NEWBORN PATIENT PROFILE (0 to 6-months)

Today's date: _____ Initial visit scheduled with (circle one): Dr. Justin Pollack / Dr. Kim Nearpass / Dr. Eryn J. Scott

Last Name:_____ First Name:_____ MI: _____

Nickname:_____ Birthdate:_____ Age:_____

Sex/Gender:_____ Parent/Guardian name(s):_____

Mailing address: _____

Physical address (if different): _____

Phone: _____ Alternate: _____

May we leave detailed phone messages? □ Y □ N

Email address: _____

Does the patient have a pediatric or primary MD? If yes, please provide name: _____

Date of last wellness exam: _____ Additional health care providers: _____

Emergency contact name: _____ Relationship to child: _____

Address: _____ Phone: _____

How did you hear about us? _____

Would you like to be listed as a supporter of Naturopathic Medicine for our legislative efforts? □ Y □ N

Please list any **allergies** (medication, food & environmental): _____

_____

A note to our patients: *Naturopathic healthcare is possible only when the physician completely understands the patient's physical, mental and emotional condition. The information you provide helps the doctor understand your needs and how to help you reach your health goals. This information is kept confidential between you and your doctor. Please answer all questions as completely as possible, and mark anything that you have a question about. Welcome!*

PRESENT HEALTH CONCERNS: Please list most important health concerns in their order of significance.

1._____

2._____

3._____

Please list any supplements/medications the *infant & mother* (if breastfeeding) are currently taking, with dosages:

_____

_____

_____

HEALTH HISTORY:

Prenatal History: Please answer the following questions regarding the *mother's* health during pregnancy with *this child* if known.

Age: _____ Number of previous pregnancies: _____ Conception/fertility challenges: □ Y □ N

Did the mother receive medical care during pregnancy? □ Y □ N Provider: _____

□ Y □ N	Gestational diabetes	□ Y □ N	High blood pressure
□ Y □ N	Alcohol use during pregnancy	□ Y □ N	Tobacco use during pregnancy
□ Y □ N	Drug use during pregnancy	□ Y □ N	Trauma/injury
□ Y □ N	Bleeding	□ Y □ N	Nausea
□ Y □ N	Mood disturbance (anxiety/depression)	□ Y □ N	Illness/toxemia
□ Y □ N	Exposure to X-rays	□ Y □ N	Thyroid disorder
□ Y □ N	Group B strep positive	□ Y □ N	Other _____
□ Y □ N	Received antibiotics in labor		

Birth History: Please answer the following questions regarding *this child's* birth history.

Was this child adopted? □ Y □ N If so, what is the country of origin? _____

Term (check one): _____ Premature (before 37 wks) _____ On time (after 37 wks) _____ Late (after 42 wks)

Pregnancy/birth can be described as (check one): _____ Easy _____ Moderate _____ Difficult

Birth site (check one): _____ Home _____ Clinic/Birth center _____ Hospital _____ Other

Name of clinic/hospital & birth attendants: _____

Birth weight: _____ lbs _____ oz Time of birth _____ am / pm

□ Vaginal	□ Cesarean birth (c-section)	□ Forceps	□ Vacuum
□ Jaundice	□ Hospitalization	□ Trauma	□ Other complications _____

Procedures & Screenings: Did your child receive the following at birth or shortly after birth?

□ Y □ N	Vitamin K injection	□ Y □ N	Hearing screen Pass / Fail (circle one)
□ Y □ N	Erythromycin eye ointment	□ Y □ N	HepB vaccination
□ Y □ N	1st newborn metabolic (PKU) screen	□ Y □ N	2nd newborn metabolic (PKU) screen

Medical History:

How would you describe your infant's general state of health (check one): ___ Excellent ___ Good ___ Fair ___ Poor

How would you describe your infant's behavior/disposition? _____

Please list any surgeries, hospitalizations, or serious injuries/illnesses your child has experienced with approximate dates:

_____

Has your child ever received antibiotics? □ Y □ N If yes, when and for what condition(s)? _____

Patient Health History: Mark *"Y" for current concerns*, *"P" for past concerns* regarding *this child's* health:

□ Y □ P Failure to thrive	□ Y □ P Birth defects	□ Y □ P Developmental delay	□ Y □ P Head injury
□ Y □ P Fever > 100.4°F	□ Y □ P Thrush	□ Y □ P Ear infections	□ Y □ P Rash
□ Y □ P Cold sores	□ Y □ P Heart murmur	□ Y □ P Diabetes	□ Y □ P Pink eye
□ Y □ P Croup	□ Y □ P Whooping cough	□ Y □ P Pneumonia	□ Y □ P Bronchitis
□ Y □ P Mumps	□ Y □ P Rubella	□ Y □ P Measles	□ Y □ P Chicken pox
□ Y □ P Scarlet fever	□ Y □ P Rheumatic fever	□ Y □ P Meningitis	□ Y □ P Reflux / Colic
□ Y □ P Constipation	□ Y □ P Diarrhea	□ Y □ P Urinary infection (UTI)	□ Y □ P Seizures / convulsions
□ Y □ P Sleep difficulties	□ Y □ P Cancer	Other _____	

Nutritional History: Please check all that apply

□ Breastfed □ Formula-fed □ Mixed breastmilk & formula

How often is your infant breastfeeding or bottle feeding? _____

If using formula, what kind(s)? _____

Do you have any concerns about breastfeeding or formula feeding your infant? □ Y □ N

If you answered 'yes', please complete our infant feeding questionnaire.

Vaccination History: Have you chosen to vaccinate your child? □ Y □ N

If yes, are they on a standard or delayed/spaced schedule? (circle one)

If they are on a delayed/spaced schedule, please check the vaccines your child has received thus far:

HepB_____ DTaP_____ Polio _____ Hib_____ Pneumococcal_____ Rotavirus_____

Other _____

Any adverse reactions? □ Y □ N Please explain: _____

_____

SOCIAL HISTORY:

Parents: _____ Married _____ Separated _____Divorced _____ Widowed _____ Partnered

Parent occupation: _____ □ Mother □ Father □ Other _____

Parent occupation: _____ □ Mother □ Father □ Other _____

Other caregivers: _____

□ Y □ N Does your child attend daycare? Daycare name: _____

□ Y □ N Siblings in the home (If yes, please list names & ages) _____

□ Y □ N Does anyone in the household smoke? _____ Tobacco _____ E-cigarettes / vape _____ Cannabis

FAMILY HISTORY: Have any family members had any of the following conditions? If yes, please specify relationship to child (M = mother; F = father; PGF = paternal grandfather; MGM = maternal grandmother; S = sibling)

Condition	Yes	Relation	Condition	Yes	Relation
Birth defects			Infant hearing loss		
Allergies / Hay fever			Asthma		
Obesity			Anemia / Bleeding disorders		
Diabetes			Heart disease / Stroke		
High cholesterol			High blood pressure		
Liver disease			Gallbladder disease		
Kidney disease			Juvenile arthritis / Joint pain		
Autoimmune disorder			Rash / Skin condition		
Epilepsy / seizures			Cancer		
Alcoholism / addiction			Mental illness		

Any other relevant family history? _____

Thank you for taking the time to fill out this form.

We look forward to working with you and your family in supporting your health goals!