PEDIATRIC PATIENT HEALTH HISTORY QUESTIONNAIRE
Birth to Thirteen Years of Age

Name: ____
Last *First* *M.I.*

Date of Birth: ____________________ Age: _______ Gender: (circle one) F M

Parent or Guardian: ____
Mother *Father* *Guardian*

Contact Info: Please *circle the preferred number* to contact you:

Home #:____________________________ Cell #:________________________

E-mail:____

Home/Billing Address: ____

____

Name and address of physician's office or hospital/ clinic that keeps medical records for your child:

____
Office/Hospital/Clinic *City State Zip Code*

*Natural medical healthcare is possible only when the Practitioner completely understands the patient's physical, mental and emotional condition. The information you provide helps the Practitioner understand your needs and how to help you reach your health goals. Please answer each question completely. Print all information and feel free to ask any questions.

ALL RESPONSES WILL BE KEPT CONFIDENTIAL

What are your child's most important health concerns?

1)______________________________ 2) ______________________________

3)______________________________ 4)______________________________

MEDICATIONS

Now = currently being taken. Past =taken at one time or another

	Now	Past		Now	Past
Aspirin	____	____	*Asthma Medications*	____	____
Ibuprofen	____	____	*Decongestants*	____	____
Inhalers	____	____	*Topical Steroids*	____	____
Antibiotics	____	____	*Anti-histamine*	____	____

Other ____

Does your child have any allergies to foods, drugs or other allergens in your environment (cats, mold, dust)?

Yes No

If yes, please list and explain:

____

____

____

MEDICAL HISTORY

Check those that apply

Chicken Pox	Scarlet fever	Bronchitis	Asthma
Measles	Pneumonia	Rubella	Mumps
Frequent colds	Eczema	Croup	Ear infections
Tonsillitis			

Are any of the conditions for which you check "yes" recurrent conditions? _______

Other: ______________________________

X-RAYS AND SPECIAL STUDIES

Please include RESULTS, WHEN, & WHERE

Electroencephalogram
____

Psychological Evaluation
____

Speech/Language
____

Hearing
____

INJURIES/SURGERIES/HOSPITALIZATIONS

____

____

____

IMMUNIZATIONS

Measles DPT Small Pox
Mumps MMR Diphtheria
Polio Tetanus Influenza
Other ___________________________

Did your child have any adverse reactions to immunizations? (Please specify)

___

___

___

As a baby, did / does your child have any of the following problems?

____*Jaundice* ____*Diarrhea* ____*Birth defects* ____*Rashes*
____*Cerebral palsy* ____*Blue baby* ____*Birth injuries*
____*Colic* ____*Fever* ____*Allergies* ____*Seizures*
____*Other*____

Feeding: ________*Breast fed* ______*How long?* ______ *Formula: Milk or Soy*

Age Began: ______*Solid foods* ______*Sitting* ______*Crawling* ______*Walking*
______*First words*

What were your child's sleep patterns during the first year?

___

___

___

BIRTH HISTORY

Date of Birth _________________ **Term** Full
Time of Birth ____________a.m. ____________p.m. Premature
Weight at birth __________________ Late
Gestation according to LNMP: _______________weeks
Sonogram _______________weeks
Gestational Assessment _______________weeks
Place of birth Home Birth Clinic Hospital Other___________________

Address of Birthplace ____
STREET / PO Box
____
CITY, STATE, ZIP

Onset of Labor _______________ Date _______________ Time _______________

Duration of Labor _______________
Was your labor induced? Yes No If yes, with what method(s)?__________________

Complications of Pregnancy Yes No

Complications of Labor/Delivery Yes No

____

Complications of Post Partum Yes No

____

Medications Given
____

MOTHER'S HISTORY

Previous pregnancies by natural mother, miscarriages or complications:
____
____

Mother's age at child's birth: _________________
Mother's health during pregnancy

Bleeding	Diabetes	Cigarettes, alcohol, drugs
Nausea	Illness	Physical or emotional trauma
Hypertension	Thyroid problems	

