SONOMA NATUROPATHIC MEDICINE

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PEDIATRIC PATIENT HEALTH HISTORY
BIRTH TO FIVE YEARS OF AGE

Name: _____
Last *First* *M.I.*

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

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*

Name of responsible party: _____ SS#: _____

Relationship to patient: _____ Phone #: _____

Address: _____

City:_____ State: _____Zip Code:_____

Telephone: Please ***circle the preferred number*** to contact you below:

Home #:_____Work #:_____Cell #:_____

How did you hear about our clinic? _____

☐ Yes, please send us the quarterly newsletter: Email : _____

Naturopathic healthcare is most effective when the doctor completely understands the patient's physical, mental, and emotional concerns and conditions. The information you provide helps me understand your child's needs. Your time, honesty, and thoughtfulness is appreciated. Feel free to mark anything you may have a question about.

What are your child's most important health concerns? If none, please write "well child care"

1) _____ 3) _____

2) _____ 4) _____

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MEDICATIONS

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

	Now	Past		Now	Past
Aspirin	____	____	*Asthma Medications*	____	____
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 and explain. _____
_____
_____

HAS YOU CHILD EVER HAD: (Check those that apply)

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

X-RAYS AND SPECIAL STUDIES

	When	Where	Results
Electroencephalogram (EEG)			
____ *Psychological Evaluation:*			
____*Hearing:*			
____*Speech/Language:*			

INJURIES/SURGERIES/HOSPITALIZATIONS

_____
_____
_____

IMMUNIZATIONS RECIEVED please check all that apply

_____*Measles* ____*Polio* _____*MMR* _____*Small Pox* ____*Hep B*
____*Mumps* ____*DPT* _____*Tetanus* _____*Influenza* ____*Other*_____

Any adverse reactions to immunizations? (Please specify)

_____
_____

As a baby, did/does your child have any of the following problems?

_____*Jaundice* ____*Diarrhea* ____*Birth defects* ____*Rashes*

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____*Colic*	____*Fever*	____*Cerebral palsy*	____*Allergies*
____*Blue baby*	____*Seizures*	____*Birth injuries*	____*Other*_____

Feeding: ____*Breast fed* _____*How long?* _____*Formula: Milk or Soy*

Age Began: _____*Solid foods* _____*Sitting* _____*Crawling*
_____*Walking* _____*First words*

For those over 1 yo., what were your child's sleep patterns the first year? ____
_____

SYMPTOMS

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

Hives	Y P N	*Burning of urine*	Y P N	*Bloody urine*	Y P N
Eczema	Y P N	*Frequent urination*	Y P N	*Cries easily*	Y P N
Bleeding gums	Y P N	*Heart Murmur*	Y P N	*Nervous*	Y P N
Nose bleeds	Y P N	*Vomiting spells*	Y P N	*Sleep problems*	Y P N
Acne	Y P N	*Anemia*	Y P N	*Night sweats*	Y P N
High fever	Y P N	*Stomach aches*	Y P N	*Sensitive to light*	Y P N
Chronic rash	Y P N	*Jaundice*	Y P N	*Body/Breath odor*	Y P N
Hearing loss	Y P N	*Easy bruising*	Y P N	*motion/car sick*	Y P N
Diarrhea	Y P N	*Flat feet*	Y P N	*No appetite*	Y P N
Sore throats	Y P N	*Constipation*	Y P N	*Nightmares*	Y P N
Gas	Y P N	*Canker sores*	Y P N	*Wheezing*	Y P N
Joint pains	Y P N	*Cough*	Y P N	*Dizzy spells*	Y P N
Hair loss	Y P N	*Frequent Headaches*	Y P N	*Frequent colds*	Y P N
Unusual fears	Y P N	*Bleeding tendency*	Y P N	*Excessive fatigue*	Y P N

Does your child have any other condition not mentioned? _____
_____

DIET

Please briefly describe your child's typical daily diet: _____
_____

Does your child have any food intolerance's that you know of? Yes _____ No _____
If yes, please explain: _____
_____

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FAMILY HISTORY

_____*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* ____*Cigarettes, alcohol, drugs*
____*Nausea* ____*Diabetes* ____*Thyroid Problems*
____*Physical or emotional trauma*

Delivery/Term:

____*Full* ____*Premature* ____*Late*
____*Length of labor* *Complications?* _____*Yes* _____*No*

_____*Weight at Birth* _____ *Length* _____*Head*

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:

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