Today's Date ____/____/____

Child's Name___________________________ Date of Birth ___/___/___ Age _____ Sex: M F

Address________________________________ City_______________ State___________ Zip______

**Parent/Guardian Contact Information:**

Name_________________________________ Relationship to child __________________________

Address________________________________ City_______________ State___________ Zip______

Home Phone___________________ Cell/Work_________________ Email______________________

How did you hear about us?____________________________________________________________

**Health History**

What is the main reason for seeing the doctor today? If there is a specific health condition, please describe in detail including the first time you noticed the condition. Please list any factors you suspect may have played a role in its onset and continuation.

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

How long has the main problem been an issue?___________________________________________

**List in order of importance other health problems that are an issue:**

1.__________________________________________________ Length of time___________________

2.__________________________________________________ Length of time___________________

3.___________________________________________________Length of time__________________

Who is the child's pediatrician?
Name___________________________________________ Phone_____________________________

Has the child ever seen a naturopath or a chiropractor before? Y N
If so, who was the doctor and what were the
results?_____________________________________________________________________________

Does the child now, or in the past, experience(d) the following: (circle all that apply):

Anemia Hepatitis Bladder infections Hernia Blood disorders Asthma Epilepsy
Ear infections Thyroid disease Diabetes Hives/Eczema Gastric reflux Bedwetting
Hyperactivity
Any other condition:__________________________________________________________________

How would you describe your child's overall state of health? (please circle one)
Excellent Good Average Fair Poor

Previous hospitalizations/Surgeries/Serious Illnesses:
___________________________________________ ________________Date__________________

___________________________________________________________ Date__________________

Does the child have known allergies to any drugs, foods, animals, herbs or other substances?
Please list allergen and the reaction to it:
_________________________________________________________________________________

Medications: (please give full name, strength, dosage and how long child has been taking it)
_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

Vitamins/Herbs: (please give full name, strength, dosage and how long child has been taking it)

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

**Typical Food Intake:**
Breakfast________________________________________________________________________

Lunch___________________________________________________________________________

Dinner__________________________________________________________________________

Snacks__________________________________________________________________________

Drinks__________________________________________________________________________

**Birth History:**

At how many weeks gestation was the child born?_____ Was it vaginal or a C-Section_________

How much did he/she weigh?_____ How long in inches__________

Were there any birth complications?____________________________________________________

Was the child breast fed?_________ If yes, for how long?__________________________________

Were there any difficulties introducing foods? Which ones?_______________________________

_________________________________________________________________________________

**Immunization History:**

Has the child had all immunizations? Y N
Please circle all administered:
Hep B DTaP/DTP Hib Polio MMR Varicella(Chicken Pox) Other:______________

Any reactions/complications from the immunizations?_____________________________________