Whole Health Clinic

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Date: ____________________

PEDIATRIC/ADOLESCENT PATIENT PROFILE

Patient's Name: ________________________________ Age: __ Sex: _______ Birthdate: __________

Address: ____City: _____________State: __

Mother's Name: ___________________ Father's Name: __________________

Phone (home): __________________ (work): _______________________ mother/father/other

How did you hear about us? ____

Child's Primary Care Physician: ____

Person To Be Notified
In Case of Emergency: Name: _____________________________ Relationship: ______________

Insurance information: Name of the insurance company? ____________________________________

Subscriber's name (This could be the child or his/her parents)?__________________________

Subscriber's employer? __________________________

Subscriber's date of birth? ________________________

PLEASE LIST THE HEALTH CONCERN/PROBLEM THAT BRINGS YOU IN TODAY:

1. ____ 3. ____

2. ____ 4. ____

HISTORY OF THIS CONCERN/PROBLEM:

1. Has child received any treatment for this illness? yes no
   If yes, what? __________________
2. Has child ever had this illness in the past? yes no
   If yes, when? _________________

3. How long has he/she had this illness? ____

____

MEDICATIONS:

	now	past	frequency
Aspirin	___	___	_______
Tylenol	___	___	_______
Antibiotics	___	___	_______
Decongestants	_	___	_______
Other	___	___	_______

SUPPLEMENTS:

	now	past	dose
Vitamins	____	___	___
Minerals	___	___	___
Fluoride	___	___	___
Herbs:	___	___	___

Allergies to drugs or medications: ____

____

HOSPITALIZATIONS / SURGERIES / ACCIDENTS / SERIOUS INJURIES: Describe each incident and give date & age:

MEDICATIONS TAKEN IN THE LAST 5 YEARS: (Include dates and duration)

IMMUNIZATIONS: (List types, dates given, and any adverse reactions)

SOCIAL HISTORY:

1) Parents: Single______ Married ____ Separated ____ Divorced ____
   Mother's Occupation ___________________ Full Time _______ Part Time ________
   Father's Occupation ___________________ Full Time _______ Part Time ________
2) Other Guardian: ______________________________________ Relationship ___________
3) Others Residing in Home: ______________________________ Relationship ___________
4) Daycare/Preschool/School: ________________ Where ______________________________
   How Many Hours Each Day? _____________ How Many Days Of The Week? _____
5) Siblings: NAME AGE HEALTH PROBLEMS
   1)
   2)
   3)
6) Interaction With Relatives: Who? ________________ How Often? __________

____

CHILD'S HEALTH HISTORY (please check)

NOW PAST NEVER NOW PAST NEVER

____	____	____ Acne	____	____	____ Epilepsy/Seizures
____	____	____ Allergies	____	____	____ Fatigue
____	____	____ Anemia	____	____	____ Frequent Infections
____	____	____ Asthma	____	____	____ Headaches
____	____	____ Bed Wetting	____	____	____ Heart Murmur
____	____	____ Birth Defects	____	____	____ High Fever
____	____	____ Colic	____	____	____ Hyperactivity/ ADD
____	____	____ Constipation	____	____	____ Insomnia
____	____	____ Cough/Wheeze	____	____	____ Jaundice
____	____	____ Cradle Cap	____	____	____ Learning Difficulties
____	____	____ Depression	____	____	____ Moodiness
____	____	____ Diarrhea	____	____	____ Stuffy Nose
____	____	____ Dizzy Spells	____	____	____ Thrush
____	____	____ Earaches	____	____	____ Vomiting Spells
____	____	____ Eczema	____	____	____ Other ______________
____					

CHILDHOOD ILLNESSES (Please check and indicate at what age)

_________ Chicken pox	__________ Scarlet Fever	_________ Mononucleosis
_________ Measles	__________ Rheumatic Fever	_________ Ear Infections
_________ Mumps	__________ Strep Throat	_________ Tonsillitis
_________ Rubella	__________ Pneumonia	_________ Croup
_________ Whooping Cough	__________ Asthma	_________ other ________

FAMILY HISTORY: Identify all family members who have or have had any of the following:

____________ Alcoholism	_____________ Cancer	______________ High Blood Pressure
____________ Allergies	_____________ Diabetes	______________ Hypoglycemia
____________ Anemia	_____________ Eczema	______________ Mental Illness
____________ Arthritis	_____________ Epilepsy	______________ Thyroid disorder
____________ Asthma	_____________ Stroke	______________ Heart Disease
____________ Birth Defects	_____________ Obesity	______________ Hearing Loss
____________ Other (Describe)		

PRENATAL/ BIRTH HISTORY:

MOTHER'S health during the pregnancy with this INFANT/ CHILD/ ADOLESCENT (check and describe in space provided) :

________ Age	________ Trauma/Injury	_________ Alcohol Consumption	________ Illness
________ Bleeding	________ Stress	_________ Nausea	________ Drugs
________ Smoking	________ X-rays	_________ High Blood Pressure	_________ Toxemia
________ Medications	________ Other		

Describe:

TERM: Full ________ Premature ________ Late ________ Birth Weight: _______ LBS______OZ
Was birth / pregnancy: Easy? ____________ Difficult? ________________

Place of Birth: ___ Hospital _____ Home ___ Clinic _____ Other ______ Method

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HABITS:

1.) Does your child eat a special diet?

2.) What are your child's favorite foods?

3.) What is your child's general disposition?

4.) How much does your child sleep?

5.) Does your child wear: _____ cloth diapers _____ disposable _____ none

6.) Date of last check-up______________ with Dr. _________________

7.) List any chemicals, metals, dusts, smoke or fumes your child has been repeatedly exposed to:

8.) Does your child react to pollens? If so, then which ones?

9.) Does your child react to foods? If so, then which ones?

(Check appropriate boxes)

FEEDING:	NEVER	RARELY	FREQUENTLY	WEEKLY	TIMES PER DAY 1X	2x	3X	4X	5X
MOTHER'S MILK (or weaned when?: ________)	________	________	_________	________	___	___	___	___	___
MILK OR FORMULA ____________(KIND)	________	________	_________	________	___	___	___	___	___
SUGAR SWEETS	________	________	_________	________	___	___	___	___	___
FRUIT SWEETENERS	________	________	_________	________	___	___	___	___	___
WHITE FLOUR	________	________	_________	________	___	___	___	___	___
PROTEIN FOODS	________	________	_________	________	___	___	___	___	___
VITAMINS-MINERALS ___________(KIND)	________	________	_________	________	___	___	___	___	___

ASPIRIN ___ ___ ___ ___ ___ ___ ___ ___ ___
LAXATIVES ___ ___ ___ ___ ___ ___ ___ ___ ___

ARE YOU WILLING TO CHANGE YOUR HABITS TO HELP IMPROVE YOUR CHILD'S HEALTH?____

DOES YOUR CHILD HAVE ANY OTHER PROBLEMS YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR? ____

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