



Please fill this form out entirely and bring it with you to your first office visit.

Child's Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

Mother \_\_\_\_\_ Father \_\_\_\_\_ Live w/both parents? Y N \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home/Cell Telephone \_\_\_\_\_ E-mail address \_\_\_\_\_

- Ok to leave message with detailed information       Ok to e-mail with detailed information
- Leave message with call back number only

Work Phone \_\_\_\_\_ Other (please specify) \_\_\_\_\_

- Okay to leave messages with detailed information
- Leave messages with call back information only

How did you hear about Woodstock Natural Health Clinic? \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

**What are your primary health concerns? Please list in the order of their importance to you.**

\_\_\_\_\_  
\_\_\_\_\_

**Medications:**

- |                                  |     |      |                                          |     |      |                                           |     |      |
|----------------------------------|-----|------|------------------------------------------|-----|------|-------------------------------------------|-----|------|
|                                  | now | past |                                          | now | past |                                           | now | past |
| <input type="checkbox"/> aspirin | ___ | ___  | <input type="checkbox"/> Antibiotics     | ___ | ___  | <input type="checkbox"/> decongestant     | ___ | ___  |
| <input type="checkbox"/> tylenol | ___ | ___  | <input type="checkbox"/> anti-histamines | ___ | ___  | <input type="checkbox"/> ibuprofen        | ___ | ___  |
| <input type="checkbox"/> inhaler | ___ | ___  | <input type="checkbox"/> asthma meds     | ___ | ___  | <input type="checkbox"/> topical steroids | ___ | ___  |

Other: \_\_\_\_\_

Allergies to medicine if known: \_\_\_\_\_

**Medical History:**

- |                                      |                                        |                                     |                                                    |
|--------------------------------------|----------------------------------------|-------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> croup         | <input type="checkbox"/> bronchitis | <input type="checkbox"/> tonsillitis # times _____ |
| <input type="checkbox"/> measles     | <input type="checkbox"/> scarlet fever | <input type="checkbox"/> rubella    | <input type="checkbox"/> ear infection # _____     |
| <input type="checkbox"/> mumps       | <input type="checkbox"/> pneumonia     | <input type="checkbox"/> eczema     | <input type="checkbox"/> asthma                    |

Has your child had any special evaluations? If so, what was the date and reason?

electroencephalogram \_\_\_\_\_ speech/language eval \_\_\_\_\_

Hearing evaluation \_\_\_\_\_ psychological eval \_\_\_\_\_

Injuries/Surgeries/ Hospitalizations: \_\_\_\_\_

Immunizations: \_\_\_ measles \_\_\_ mumps \_\_\_ polio \_\_\_ DPT \_\_\_ MMR \_\_\_ tetanus  
\_\_\_ influenza \_\_\_ Hep series \_\_\_ Hib

Any adverse reaction to immunizations? \_\_\_\_\_

**Family History:** Does your child have a family history of any of the following diseases or conditions? When answering, include parents, brother/sisters, and grandparents, if known. Check all that apply.

- |                                        |                                   |                                        |                                             |
|----------------------------------------|-----------------------------------|----------------------------------------|---------------------------------------------|
| <input type="checkbox"/> heart disease | <input type="checkbox"/> cancer   | <input type="checkbox"/> birth defects | <input type="checkbox"/> mental illness     |
| <input type="checkbox"/> hypertension  | <input type="checkbox"/> diabetes | <input type="checkbox"/> tuberculosis  | <input type="checkbox"/> multiple sclerosis |
| <input type="checkbox"/> asthma        | <input type="checkbox"/> epilepsy | <input type="checkbox"/> allergies     |                                             |

Previous pregnancies by natural mother; miscarriages; complications:

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Mother's health during pregnancy: \_\_\_\_\_

Mother smoked during pregnancy? Yes No

**Birth History**

Term: Full \_\_\_\_\_ Premature \_\_\_\_\_ Late \_\_\_\_\_ Weight at Birth \_\_\_\_\_

Length of Labor: \_\_\_\_\_ Complications? \_\_\_\_\_

Does or did your baby have any of the following:

- |                |                    |                    |                 |
|----------------|--------------------|--------------------|-----------------|
| _____ Jaundice | _____ Diarrhea     | _____ Birth Defect | _____ Rashes    |
| _____ Colic    | _____ Fever        | _____ Allergies    | _____ Blue Baby |
| _____ Seizures | _____ Birth Injury | _____ Other: _____ |                 |

**Symptoms**

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

- |                |       |                    |       |                 |       |
|----------------|-------|--------------------|-------|-----------------|-------|
| Hives          | Y N P | burning of urine   | Y N P | bloody urine    | Y N P |
| Eczema         | Y N P | frequent urination | Y N P | cries easily    | Y N P |
| Bleeding gums  | Y N P | heart murmur       | Y N P | nervous         | Y N P |
| Nose bleeds    | Y N P | vomiting spells    | Y N P | sleep problems  | Y N P |
| Acne           | Y N P | anemia             | Y N P | night sweats    | Y N P |
| High fevers    | Y N P | stomach aches      | Y N P | light sensitive | Y N P |
| Chronic rash   | Y N P | jaundice           | Y N P | odors           | Y N P |
| Hearing loss   | Y N P | easy bruising      | Y N P | carsick         | Y N P |
| Diarrhea       | Y N P | flat feet          | Y N P | no appetite     | Y N P |
| Sore throat    | Y N P | constipation       | Y N P | nightmares      | Y N P |
| Headaches      | Y N P | gas                | Y N P | canker sores    | Y N P |
| Frequent colds | Y N P | bleeds easily      | Y N P | unusual fears   | Y N P |
| Wheezing       | Y N P | dizzy spells       | Y N P | hair loss       | Y N P |

Any condition not mentioned? \_\_\_\_\_

**Diet:** Describe your child's typical daily diet: \_\_\_\_\_

Feeding: \_\_\_\_\_ Breast Fed How long: \_\_\_\_\_ Formula \_\_\_\_\_ Milk/Soy

Age began: Solids \_\_\_\_\_ What solids? \_\_\_\_\_ Sitting \_\_\_\_\_

Crawling \_\_\_\_\_ Walking \_\_\_\_\_ First Words \_\_\_\_\_

Baby's Sleep Patterns for the first year: \_\_\_\_\_

Anything else not listed on this form? \_\_\_\_\_

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_