VITALITY NW

NATURAL MEDICINE CLINIC

Today's date: _____

Patient's Name_____

Date of Birth ___/___/___ Age _____

Gender_____ Sex assigned at birth_____

Parent's name _____ Parent's name_____

Please indicate the type of care that you are seeking for your child:

- ○ Primary management of my child's health
- ○ Adjunctive care for my child's health
- ○ Ongoing management of my child's health
- ○ One time advice for my child's health
- ○ I don't know at this time.

Last Physician Seen/ For what condition? _____

Have you ever consulted a Naturopathic Doctor, IBCLC, or Acupuncturist before?

Does your child have any medication, environmental, or food allergies? [ ] yes [ ] no
If yes, please explain to what and what kind of reaction you had:

Allergy (e.g., bees)	Reaction (e.g. anaphylaxis, rash, etc)

Please list all medications and supplements your child is taking including prescriptions, over the counter medications, vitamins, minerals, herbs, homeopathic remedies, and probiotics. Attach another page if needed.

Name of Medication (such as culturelle, Vitamin C, etc)	Strength of medication (81 mg, etc)	Directions (take twice a day away from food, etc)

From the Beginning…

Prenatal/Birth History:
Is your child adopted? _____
Was your child born pre-term? _____How many weeks gestation?_____
Were there pregnancy complications? _____
Type of birth_____
Were there any birth complications? (i.e. shoulder dystocia, low APGAR, forceps, etc)
_____
Did you have an epidural? _____ IV fluids?_____
Is/was your child breastfed? ○ yes ○ no ○ mixed feed ○ donor milk
Amount of time:_____

Breastfeeding history: (if not applicable, leave blank)
Does/is baby....

- ○ click while nursing
- ○ frequently break latch
- ○ have nursing blisters
- ○ favor one side over the other
- ○ colicky
- ○ have reflux
- ○ drool excessively
- ○ have difficulty latching
- ○ favor a nursing shield

How many feeds per day?_____
How long is each nursing session?_____
How many wet diapers per day?_____
How many bowel movements per day?_____

Does/ is mama....

- ○ experience discomfort while nursing
- ○ have plugged ducts
- ○ have or has had thrush
- ○ have or has had mastitis
- ○ have nipple trauma
- ○ sleep deprivation due to continual nursing
- ○ have mood swings with let down
- ○ have painful let down

How much water is mama getting?_____
How much food is mama getting? _____

VITALITY NW
NATURAL MEDICINE CLINIC

Does mama have support? _____

Important for coordinating your care right now…

Medical history: (Check conditions and illnesses for which you have been treated and include year of onset. List any other conditions which may not be included below.)

- ○ No known medical problems
- ○ asthma
- ○ sensory issues
- ○ frequent colds
- ○ developmental delays
- ○ allergies
- ○ nerve palsy
- ○ constipation
- ○ diabetes
- ○ diarrhea
- ○ ADHD/ ADD
- ○ reflux
- ○ torticollis
- ○ bleeding disorder
- ○ genetic diagnosis
- ○ Other Conditions?

Past Surgical History: (indicate year)
Appendectomy
tonsillectomy
hernia repair

Other _____

_____

Family History
Please indicate who in your family has had these health problems and the age at diagnosis if known

- ○ Diabetes_____
- ○ Heart disease _____
- ○ High blood pressure_____
- ○ Cancer (specify type) _____
- ○ Auto immune diseases_____
- ○ Addiction problems _____
- ○ Psychiatric diagnosis_____
- ○ Bleeding problems _____
- ○ Genetic problems _____

Social History:

- Do you feel safe in your home? _____
- Do you have access to enough food to eat? _____
- Is your child in daycare or school? _____
- What grade is your child in?_____
- Child's extracurricular activities: _____

Does anyone in the house smoke? never past, ___pack(s) per day for ___years
yes, ____pack(s) per day for _____years

Exercise: ○ none ○ days per week___ type_____

Average/ Typical daily diet:

Breakfast	
Lunch	
Dinner	
Snacks	
Dessert	
Drinks	
Water	

Childhood illnesses has your child had:

[ ] Scarlet fever [ ] Chicken pox [ ] Measles [ ] Mumps [ ] Rubella
[ ] RSV [ ] Pertussis [ ] other, please specify: _____
_____

VITALITY NW

NATURAL MEDICINE CLINIC

Vaccinations:

DtaP, Hib, PCV, IPV, MMR, Hep B, Hep A, Varicella, Pneumovax, and Influenza are typical American vaccines. Please also note vaccines given that are more common to other countries, such as tuberculosis.

Vaccine	Date given	reaction, if any