SONOMA NATUROPATHIC MEDICINE

Marcus Porrino, ND
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710 West Napa Street, Suite 1
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PEDIATRIC PATIENT HEALTH HISTORY
SIX YEARS OF AGE TO ADOLESCENCE

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

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

Name and address of Dr's office/hospital/clinic where your child's health records are kept:

_____
Office/Hospital/Clinic Name *Street/ P.O. Box*

_____
City *State* *Zip Code*

Parent or Guardian: _____ _____ _____
Father *Mother* *Guardian*

Name of responsible party: _____SS#: _____

Relationship to patient: _____ Phone #: _____

Address: _____

City:_____ State: _____Zip Code:_____

Telephone: Please ***circle the preferred number*** to contact you below:

Home #:_____Work #:_____Cell #:_____

How did you hear about our clinic? _____

☐ **Yes, please send us the quarterly newsletter:** Email : _____

Naturopathic healthcare is most effective when the doctor completely understands the patient's physical, mental, and emotional concerns and conditions. The information you provide helps me understand your child's needs. Your time, honesty, and thoughtfulness is appreciated. Feel free to mark anything you may have a question about.

Please list your child's most important health concerns? If none, write "well child care"

1) 3)

2) 4)

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Why did you choose to come to this clinic? _____

Are you currently receiving healthcare? Y N

If yes, where and from whom? _____
_____

If no, when and where did you last receive medical or health care? _____
_____

GENERAL

Weight: _____ lbs. Maximum Weight _____ lbs.
Weight 1 year ago: _____lbs. When: _____
Height _____

MEDICATIONS

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

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

MEDICAL HISTORY

Does your child have any **allergies** to foods, medications, or other allergens in your environment (cats, mold, dust)? Yes _____ No _____ If yes, list ALL and explain.
_____
_____
_____

Has your child ever had: (Check those that are applicable)

_____*Chicken pox*	____ *Scarlet fever*	____*Bronchitis*	____*Asthma*
_____ *Measles*	____ *Pneumonia*	____*Rubella*	____*Mumps*
_____*Frequent Colds*	____*Eczema*	____*Croup*	*Other:*_____
Tonsillitis-How many times?	____*Ear infections---How many?*____		_____

X-RAYS AND SPECIAL STUDIES

	When	Where	Results
____ *Electroencephalogram (EEG)*			
____ *Psychological Evaluation:*			
____*Hearing:*			
____*Speech/Language:*			

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INJURIES/SURGERIES/HOSPITALIZATIONS

_____
_____
_____

IMMUNIZATIONS (Y or N)

_____*Measles*	____*Polio*	_____*MMR*	_____*Small Pox*	____*Hep B*
____*Mumps*	____*DPT*	_____*Tetanus*	_____*Influenza*	____*Other*_____

Any adverse reactions to immunizations? (Please specify)

_____
_____

SYMPTOMS

Please circle: Y=a condition your child has now N=never had P=has had in the past

Hives	*Y P N*	*Burning of urine*	*Y P N*	*Bloody urine*	*Y P N*
Eczema	*Y P N*	*Frequent urination*	*Y P N*	*Cries easily*	*Y P N*
Bleeding gums	*Y P N*	*Heart Murmur*	*Y P N*	*Nervous*	*Y P N*
Nose bleeds	*Y P N*	*Vomiting spells*	*Y P N*	*Sleep problems*	*Y P N*
Acne	*Y P N*	*Anemia*	*Y P N*	*Night sweats*	*Y P N*
High fever	*Y P N*	*Stomach aches*	*Y P N*	*Sensitive to light*	*Y P N*
Chronic rash	*Y P N*	*Jaundice*	*Y P N*	*Body/Breath odor*	*Y P N*
Hearing loss	*Y P N*	*Easy bruising*	*Y P N*	*motion/car sick*	*Y P N*
Diarrhea	*Y P N*	*Flat feet*	*Y P N*	*No appetite*	*Y P N*
Sore throats	*Y P N*	*Constipation*	*Y P N*	*Nightmares*	*Y P N*
Gas	*Y P N*	*Canker sores*	*Y P N*	*Wheezing*	*Y P N*
Joint pains	*Y P N*	*Cough*	*Y P N*	*Dizzy spells*	*Y P N*
Hair loss	*Y P N*	*Frequent Headaches*	*Y P N*	*Frequent colds*	*Y P N*
Unusual fears	*Y P N*	*Bleeding tendency*	*Y P N*	*Excessive fatigue*	*Y P N*
Anxiety	*Y P N*	*Depression*	*Y P N*	*Suicidal thoughts*	*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 that you know of? Yes _____ No _____
If yes, please explain: _____

_____

_____

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FAMILY HISTORY (Y or N)

____Heart Disease ____Diabetes ____Birth defects ____Cancer ____Mental Illness
____Hypertension ____Arthritis ____Tuberculosis ____Allergies ____Hay fever
____Eczema ____Other (please explain)_____

BIRTH HISTORY

Mother's age at child's birth: _____

Mother's health during pregnancy:
____Bleeding ____Hypertension ____Illness
____Nausea ____Diabetes ____Thyroid Problems
____Physical or emotional trauma ____Cigarettes, alcohol, drugs

Term Length:
____Full term (40 wks) ____Premature (born before 36 wks) ____Late

Are there any cultural or religious practices we should be aware of when providing healthcare to you or your family? _____

_____

Is there any information about your health you would like to add:

_____

_____

Please fax or mail this intake form prior to your first visit:

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