

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 | ☐ Decongestants | ☐ Other |
| ☐ Anti-inflammatory | ☐ Laxatives | _____ |
| ☐ Aspirin/Tylenol | ☐ Thyroid | _____ |

Check if your child eats, drinks or uses:

- | | | |
|--|---|---|
| ☐ Alcohol | ☐ Eat at fast food restaurants regularly | ☐ Special Diet (be specific) |
| ☐ Artificial Sweeteners | ☐ Filtered Water | _____ |
| ☐ Candy | ☐ Fluoridated Water | _____ |
| ☐ Carbonated Beverages | ☐ Fried Foods | ☐ Sugar Products |
| ☐ Chlorinated Water | ☐ Luncheon Meats | |
| ☐ Dairy Products | ☐ Margarine | |

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		Self	PA	PB	Sib	G	C
Smoking	☐	☐	☐	☐	☐	☐	High Blood Pressure	☐	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐	☐	Hypoglycemia	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	Kidney Disease	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	Memory Loss	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	Mental Illness	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	Pneumonia	☐	☐	☐	☐	☐	☐
Birth Defects	☐	☐	☐	☐	☐	☐	Strep Throat	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	Stroke	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	Thyroid Disorder	☐	☐	☐	☐	☐	☐
Ear Infections	☐	☐	☐	☐	☐	☐	Tuberculosis	☐	☐	☐	☐	☐	☐
Epilepsy/Seizures	☐	☐	☐	☐	☐	☐							
Hearing Loss	☐	☐	☐	☐	☐	☐	Other _____	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	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 | ☐ High Blood Pressure | ☐ Other | ☐ Trauma/Injury |
| ☐ Alcohol Consumption | ☐ Illness | ☐ Smoking | ☐ X-Rays |
| ☐ Bleeding | ☐ Medications | ☐ Stress | |
| ☐ Drugs | ☐ Nausea | ☐ Toxemia | |

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 | ☐ Ear Noises | ☐ Heart Pain | ☐ Pleurisy |
| ☐ Anxiety | ☐ Enlarged Thyroid | ☐ Hemorrhoids | ☐ Poor Circulation |
| ☐ Asthma | ☐ Excessive menstrual Flow | ☐ Insomnia | ☐ Poor Posture |
| ☐ Bed-wetting | ☐ Failing Vision | ☐ Irregular Cycle | ☐ Rapid Heart-rate |
| ☐ Bruise Easily | ☐ Fatigue | ☐ Irregular Heart-rate | ☐ Root Canals |
| ☐ Chest Pain | ☐ Food Allergies | ☐ Jaundice | (how many?) ____ |
| ☐ Child Abuse | ☐ Foot Trouble | ☐ Learning Disorder | ☐ Sciatica |
| ☐ Colon Trouble | ☐ Frequent Colds | ☐ Low Back Pain | ☐ Scoliosis |
| ☐ Constipation / Diarrhea | ☐ Frequent Urination | ☐ Low Blood Pressure | ☐ Sinus Infections |
| ☐ Cramps or Backache | ☐ Gas / Bloating | ☐ Mercury Fillings | ☐ Swollen Ankles |
| ☐ Deafness | ☐ Hay Fever | (how many?) ____ | ☐ Swollen Joints |
| ☐ Depression | ☐ Head Injury | ☐ Nausea | ☐ Ulcers |
| ☐ Difficult Breathing | ☐ Headaches | ☐ Neck Pain/Stiffness | ☐ Varicose Veins |
| ☐ Difficult Digestion | ☐ Heart Murmur | ☐ Nosebleeds | ☐ Vomiting Spells |
| ☐ Dizziness | | ☐ Numbness | |

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?
