

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: _____

- | | | | |
|---|---------------------------------------|---|------------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N | Gestational diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N | High blood pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Alcohol use during pregnancy | <input type="checkbox"/> Y <input type="checkbox"/> N | Tobacco use during pregnancy |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Drug use during pregnancy | <input type="checkbox"/> Y <input type="checkbox"/> N | Trauma/injury |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N | Nausea |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Mood disturbance (anxiety/depression) | <input type="checkbox"/> Y <input type="checkbox"/> N | Illness/toxemia |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Exposure to X-rays | <input type="checkbox"/> Y <input type="checkbox"/> N | Thyroid disorder |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Group B strep positive | <input type="checkbox"/> Y <input type="checkbox"/> N | Other _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> 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:

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