

NATURE'S PATH OF INTEGRATED HEALTH

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Date: _____

PEDIATRIC/ADOLESCENT PATIENT PROFILE

Patient's Name: _____ Age: ___ Sex: _____ Birthdate: _____

Address: _____

Email: _____

Mother's Name: _____ Father's Name: _____ Other: _____

Phone (home): _____ (work): _____ mother/father/other

Who can I thank for referring you to me? _____

Child's Primary Care Physician: _____

Person To Be Notified

In Case of Emergency: Name: _____ Relationship: _____

PLEASE LIST THE HEALTH CONCERN/PROBLEM THAT BRINGS YOU IN TODAY:

1. _____ 3. _____

2. _____ 4. _____

HISTORY OF THIS CONCERN/PROBLEM:

1. Has child received any treatment for this illness? yes no
If yes, what? _____
2. Has child ever had this illness in the past? yes no
If yes, when? _____
3. How long has he/she had this illness? _____

MEDICATIONS:

	now	past	frequency
Aspirin	_____	_____	_____
Tylenol	_____	_____	_____
Antibiotics	_____	_____	_____
Decongestants	_____	_____	_____
Other	_____	_____	_____

SUPPLEMENTS:

	now	past	dose
Vitamins	_____	_____	_____
Minerals	_____	_____	_____
Fluoride	_____	_____	_____
Herbs:	_____	_____	_____

Allergies to drugs or medications: _____

CHILDHOOD ILLNESSES (Please check and indicate at what age)

<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Measles	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Ear Infections
<input type="checkbox"/> Mumps	<input type="checkbox"/> Strep Throat	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Rubella	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Croup
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Asthma	<input type="checkbox"/> other _____

FAMILY HISTORY: Identify all family members who have or have had any of the following:

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypoglycemia
<input type="checkbox"/> Anemia	<input type="checkbox"/> Eczema	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Thyroid disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Obesity	<input type="checkbox"/> Hearing Loss
<input type="checkbox"/> Other (Describe)		

PRENATAL/ BIRTH HISTORY:

MOTHER'S health during the pregnancy with this INFANT/ CHILD/ ADOLESCENT (check and describe in space provided) :

<input type="checkbox"/> Age	<input type="checkbox"/> Trauma/Injury	<input type="checkbox"/> Alcohol Consumption	<input type="checkbox"/> Illness
<input type="checkbox"/> Bleeding	<input type="checkbox"/> Stress	<input type="checkbox"/> Nausea	<input type="checkbox"/> Drugs
<input type="checkbox"/> Smoking	<input type="checkbox"/> X-rays	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Toxemia
<input type="checkbox"/> Medications	<input type="checkbox"/> Other		

Describe:

TERM: Full _____ Premature _____ Late _____ Birth Weight: _____ LBS _____ OZ

Was birth / pregnancy: Easy? _____ Difficult? _____

Place of Birth: _____ Hospital _____ Home _____ Clinic _____ Other _____ Method

HABITS:

- 1.) Does your child eat a special diet?

- 2.) What are your child's favorite foods?

- 3.) What is your child's general disposition?

- 4.) How much does your child sleep?

5.) Does your child wear: _____ cloth diapers _____ disposable _____ none

6.) Date of last check-up _____ with Dr. _____

7.) List any chemicals, metals, dusts, smoke or fumes your child has been repeatedly exposed to:

8.) Does your child react to pollens? If so, then which ones?

9.) Does your child react to foods? If so, then which ones?

(Check appropriate boxes)

FEEDING:	NEVER	RARELY	FREQUENTLY	WEEKLY	TIMES PER DAY				
					1X	2x	3X	4X	5X
MOTHER'S MILK (or weaned when?: _____)	_____	_____	_____	_____	_____	_____	_____	_____	_____
MILK OR FORMULA _____ (KIND)	_____	_____	_____	_____	_____	_____	_____	_____	_____
SUGAR SWEETS	_____	_____	_____	_____	_____	_____	_____	_____	_____
FRUIT SWEETENERS	_____	_____	_____	_____	_____	_____	_____	_____	_____
WHITE FLOUR	_____	_____	_____	_____	_____	_____	_____	_____	_____
PROTEIN FOODS	_____	_____	_____	_____	_____	_____	_____	_____	_____
VITAMINS-MINERALS _____ (KIND)	_____	_____	_____	_____	_____	_____	_____	_____	_____
ASPIRIN	_____	_____	_____	_____	_____	_____	_____	_____	_____
LAXATIVES	_____	_____	_____	_____	_____	_____	_____	_____	_____

ARE YOU WILLING TO CHANGE YOUR HABITS TO HELP IMPROVE YOUR CHILD'S HEALTH? _____

DOES YOUR CHILD HAVE ANY OTHER PROBLEMS YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR? _____
