Dayspring Naturopathic Clinic

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Dear parent,
Please fill out this form and bring it with you on the first visit. Please note that all information disclosed is *confidential and will not be released* without your permission.

Child's name: _____ Date: _____
Address: _____
Zip Code: _____Age: _____Sex: _____Birth date: _____

Parent or Guardian's name: _____Occupation: _____
Address (if different from above): _____
Telephone (Home): _____ (Work): _____
Email: _____
Name of family physician: _____Telephone: _____

How did you hear about us? _____

List reason(s) for your visit in order of importance (include date of onset with each concern):
1. _____
2. _____
3. _____
4. _____
5. _____

Is your child currently receiving any treatment(s) for these concerns? Have they been effective?
_____
_____

List any current medications (prescription, over-the counter, vitamins, herbs, homeopathics): ___
_____
_____
_____
_____

List any past prescription medications: _____
_____
_____

List any surgeries, hospitalizations, accidents, or serious injuries that your child has had: _____
_____
_____
_____

List any allergies or intolerances: _____
_____
_____
_____

IMMUNIZATIONS

o Measles, mumps, rubella
o Diptheria, pertussis, tetanus
o Polio
o Other _____
o Influenza
o Small pox
o Hepatitis

Has he/she had any adverse reactions to any immunizations? _____
_____

FAMILY HISTORY
Have any family members (including immediate family, grandparents, aunts and uncles) had any of the following conditions?

o Alcoholism
o Allergies
o Anemia
o Arthritis
o Asthma
o Cancer
o Depression
o Diabetes
o Drug addiction
o Epilepsy
o Headaches
o Heart disease
o Hypertension
o Kidney disease
o Mental illness
o Stroke
o Tuberculosis
o Other? _____

CHILDHOOD ILLNESSES
Has he/she ever had any of the following?

o Chicken Pox
o Measles
o Polio
o Scarlet fever
o Other _____
o Ear infections
o Mumps
o Rheumatic fever
o Tonsillitis
o Frequent colds
o Pneumonia
o Rubella
o Whooping cough

PRENATAL HISTORY

	Poor	**Fair**	**Good**	**Excellent**
Health of father at conception:	o	o	o	o
Health of mother at conception:	o	o	o	o
Physical health of mother during pregnancy:	o	o	o	o
Emotional health of mother during pregnancy:	o	o	o	o
Emotional health of mother following pregnancy:	o	o	o	o
Mother's diet during pregnancy:	o	o	o	o

Number of pregnancies: ____Number of miscarriages: ____Mother's age at birth of child: _____
List any illness or other difficulties during pregnancy: _____
_____
Indicate any drug or alcohol consumption or cigarette smoking during pregnancy. (circle) _____
_____
List any medication, supplements or herbal remedies taken during pregnancy: _____
_____

LABOR AND DELIVERY

Location of birth: _____Duration of labor: _____
Description of birth:

o Induced	o Forceps	o C-section	o Late	o Pain medications
o Spontaneous	o Epidural	o Natural	o Premature	o Other?

Birth weight: _____Birth length: _____Head circumference: _____

NEONATAL HISTORY

List any difficulties or complications soon after birth: _____
List any therapies or medications administered: _____

	Poor	**Fair**	**Good**	**Excellent**
Health of child at birth:	o	o	o	o
Health of child in first year:	o	o	o	o
Sleep patterns in first year of life:	o	o	o	o

NUTRITION

Infant feeding: Breast fed? _____How long? _____
Formula? _____ Describe: _____
Milk?
o cow o goat o soy o nut o other _____

Current weight: _____Current height: _____
Age of introduction to solid foods: _____What foods introduced first? _____
Favorite foods: _____ Excluded foods: _____

GROWTH AND DEVELOPMENT

Age he/she began:

Crawling: _____ Toilet training: _____
Sitting: _____ Teething: _____
Walking alone: _____ Saying first words: _____

Any concerns (by parents and / or teachers) in regards to his/her physical, social or mental development? _____

LIFESTYLE / ENVIRONMENTAL FACTORS

Is he/she exposed to any chemicals or tobacco smoke at home or at school? Explain: _____
_____
What are his/her hobbies? _____
How is his/her energy level? Rate on scale of 1 to 10 (1=very low; 10=excellent) _____
Emotional climate at home: o very stable o stable o stressful o very stressful

CONSENT FOR TREATMENT & FINANCIAL AGREEMENT: *By signing this, I hereby authorize the staff of Dayspring Naturopathic Clinic to treat my child using naturopathic medicines according to the principles of naturopathic practice. If I desire allopathic medical treatment, I am free to seek such treatment from a physician. I understand Dayspring Naturopathic Clinic will make the best effort to treat my child but make no guarantee to cure my child.*

I certify that the above information is true. I understand that charges will be made and herby agree that I am financially responsible for any such charges.

Signature_____ Date_____