Queen Anne Naturopathic Center, Ltd.

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CONFIDENTIAL PATIENT PROFILE – CHILD/TEENAGER

Please print clearly!

NAME _____ Sex _____ Today's date _____
ADDRESS _____ Height: _____
CITY/STATE/ZIP _____ Weight: _____
AGE _____ BIRTH DATE _____ PHONE (home) (_____) _____ - _____

PARENT NAME _____ work phone (_____) _____ - _____
cell phone (_____) _____ - _____
PARENT NAME _____ work phone (_____) _____ - _____
cell phone (_____) _____ - _____
PARENT EMAIL _____

Please tell us how you found out about our office or who you were referred by:
_____
Are you currently being seen by other health practitioners? (Please list names & phone # if avail.)
_____
_____
_____

Social History:
School grade _____
Siblings? (if yes, list name(s) & ages) _____
Pets? (if yes, list name(s) and type) _____

Physical History: (This is a confidential medical record and will not be released without legal authorization)
What is the reason for your visit? Please list your most important present health concerns in order of significance.

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

List prescription (Rx) and non-prescription medications presently taking, with dosage:

_____ _____
_____ _____
_____ _____

List Vitamins, minerals, herbs, homeopathic remedies presently taking, with dosage:

_____ _____
_____ _____
_____ _____
_____ _____

PLEASE COMPLETE INFORMATION ON REVERSE

Birth History: ___ Normal ___ Premature Birth Weight & Inches: _____
Birth Complications? _____

Hospitalizations: (List reason and approximate age or year it occurred)

_____
_____
_____

Other accidents or serious illnesses?

_____
_____

Childhood illnesses:

_____ Chicken Pox _____ Measles _____ Mumps/Rubella
_____ other: _____
Any complications? _____

Has child been vaccinated? If yes, which vaccines?

Are you allergic to any medications or supplements? _____ **YES** _____ **NO**

If YES, list drug/supplement and reaction: _____
_____

Are you allergic to any foods? Are there any foods that don't agree with you? (list food and reaction)

_____
_____

Any environmental allergies? _____

Lifestyle History:

Average hours of sleep/night _____ Do you awake easily? _____
Describe any difficulties or patterns with your sleep _____
Freq. of bowel movements: _____ per day or _____ per week, ___ loose ___ normal ___ hard

Diet History:

I eat on average # servings per day (/d) or week (/w):

_____ meat _____ vegetables _____ fruit _____ whole grains
What do you drink daily? (?glasses/day) _____ Milk _____ Soda pop _____ Juice _____ Water
Do you drink diet sodas or other foods/liquids with NutraSweet/Aspartame? _____
Describe your appetite: _____
What are your favorite foods that you eat frequently? _____
_____
_____

Family History (blood relatives): List major illnesses/health challenges. Also, list age. If deceased, circle the age.

Father: (age _____)

Grandfather: (age _____)

Grandmother: (age _____)

Mother: (age _____)

Grandfather: (age _____)

Grandmother: (age _____)

Aunts/Uncles/Siblings: