Child's Name _____ Age___ Birth Date_____❑ F ❑ M Blood Type _____
# of Siblings _____ Names & Ages_____

List Child's Current Health Problems
Prioritize by listing the problems in order of importance.
1. _____ 3. _____
2. _____ 4. _____

Complete the following section for your top 3 problems (Check the bold descriptors that apply):

Problem #1: _____ Date of Onset: _____

Describe: _____

_____

Cause: _____❑ **Constant? or** ❑ **Intermittent?**

❑ **Worsening** or ❑ **Improving**? Why? _____

_____

Rx / Surgery / Treatments tried & the results: _____

_____

Associated personal and/or family history: _____

_____

How does problem #1 effect your child's body / their life?: _____

_____

Office Use Only _____
_____
_____

Problem #2: _____ Date of Onset: _____

Describe: _____

_____

Cause: _____❑ **Constant? or** ❑ **Intermittent?**

❑ **Worsening** or ❑ **Improving**? Why? _____

_____

Rx / Surgery / Treatments tried & the results: _____

_____

Associated personal and/or family history: _____

_____

How does problem #2 effect your child's body / their life?: _____

_____

Office Use Only _____

_____

_____

Problem #3: _____ Date of Onset: _____

Describe: _____

_____

Cause: _____ ❑ **Constant? or** ❑ **Intermittent?**

❑ **Worsening** or ❑ **Improving**? Why? _____

_____

Rx / Surgery / Treatments tried & the results: _____

_____

Associated personal and/or family history: _____

_____

How does problem #3 effect your child's body / their life?: _____

_____

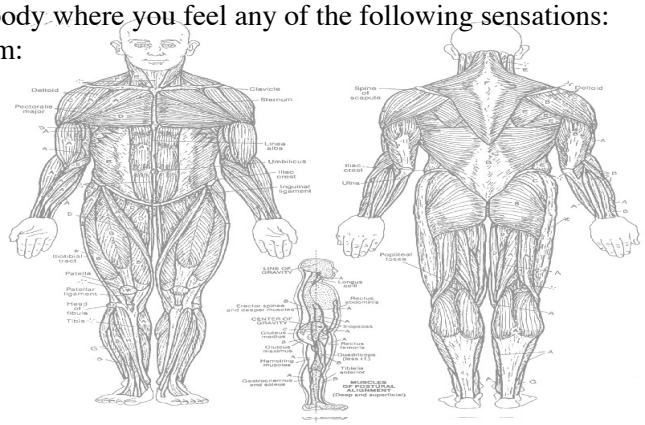
Office Use Only _____

_____

_____

Use diagram to illustrate the areas on your body where you feel any of the following sensations:
Use the following letters to mark the diagram:

A = Numbness
B = Deep Aching
C = Burning
D = Stabbing
E = Pins & Needles
F = Throbbing
G = Itching



General Information

Has your child seen a naturopathic doctor before? ❑ No ❑ Yes
Are they currently seeing one? ❑ No ❑ Yes Doctor's name: _____
Does your child have a medical doctor? ❑ No ❑ Yes Doctor's name: _____
Have you seen a chiropractic doctor before? ❑ No ❑ Yes
Are you currently seeing one? ❑ No ❑ Yes Doctor's name: _____

Does your child see any other healthcare professional (i.e. acupuncturist, massage therapist, counselor)? ❑No❑Yes
Explain: _____
What are the most significant measures that you have taken to improve your child's health? _____
_____
_____

Medications/ Nutritional Supplements

List prescribed meds current and past: _____
List all "over the counter" RX & supplements used: _____
Allergies to medications: _____

Review of Child's Body Systems

Please **check** all the problems your child currently has:

Constitutional	**Gastrointestinal**	**Integumentary/Skin**
Good general health ❑	Nausea/vomiting ❑	Abnormal nails ❑
Recent weight change ❑	Abdominal pain/stomach aches ❑	Rashes or itching ❑
Night sweats, fevers ❑	Rectal bleeding ❑	Acne ❑
Fatigue/weakness ❑	No appetite ❑	Dry/discolored Skin ❑
Developmental disorders ❑	Constipation/diarrhea ❑	Body odor ❑
Ears / Nose / Mouth / Throat	**Musculoskeletal**	**Allergic / Immunologic**
Hearing loss or ringing ❑	Muscle pain or cramps ❑	Food allergies ❑
Sinus problems ❑	Stiffness/swelling joints ❑	Frequent infections/colds ❑
Nose bleeds/bleeding gums ❑	Joint pain ❑	Hay fever ❑
Sore throat/voice change ❑	Trouble walking/flat feet ❑	
Canker/cold sores ❑	Growth/bone disorders ❑	
Eyes	**Neurological**	**Genitourinary**
Wear glasses/contacts ❑	Frequent headaches ❑	Blood in urine ❑
Blurred/double vision ❑	Paralysis or tremors ❑	Pain/burning on urination ❑
Eye disease or injury ❑	Convulsions/seizures ❑	Frequent urination ❑
Eye pain/dryness ❑	Numbness/tingling ❑	Kidney disease ❑
	Motion/car sickness ❑	
Cardiovascular	**Hematologic / Lymphatic**	**Genitourinary – Continued**
Chest pain ❑	Anemia ❑	Bed wetting ❑
Palpitations ❑	Bruise easily ❑	Testicle/ovary pain ❑
Heart trouble ❑	Slow to heal ❑	Menstrual problems ❑
Swelling hands/feet ❑	Enlarged glands ❑	
Lightheaded/dizzy/faints ❑		
Respiratory	**Endocrine**	**Psychiatric**
Shortness of breath ❑	Excessive Thirst/urination ❑	Insomnia/nightmares ❑
Cough ❑	Hair loss ❑	Confusion/memory loss ❑
Wheezing/Asthma ❑	Cold hands/feet ❑	Depression/fears/cries easily ❑
Bad breath ❑	Hormone problems ❑	Anxiety/panic attacks ❑
	Light sensitivity ❑	

