NAME_____

DATE OF BIRTH_____

HEIGHT_____ PERCENTILE_____

WEIGHT_____ PERCENTILE_____

ALLERGIES_____

PLEASE LIST ALL DOCTORS THAT YOU SEE_____

WHAT ARE YOU SEEKING TREATMENT FOR?_____

_____

HISTORY OF CONDITION – please include what was happening when it first occurred___

_____

_____

PLEASE LIST ALL CURRENT HEALTH PROBLEMS_____

_____

PLEASE LIST ALL PAST MEDICAL PROBLEMS_____

_____

DO YOU GET COLDS/FLU OFTEN?_____

HOW OFTEN HAVE YOU TAKEN ANTIBIOTICS?_____

HAVE YOU EVER HAD ANY INFECTIONS OR TICK BITES_____

_____

HAVE YOU HAD ANY ACCIDENTS OR OTHER TRAUMA_____

_____

PLEASE LIST ANY TRAVEL OUTSIDE THE UNITED STATES_____

_____

PLEASE LIST ALL IMMUNIZATIONS/FLU SHOTS_____

_____

_____

PLEASE LIST ALL MEDICATIONS, VITAMINS AND SUPPLEMENTS_____

_____

_____

PLEASE LIST ALL DOCTORS THAT YOU SEE_____

_____

DO YOU HAVE ANY PETS?_____

FOR MOM

How was the pregnancy – please include problems getting pregnant, morning sickness, cravings, allergies, stresses, illnesses, etc._____

How was labor and delivery – please include length of labor, use of drugs and/or epidural, vaginal/C-section, Apgar scores, etc._____

How was the child's progression through infancy, toddlerhood, preschool, and school years? Please include developmental milestones, illnesses, social behaviors, and personality traits.

FOR CHILD

FAMILY HISTORY – please indicate present age, state of health, and any illnesses they have had in the past and when they occurred

Mother_____

Father_____

Brothers/Sisters_____

Other relatives with significant illnesses_____

DO YOU HAVE HEADACHES, HEAD INJURY/CONCUSSION please include frequency, location, and triggers_____

EYE, EAR, NOSE, THROAT, OR TEETH PROBLEMS_____

SKIN PROBLEMS_____

CHEST OR BREATHING PROBLEMS_____

_____

BONE OR MUSCLE PROBLEMS_____

_____

DIGESTION PROBLEMS_____

_____

How is your appetite_____

Do you feel thirsty_____

How often do you have a bowel movement_____

Do you tend to have diarrhea or constipation_____

Please list the food that you eat on a typical day_____

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

Do you have any cravings_____

Do you drink soda – how much/how often_____

URINARY PROBLEMS_____

SLEEP PROBLEMS_____

_____

What time do you go to bed_____

How long does it take to fall asleep_____

Quality of sleep_____

Do you wake up during the night_____

Do you have trouble going back to sleep_____

What time do you get up in the morning_____

Do you wake up naturally or use an alarm_____

Do you feel refreshed or tired when you wake up_____

Do you take naps during the day_____

DO YOU TEND TO FEEL WARM OR COLD_____

HOW MUCH EXERCISE DO YOU GET_____

HOW IS YOUR ENERGY LEVEL_____

HOW IS YOUR STRESS LEVEL_____

Thank you.