

PATIENT INFORMATION

CONFIDENTIAL

Thank you for the opportunity to serve you. If you have any questions, do not hesitate to ask. We will be happy to help.

Name _____ Date ____/____/____ S/S ____-____-____

First MI Last

Birth Date ____/____/____ Current: Height _____ Weight _____ Sex: Female Male

Parent/Guardian Name _____ Phone _____

Address _____ City _____ State ____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Who may we thank for referring you to us? _____

HEALTH HISTORY

Does your child currently have or have they previously had any of the following symptoms:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Light Sensitivity to Eyes | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Ringing/ Buzzing in Ears | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Upset Stomach | <input type="checkbox"/> Neck Stiffness |
| <input type="checkbox"/> Excessive Spitting up | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Constipation | <input type="checkbox"/> Mid Back Pain |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Low Back Pain |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fever | <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> Arm Pain |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Fainting | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Leg Pain |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Cold Hands |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Allergies | <input type="checkbox"/> Cold Feet |

Chief Health Concerns:

List other types of Care undergone for this complaint (including medications): _____

Date of onset: _____ Onset was: Sudden Gradual Associated with an event

Duration of problem (episode): _____ How often do you notice the symptoms? Constantly Frequently Occasionally

Does anything alleviate the symptoms? _____ Is the condition getting worse? No Yes

Effects of problems on body function and daily activities: _____

Was there an injury or fall? No Yes, Describe _____

Have you had x-rays before? No Yes, When? _____ What areas? _____

List any other concerns: _____

History of Birth:

Hospital Birthing Center Home Midwife Birth Weight: _____ Duration of Gestation: _____ weeks

Was the birth assisted? No Yes, if Yes: forceps vacuum c-section induced labor

Evidence of Birth Trauma? (i.e., bruises, odd shaped head, stuck in birth canal, fast or excessively long labor, respiratory depression, cord around neck) _____

Medication delivered to mother at birth? No Yes, what? _____

Duration of labor: _____ Complications at birth: No Yes, explain: _____

Growth and Development:

Was the infant alert and responsive within twelve hours of delivery? No Yes If No, Explain: _____

At what age did the child: Hold head up: _____ Sit alone: _____ Crawl: _____ Walk: _____

Do your child's sleeping patterns seem normal to you: Yes No, _____

Chemical Stressors:

Was (is) the baby breast-fed? Yes, for how long? _____ No, explain reason _____

Formula introduced at age: _____ Type of formula used: _____

Cow's milk introduced at age: _____ Began solid food at age: _____ Type: _____

Food/Juice intolerance: No Yes, type: _____

During pregnancy did the mother: Smoke? No Yes Drink Alcohol? No Yes

Supplements taken during pregnancy: _____ None

Drugs taken during pregnancy: _____ None

Any other complications during pregnancy: _____ None

Has your child received vaccinations: No Yes, which ones and reactions _____

Has your child received antibiotics: No Yes, Total courses of antibiotics to date _____

Current medications and reasons: _____ None

Surgical History: _____ None

DATE: ____/____/____ PARENT/ GUARDIAN Signature: _____