



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.**

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**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     |   |

**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: \_\_\_\_\_

\_\_\_\_\_

Food intolerances (known) \_\_\_\_\_

Anything else not listed on this form?

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

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