y P N</i>
<i>Diarrhea</i>	<i>Y P N</i>	<i>Flat feet</i>	<i>Y P N</i>	<i>No appetite</i>	<i>Y P N</i>
<i>Sore throats</i>	<i>Y P N</i>	<i>Constipation</i>	<i>Y P N</i>	<i>Nightmares</i>	<i>Y P N</i>
<i>Gas</i>	<i>Y P N</i>	<i>Canker sores</i>	<i>Y P N</i>	<i>Wheezing</i>	<i>Y P N</i>
<i>Joint pains</i>	<i>Y P N</i>	<i>Cough</i>	<i>Y P N</i>	<i>Dizzy spells</i>	<i>Y P N</i>
<i>Hair loss</i>	<i>Y P N</i>	<i>Frequent Headaches</i>	<i>Y P N</i>	<i>Frequent colds</i>	<i>Y P N</i>
<i>Unusual fears</i>	<i>Y P N</i>	<i>Bleeding tendency</i>	<i>Y P N</i>	<i>Excessive fatigue</i>	<i>Y P N</i>

**Does your child have any other condition not mentioned?** \_\_\_\_\_

**DIET**

**Please describe your child's typical daily diet:** \_\_\_\_\_

**Does your child have any food intolerances that you know of? Yes \_\_\_\_\_ No \_\_\_\_\_**

**If yes, please explain:** \_\_\_\_\_

**FAMILY HISTORY (Y or N)**

\_\_\_\_\_ *Heart Disease*      \_\_\_\_\_ *Diabetes*      \_\_\_\_\_ *Birth defects*      \_\_\_\_\_ *Cancer*      \_\_\_\_\_ *Mental Illness*  
 \_\_\_\_\_ *Hypertension*      \_\_\_\_\_ *Arthritis*      \_\_\_\_\_ *Tuberculosis*      \_\_\_\_\_ *Allergies*      \_\_\_\_\_ *Hay fever*  
 \_\_\_\_\_ *Eczema*      \_\_\_\_\_ *Other (please explain)* \_\_\_\_\_

**BIRTH HISTORY**

**Previous Pregnancies by natural mother, miscarriages or complications:** \_\_\_\_\_

**Mother's age at child's birth:** \_\_\_\_\_

**Mother's health during pregnancy:**

\_\_\_\_\_ *Bleeding*      \_\_\_\_\_ *Hypertension*      \_\_\_\_\_ *Illness*  
 \_\_\_\_\_ *Nausea*      \_\_\_\_\_ *Diabetes*      \_\_\_\_\_ *Thyroid Problems*  
 \_\_\_\_\_ *Physical or emotional trauma*      \_\_\_\_\_ *Cigarettes, alcohol, drugs*

**Term:**

\_\_\_\_\_ *Full term (40 wks)*      \_\_\_\_\_ *Premature*      \_\_\_\_\_ *Late*      \_\_\_\_\_ *Length of labor*

*Complications of labor?* No \_\_\_\_\_ Yes \_\_\_\_\_

*Weight at Birth* \_\_\_\_\_ *Length* \_\_\_\_\_ *Head* \_\_\_\_\_



Marcus Porrino, ND  
Rebecca H. Porrino, ND  
710 West Napa Street, Suite 1  
Sonoma, CA 94576  
707-996-9355

Are there any cultural or religious practices we should be aware of when providing healthcare to you? \_\_\_\_\_  
\_\_\_\_\_

Is there any information about your health you would like to add:  
\_\_\_\_\_  
\_\_\_\_\_

**Please fax or mail this intake form or bring it on your first visit::**

Sonoma Naturopathic Medicine  
710 West Napa Ave, Suite 1  
Sonoma, CA 95476

FAX(707) 996-9356