

# CHAMPLAIN CENTER FOR NATURAL MEDICINE

## Pediatric Patient Profile

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Nickname: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

### Present Health Concerns

Please list your child's health concerns in order of priority, including date of onset and severity of symptoms.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

What do you believe is causing your child's most important health concerns? \_\_\_\_\_

What goals do you have for your child's visit today? \_\_\_\_\_

**Healthcare Practitioners:** Please list your child's current medical practitioners with their contact information.

	Practitioner's Name	Office Name	City	Phone
Pediatrician				
Specialist				
Specialist				
Therapist				
Pharmacy				

**Medications:** Please list any prescription drugs, over-the-counter medications and supplements (vitamins, minerals, nutrients, herbs, homeopathic remedies, etc.) you child is currently taking.

Medication/Supplement	Reason	Date began	Dose

**Allergies:** Please list and describe any severe or life-threatening allergies (medications, stings, foods, etc.):

(OVER)

**Past Medical History:** Please list the date of or age at each event and describe:

Serious Illnesses and Injuries: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Hospitalizations: \_\_\_\_\_

Date of last physical: \_\_\_\_\_ Date of last blood tests: \_\_\_\_\_

**Childhood Illnesses:** Your child's health is:  Good  Fair  Poor

- |  |  |  |
|--|--|--|
| <input type="radio"/> Chicken Pox              | <input type="radio"/> Mononucleosis (Mono)       | <input type="radio"/> Rheumatic Fever          |
| <input type="radio"/> Diphtheria               | <input type="radio"/> Mumps                      | <input type="radio"/> Tonsillitis              |
| <input type="radio"/> Ear Infections           | <input type="radio"/> Pertussis (whooping cough) | <input type="radio"/> Scarlet Fever            |
| <input type="radio"/> German Measles (Rubella) | <input type="radio"/> Pneumonia                  | <input type="radio"/> Strep Throat (recurrent) |
| <input type="radio"/> Measles                  | <input type="radio"/> Polio                      | <input type="radio"/> Positive TB test         |
| <input type="radio"/> Other: _____             |  |  |

**Immunizations:** Indicate which immunizations have been given to your child and any adverse reactions.

All immunizations up to date  Delayed schedule  Refused immunizations

- |  |  |
|--|--|
| <input type="radio"/> DTP <i>or</i> <input type="radio"/> DTaP _____                               | <input type="radio"/> Pneumococcus (PCV) _____ |
| <input type="radio"/> MMR _____  | <input type="radio"/> Hep B _____              |
| <input type="radio"/> Polio ( <input type="radio"/> IPV <i>or</i> <input type="radio"/> OPV) _____ | <input type="radio"/> Varicella _____          |
| <input type="radio"/> Hib _____  | <input type="radio"/> Other _____              |

**Pregnancy History:** Birth Mother: # of pregnancies: \_\_\_\_\_ # of children: \_\_\_\_\_ Age at delivery: \_\_\_\_\_

Please check any factors during pregnancy. Health during pregnancy:  Good  Fair  Poor

- |   |  |                                     |
|---|--|-------------------------------------|
| <input type="radio"/> Alcohol Consumption | <input type="radio"/> Nausea             | <input type="radio"/> Toxemia       |
| <input type="radio"/> Bleeding            | <input type="radio"/> Recreational Drugs | <input type="radio"/> Trauma/Injury |
| <input type="radio"/> High Blood Pressure | <input type="radio"/> Smoking            | <input type="radio"/> X-Ray         |
| <input type="radio"/> Stress              | <input type="radio"/> Medications: _____ |                                     |

Other health problems or complications during pregnancy: \_\_\_\_\_

**Birth History:**

Term:  Early \_\_\_\_\_ weeks  Full  Late \_\_\_\_\_ weeks Length of labor: \_\_\_\_\_ hours

Place of Birth:  Hospital  Birth Center  Home  Other: \_\_\_\_\_

Birth Medications (if any): \_\_\_\_\_

Complications: \_\_\_\_\_

**Newborn:** Weight at birth: \_\_\_\_\_ lbs \_\_\_\_\_ oz Home from hospital in \_\_\_\_\_ days

- |                                |                                 |                                |
|--------------------------------|---------------------------------|--------------------------------|
| <input type="radio"/> Jaundice | <input type="radio"/> Infection | <input type="radio"/> Seizures |
| <input type="radio"/> Cyanosis | <input type="radio"/> Fever     | <input type="radio"/> Anemia   |