____

CHILD'S SYMPTOMS

Circle the response that applies
Y: condition now
P: condition had in the past
N: condition never had

Hives	Y	P	N	Burning of urine	Y	P	N
Eczema	Y	P	N	Bloody urine	Y	P	N
Acne	Y	P	N	Frequent urination	Y	P	N
Chronic rash	Y	P	N	Heart murmur	Y	P	N

Cries easily	Y	P	N	Vomiting spells	Y	P	N
Bleeding gums	Y	P	N	Night sweats	Y	P	N
Nervous	Y	P	N	High fever	Y	P	N
Nose bleeds	Y	P	N	Stomach aches	Y	P	N
Sleep problems	Y	P	N	Diarrhea	Y	P	N
Nightmares	Y	P	N	Constipation	Y	P	N
Dizzy spells	Y	P	N	No appetite	Y	P	N
Unusual fevers	Y	P	N	Motion/car sick	Y	P	N
Anemia	Y	P	N	Sensitive to light	Y	P	N
Jaundice	Y	P	N	Body/Breath odor	Y	P	N
Hearing loss	Y	P	N	Easy bruising	Y	P	N
Flat feet	Y	P	N	Sore throats	Y	P	N
Gas	Y	P	N	Canker sores	Y	P	N
Wheezing	Y	P	N	Cough	Y	P	N
Joint Pains	Y	P	N	Hair loss	Y	P	N
Frequent headaches	Y	P	N	Frequent colds	Y	P	N
Bleeding tendency	Y	P	N	Excessive fatigue	Y	P	N

Does your child have any other condition not mentioned?
____

DIET

Please describe your child's typical daily diet:

____

____

____

Does your child have any food intolerances or allergies that you know of?
Yes No

If yes, please explain:

____

What were the first solid foods introduced into your child's diet?
____

Are there any religious or cultural beliefs or practices of which you would like us to be aware?
____

____

____

INFORMED CONSENT

The purpose of this form is to present the risks & benefits of the therapies offered at **Origins of Health.**

<u>This must be signed before treatment is rendered.</u>
Please feel free to ask your practitioner about any questions or concerns at any time.

NATUROPATHIC MEDICINE
Naturopathy combines safe and effective traditional therapies with the most current advances in modern medicine by attempting to find the underlying cause of disease rather than focusing on symptomatic treatment. The doctors in our clinic work with a variety of conditions including issues in womens' health, stress, pain, organ dysfunction, infections, and much more. There may be risk of pharmaceutical/supplement interaction, so inform your ND of current medications. Your ND may suggest hydrotherapy, which encourages circulation, enhanced immune function and relaxation. Side effects are minimal, but may include dizziness, fatigues, detoxification reactions and irritated skin.

SUPPLEMENTS, HERBAL FORMULAS AND HOMEOPATHIC REMEDIES
These are formulas that can facilitate healing through nutritional and energetic support. Each of these can be effective for a number of conditions. Be sure to inform your practitioner about all medications you currently take to minimize drug/supplement interactions. Some transient effects may be gas, bloating, fatigue, and less commonly allergic reaction, but be sure to consult with your naturopathic physician to discern the cause of the symptoms.

IMAGING, REFERRALS
Further lab work (X-rays, MRI, blood work, urine analysis, etc.) may be necessary. When co-management or referral is indicated, a prompt referral to another specialist for evaluation or alternative therapy will be suggested. The following are examples: medical management, physical therapy, vestibular testing, psychological evaluation, surgery, other naturopathic therapies, chiropractic, acupuncture, massage, etc.

We will inform you of alternatives to the therapies offered within or external to Origins of Health. Our first concern is your health and well-being.

Please inform your practitioner of any changes in symptoms, medications, diagnoses by other doctors and if there is a chance of pregnancy at any time during your care.

I, ____ have had the opportunity to read this form and my questions are answered to my satisfaction. I hereby consent to the treatments above.

____
Patient Name (Please Print)

____
Signature (Patient or Guardian if a minor) Date