



Patient Name: _____ DOB: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Sex (M/F): _____ Grade of School: _____ Nickname: _____

Mother's Name and
Occupation: _____

Father's Name and
Occupation: _____

Parents are (circle): Married Separated Divorced Living Together Other:

Reason for Office Visit: _____

Has child been seen by any other doctor(s) for this complaint? Yes No Past

Regular Pediatrician name & phone number:

Last time any blood work was done and with what physician:

List ALL Surgeries & Hospitalizations, including date occurred:

1) _____ 3) _____

2) _____ 4) _____

List ALL medicines (from drugstore or prescription) child is currently taking:

1) _____ 3) _____

2) _____ 4) _____

List ALL Supplements the child is currently taking:

1) _____ 3) _____

2) _____ 4) _____

Any known Allergies to foods, drugs, environment, animals: _____

Previous Medical History

YES (Y) indicates the child gets the problem regularly

NO (N) indicates the child never had the problem

Past (P) indicates the child had the problem in the past, but not recently

Please circle the correct answer for your child

Ear infections Y N P If has had, how many times? _____

Colds Y N P If has had, how many times? _____

Strep throat Y N P If has had, how many times? _____

How many times has the child taken antibiotics? _____

What other medicines has the child taken and how often?

1) _____ 3) _____

2) _____ 4) _____

Hearing test Normal Y N Not tested

Vision test Normal Y N Not tested

Speech Impediments Y N Past

Learning Impediments Y N Past

Vaccination History

YES (Y) – has had NO (N) – has not had SOME – did not finish all shots

MMR : Y N Some DPT: Y N Some Hep B: Y N Some

Hib : Y N Some Chicken pox: Y N Some Polio: Y N Some

Other: _____

Any reactions to vaccinations? If yes, please explain _____

Family History

Condition	Mother	Father	Mother's Mom	Mother's Dad	Father's Mother	Father's Father	Sibling
Allergies							
Cancer							
Diabetes							
GI Disease							
Heart Disease							
Kidney disease							
Lung disease							
Mental Illness							
Tuberculosis							
Vision / Hearing Impaired							

Mothers Pregnancy History

Age at conception: _____ Is this the first child? _____
 Due date: _____ When did you start seeing the doctor? _____

Mothers Health During Pregnancy

During Pregnancy did you:

Have High Blood Pressure?	Y	N	Have gestational diabetes?	Y	N
Take any medicines?	Y	N	Smoke cigarettes?	Y	N
Drink alcohol?	Y	N	Use other drugs?	Y	N
Nausea / Vomiting?	Y	N	Emotional stress?	Y	N
Drink coffee?	Y	N	Was child premature?	Y	N
Was baby breech?	Y	N	Was it cesarean delivery	Y	N

If the birth was difficult, please explain: _____

What is Mother's blood type? _____ What is child's blood type? _____

Place of Child's birth: _____

Name of OB/Midwife/Doula: _____



Health of baby at birth:

NATUROPATHIC VITALITY

Health history of child

Baby's birth weight _____ Baby's birth length _____ Head circum _____

Did baby breathe / cry immediately? Y N

Was baby jaundiced at birth? Y N

Was PKU testing done at birth? Y N

Child breastfed: Y N If so, how long? _____

Formula: Y N At what age? _____

Kind used: _____

When was child put on solid foods: _____

Any problems/Allergies/Sensitivities: _____

Jaundice as baby:	Y N	Colic:	Y N
Cradle Cap:	Y N	Anemia:	Y N
Eczema or Psoriasis:	Y N	Asthma:	Y N
Diarrhea:	Y N	Warts:	Y N
Constipation:	Y N	Nightmares:	Y N
Finicky Eating:	Y N	Bed-wetting:	Y N
Poor Teeth:	Y N	Tantrums:	Y N
Chronic Sniffles:	Y N	Disobedient:	Y N
Bad Foot Odor:	Y N	Fears/Phobia:	Y N
Very Sweaty Baby/Child:	Y N	Diaper Rash:	Y N
Hyperactivity:	Y N	Early Puberty:	Y N
Growing Pains:	Y N	Stomach Aches:	Y N

Has the child experienced, witnessed or gone through, any household stressors?

Social Development History

Mother's age _____ Father's age _____
 Child has how many sisters? _____ Brothers? _____
 Child is _____ in the family. (oldest, middle, youngest)
 Other children's ages ____ / ____ / ____ / ____ / ____ / ____
 Who spends the most time caring for child? _____
 Does child go to daycare/babysitter/preschool on a regular basis? Y N
 Are there any pets in the home? Y N How many? ____ Type? _____
 Any smokers in the home? Y N
 At what age did the child:
 Sit up? _____ Crawl? _____ Walk? _____ Start talking? _____

Concerns / Problems

Does your baby/child have any on-going problem(s) that concern you?
 Please check all that apply.

- | | | |
|--|------------------------------|-------------------|
| Eats too little | Eats too much | Speaks unclearly |
| Cries a lot | Has frequent temper tantrums | Wets bed |
| Difficulty sleeping | Frequently constipated | Small for age |
| School problems | Behavior problems | Sees poorly |
| Doesn't always respond to noise / spoken words | | Runny noses/cough |

Are there any other problems / concerns? _____

Typical Day's Diet

Breakfast:

Lunch:

Dinner:



Snacks:

Toxin Exposure

Has the child ever lived near a refinery, polluted area or in a home with leaded paint? If so, what was the child exposed to? _____

Has the child ever lived in a house that had new carpeting, paint, cabinets or any other refurbishing that seemed to affect their health at all? _____

Does the child seem particularly sensitive to perfumes, gasoline or other vapors?

Do you spray pesticides, herbicides or other chemicals around your home?

How did you hear about our office? _____

Signature of Parent/Legal Guardian: _____

Print Name: _____

Today's Date: _____