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	**SUPPLEMENTS:**	now	past	dose
Aspirin	____	____	_______	Vitamins	____	____	____
Tylenol	____	____	_______	Minerals	____	____	____
Antibiotics	____	____	_______	Fluoride	____	____	____
Decongestants	____	____	_______				
Other	____	____	_______	Herbs:	____	____	____

Allergies to drugs or medications: ____

HOSPITALIZATIONS / SURGERIES / ACCIDENTS / SERIOUS INJURIES: Describe each incident and give date & age:

MEDICATIONS TAKEN IN THE LAST 5 YEARS: (Include dates and duration)

IMMUNIZATIONS: (List types, dates given, and any adverse reactions)

SOCIAL HISTORY:

1) Parents: Single______ Married ____ Separated ____ Divorced ____
   Mother's Occupation ___________________ Full Time _______ Part Time _________
   Father's Occupation ___________________ Full Time _________ Part Time _________
2) Other Guardian: ______________________________________ Relationship ___________
3) Others Residing in Home: ______________________________ Relationship ___________
4) Daycare/Preschool/School: ________________ Where ______________________________
   How Many Hours Each Day? _____________ How Many Days Of The Week? _____
5) Siblings: NAME AGE HEALTH PROBLEMS
   1)
   2)
   3)
6) Interaction With Relatives: Who? ________________ How Often? __________

CHILD'S HEALTH HISTORY (please check)

NOW	PAST	NEVER		NOW	PAST	NEVER	
___	___	___	Acne	___	___	___	Epilepsy/Seizures
___	___	___	Allergies	___	___	___	Fatigue
___	___	___	Anemia	___	___	___	Frequent Infections
___	___	___	Asthma	___	___	___	Headaches
___	___	___	Bed Wetting	___	___	___	Heart Murmur
___	___	___	Birth Defects	___	___	___	High Fever
___	___	___	Colic	___	___	___	Hyperactivity/ ADD
___	___	___	Constipation	___	___	___	Insomnia
___	___	___	Cough/Wheeze	___	___	___	Jaundice
___	___	___	Cradle Cap	___	___	___	Learning Difficulties
___	___	___	Depression	___	___	___	Moodiness
___	___	___	Diarrhea	___	___	___	Stuffy Nose
___	___	___	Dizzy Spells	___	___	___	Thrush
___	___	___	Earaches	___	___	___	Vomiting Spells
___	___	___	Eczema	___	___	___	Other ___________________

CHILDHOOD ILLNESSES (Please check and indicate at what age)

________ Chicken pox ________ Scarlet Fever ________ Mononucleosis
________ Measles ________ Rheumatic Fever ________ Ear Infections
________ Mumps ________ Strep Throat ________ Tonsillitis
________ Rubella ________ Pneumonia ________ Croup
________ Whooping Cough ________ Asthma ________ other _______

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

___________ Alcoholism ____________ Cancer _____________ High Blood Pressure
___________ Allergies ____________ Diabetes _____________ Hypoglycemia
___________ Anemia ____________ Eczema _____________ Mental Illness
___________ Arthritis ____________ Epilepsy_____________ Thyroid disorder
___________ Asthma ____________ Stroke _____________ Heart Disease
___________ Birth Defects ____________ Obesity _____________ Hearing Loss
___________ Other (Describe)

PRENATAL/ BIRTH HISTORY:

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

_______ Age _______ Trauma/Injury ________ Alcohol Consumption _______ Illness
_______ Bleeding _______ Stress ________ Nausea _______ Drugs
_______Smoking _______ X-rays ________ High Blood Pressure ________ Toxemia
_______Medications _______ Other

Describe:

TERM: Full _______ Premature _______ Late _______ Birth Weight: ______ LBS_____OZ
Was birth / pregnancy: Easy? ___________ Difficult? _______________

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

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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? ____

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