Other important conditions: \_\_\_\_\_

Feeding:  Breast Fed \_\_\_\_\_ months  Formula Fed \_\_\_\_\_ months Type of formula \_\_\_\_\_

**Developmental Milestones:** Please indicate your child's age at each milestone:

Sit up \_\_\_\_\_ months First Tooth \_\_\_\_\_ months Toilet Trained \_\_\_\_\_ months

Crawl \_\_\_\_\_ months First Word \_\_\_\_\_ months

Walk \_\_\_\_\_ months First Sentence \_\_\_\_\_ months

Additional comments about social, cognitive, or physical development: \_\_\_\_\_

**Personal and Family Medical History:**

Please check the  box next to each condition that applies to your child or his/her biological family members.

Key: P=Paternal; M=Maternal; GF=Grandfather; GM=Grandmother

					Grandparents				Siblings			
	Child	Mom	Dad		PGM	PGF	MGM	MGF				
Current Age or Age at Death												
Alcohol/Drug Abuse												
Allergies or Hay Fever												
Alzheimer's or Dementia												
Anemia												
Anxiety / Panic Attacks												
Arthritis / Joint Disease												
Asthma												
Autoimmune Disease												
Bleeding Disorder												
Cancer (what type?)												
Celiac Disease												
Crohns Dis./ Ulcerative Colitis												
COPD / Emphysema												
Depression / Suicide attempt												
Diabetes												
Eczema												
Epilepsy or Seizures												
Glaucoma												
Gall Bladder Disease												
Migraines / Headaches												
Heart Attack												
Heart Disease												
High Blood Pressure												
High Cholesterol												
HIV / AIDS												
Kidney Disease												
Liver Disease / Hepatitis												
Macular Degeneration												
Osteoporosis												
Schizophrenia												
Stroke												
Thyroid disorder												
Other:												
Other:												

**Social History**

Parents:  Biological  Adoptive  Foster  Step-parent(s)

Parents' Marital status:  Single  Married  Divorced  Re-married  Widowed  Significant Other

Mother's Occupation: \_\_\_\_\_ Full or Part Time Father's Occupation: \_\_\_\_\_ Full or Part Time

Siblings:  Yes  No Please list their age(s) \_\_\_\_\_

Household:  Parent(s)  Sibling(s)  Grandparent(s)  Pet(s) \_\_\_\_\_  
 Other \_\_\_\_\_

Pre-School/Daycare/School: \_\_\_\_\_ Hours per day: \_\_\_\_\_ Days per week: \_\_\_\_\_

**Personality and Habits:**

How does your child react to stressful events? \_\_\_\_\_

What are your child's primary sources of stress? \_\_\_\_\_

How much does stress impact your child's life? \_\_\_\_\_ Hours of play per day? \_\_\_\_\_

Favorite activities? \_\_\_\_\_

Does your child:

Exercise regularly?  Yes  No What kind? \_\_\_\_\_

Sleep soundly and wake rested?  Yes  No If no, why? \_\_\_\_\_

Sleep: \_\_\_\_\_ hours per night Naps: \_\_\_\_\_ hours per day

Play well with others?  Yes  No If no, why? \_\_\_\_\_

Enjoy time alone?  Yes  No If no, why? \_\_\_\_\_

Have sensory sensitivities?  Yes  No What kind? \_\_\_\_\_

Have strong fears or phobias?  Yes  No What kind? \_\_\_\_\_

Have rituals/repetitive behaviors?  Yes  No What kind? \_\_\_\_\_

**Diet:**

Age Solid Foods Begun: \_\_\_\_\_ months First Foods: \_\_\_\_\_

Age of Introduction for: Cow's Milk \_\_\_\_\_ months Wheat: \_\_\_\_\_ months

Does your child have any dietary restrictions? \_\_\_\_\_

Your child's favorite foods? \_\_\_\_\_

Foods your child refuses? \_\_\_\_\_

How is your child's appetite? \_\_\_\_\_ Thirst? \_\_\_\_\_

Please describe a typical day below:

Breakfast Time: _____	Lunch Time: _____	Dinner Time: _____	Snacks Times: _____

Water: \_\_\_\_\_ oz. per day Other beverages: \_\_\_\_\_

What else would you like us to know about your child?

This form has been reviewed by the doctor with the parent.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Doctor

\_\_\_\_\_  
Date