DR. MAURA
NATUROPATHIC DOCTOR

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Date: _____

PEDIATRIC/ADOLESCENT PATIENT PROFILE

Patient's Name: _____ Age: ___ Sex: ____ Birthdate: ___

Address: _____
Email:_____
Mother's Name: _____ Father's Name: _____ Other: ___

Phone (home): _____ (work): _____ mother/father/other

Who can I thank for referring you to me? _____
Child's Primary Care Physician: _____
Person To Be Notified
In Case of Emergency: Name: _____ Relationship: _____

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?

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

7.) Date of last check-up_____ with Dr. _____

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

9.) 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? _____

_____

_____

_____