PEDIATRIC PATIENT PROFILE (6-months to 17-years)

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:_____________________ Preferred pronouns (if any): ____

Name(s) of Parents/Guardians: ____

Mailing address: ____

Physical address (if different): ____

Phone (home): ____ 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: ___________ Date of last vision exam: ___________ Date of last dental visit: ___________

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.____

MEDICATIONS & SUPPLEMENTS:

Please list any supplements, prescription, and over-the-counter medications the patient is 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		

Medical History:

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

How would you describe your child's behavior/disposition? ____

____

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

____

____

____

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

____

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:

DTaP___ DT___ Polio ___ Hib___ Pneumococcal___ Rotavirus___ HepB___ HepA___ MMR___

Varicella (chicken pox) ___ Flu___ Meningococcal___ Td/Tdap___ HPV___ Other ____________________________

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

____

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

□ Y □ P Learning disorder	□ Y □ P Birth defects	□ Y □ P Sleep difficulties	□ Y □ P Dizzy spells
□ Y □ P Allergies	□ Y □ P Mood disorder	□ Y □ P Traumatic event	□ Y □ P Thrush
□ Y □ P Ear infections	□ Y □ P Rash	□ Y □ P Strep throat	□ Y □ P Pink eye
□ Y □ P Cold sores	□ Y □ P Heart murmur	□ Y □ P Chronic congestion	□ Y □ P Bronchitis
□ Y □ P Croup	□ Y □ P Whooping cough	□ Y □ P Frequent Headaches	□ Y □ P Chicken pox
□ Y □ P Mumps	□ Y □ P Rubella	□ Y □ P Pneumonia	□ Y □ P Meningitis
□ Y □ P Mononucleosis	□ Y □ P Scarlet fever	□ Y □ P Measles	□ Y □ P Diarrhea
□ Y □ P Constipation	□ Y □ P Abdominal pain	□ Y □ P Rheumatic fever	□ Y □ P Diabetes
□ Y □ P Appendicitis	□ Y □ P Chronic bedwetting	□ Y □ P Reflux/Colic	□ Y □ P Cancer
□ Y □ P Epilepsy/convulsions	□ Y □ P Head injury/trauma	□ Y □ P Urinary infection	□ Y □ P Frequent infections
□ Y □ P Failure to thrive / Developmental delay	□ Y □ P Hyperactivity / Difficulty concentrating	□ Y □ P Asthma / Reactive Airway Disease	Other ___________________

SOCIAL HISTORY:

Parents: _____ Married _____ Separated ______Divorced _____ Widowed _____ Partnered

Parent occupation: ____ □ Mother □ Father □ Other _______________

Parent occupation: ____ □ Mother □ Father □ Other _______________

Other caregivers: ____

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

____

□ Y □ N Does your child attend school/daycare? School name and grade level: ____________________________________

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

□ Y □ N Does the child regularly participate in physical activity? Activity type(s) & frequency: ______________________

____

Total hours of screen time per day (classroom, homework, tablet, iPad, TV, video games, etc.): _______________________

Nutritional History:

□ Breastfed □ Formula-fed □ Mixed breastmilk & formula

Age solid foods introduced: __________

Does your child follow a specific diet (vegetarian, vegan, gluten-free, etc)? □ Y □ N _________________________________

Do you have any current nutritional concerns for your child? □ Y □ N ____

____

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			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!