Medical History **Check** if your child has had any of the following (**Circle** if it has occurred in the past year):

❑ Chicken pox	❑ Scarlet Fever	❑ Tonsillitis - # of times _____
❑ Measles	❑ Pneumonia	❑ Ear Infections - # of times _____
❑ Mumps	❑ Tuberculosis (TB)	❑ Ear Infections - # of times _____
❑ Hepatitis	❑ High Fevers	
❑ Rheumatic Fever	❑ Other:	

Has your child ever had any of the following tests?

	When:	Where:	Results:
EKG	_____	_____	_____
EEG	_____	_____	_____
Psychological Eval	_____	_____	_____
Hearing test	_____	_____	_____
Speech test	_____	_____	_____

Vaccinations

❑ Measles	❑ Polio	❑ MMR	❑ Diphtheria
❑ Mumps	❑ DPT	❑ Tetanus	❑ Hepatitis
❑ Influenza	❑ Other (list): _____		

Diet (Current) Please describe your child's typical diet (Circle foods that are craved/excessively consumed):
_____

Any reactions to food? (Describe): _____

Personal | Family History (❑ Unknown - Adopted)

Please check and name who was affected (Self, Mother, Father, Grandparents, Sisters, Brothers, Children)

❑ AIDS/HIV _____
❑ Alcoholism _____
❑ Allergies _____
❑ Anemia _____
❑ Arthritis _____
❑ Asthma _____
❑ Cancer _____
❑ Depression _____
❑ Diabetes _____
❑ Drug Problems _____
❑ Eczema _____
❑ Gout _____
❑ Heart disease _____
❑ High blood pressure _____
_____
❑ Hypoglycemia _____
❑ Kidney disorder _____
❑ Mental illness _____
❑ Migraines _____
❑ Obesity _____
❑ Psoriasis _____
❑ Senility _____
❑ Sex abuse _____
❑ Seizures _____
❑ Stroke _____
❑ Suicide _____
❑ TB _____
❑ Thyroid problems _____
❑ Ulcer _____
❑ Other _____

Menstrual/Reproductive History (Females only)

Age period began? ___ Date of last period: _____Regular periods? ❑ No ❑ Sometimes ❑ Yes

Periods every days___(length of entire cycle) Flow: ❑Heavy ❑Medium ❑Light Duration: ____days

Spotting? ❑ No❑ Yes Midcycle: ❑ No❑ Yes Instead of period? ❑ No ❑ Yes Bloating? ❑No ❑Yes

Cyclical premenstrual weight gain: ❑No ❑Yes How much?____lbs.

Cramps? ❑No ❑Yes Duration:___days Intensity: ❑Mild ❑Moderate ❑Severe

PMS? ❑No ❑Yes Describe: _____

Birth History

Check if **mother** had any of the following problems during pregnancy. Mother's age at child's birth?

❑ Bleeding	❑ Illnesses	❑ Excessive weight	❑ Physical/emotional trauma
❑ Nausea	❑ Diabetes	❑ Thyroid problems	❑ Hypertension
❑ Cigarettes, alcohol, drug consumption (describe): _____			

❑ Medications (list):

Pregnancy:
Term: ❑ Full ❑ Premature ❑ Late In Weeks_____ Weight at birth ____lbs ____oz
Length of labor: ____hours Complications? _____

Check if your child had any of the following problems during their first 3 months of life:

❑ Jaundice	❑ Diarrhea	❑ Birth defects	❑ Rashes
❑ Colic	❑ Fever	❑ Cerebral palsy	❑ Allergies
❑ Blue baby	❑ Seizures	❑ Birth injuries	❑ Constipation
❑ Other:			

Child's sleep pattern (first year) _____
Feeding: ❑ Breast-fed How long? ___Formula: ❑ Milk ❑ Soy Other: _____ How long? _____
Age began solid foods _____List first foods: _____
Food intolerance (if any) _____
Age began: Sitting___ Crawling___ Walking ___ First words ____

Is there anything else you would like the Doctor to know?
_____

_____

_____