Dr. Christine White
Black Bear Naturopathic Clinic, PC
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Pediatric Health History/ Review of Systems

Name_____Date_____

Age_____Date of Birth_____Gender_____Social Security #_____

Mother's name _____ Father's name _____

Address_____City_____State_____Zip_____

Telephone—Home_____Work_____Cell_____

How did you hear about us? Phone Book Family/Friend Missoulian Independent Website

Email Address_____

If you were referred by someone, let us know who so we can thank them_____

Parents: (circle all that apply) Biological Adoptive Step- Living together Married Separated Divorced

Please Initial and Sign

_____I authorize Dr. Christine White and/or Dr. Nancy Dunne to examine and treat me.

_____I understand that the treatments and therapies provided or recommended by this clinic may be different from those offered by another licensed health care provider, and that I am at liberty to seek other care as well.

_____I understand that payment is expected at the time of service.

_____If I choose to submit billings to my insurance company, I consent to the release of all information the insurance company may request for the filing of insurance claims.

Patient Signature_____Date_____

Responsible Party, if other than the patient_____

Please list your concerns about your child's health:

_____
_____
_____
_____

MEDICAL HISTORY

__Chicken Pox	**__Scarlet Fever**	**__Tonsillitis, how many times _____**
__Measles	**__Pneumonia**	**__Ear Infections, how many times _____**
__Mumps	**__Frequent colds**	**__Other (please list) _____**
__Rubella	**__Rheumatic Fever**	**_____**

MEDICATIONS

	now	past		now	past
Aspirin	**___**	**___**	**Antibiotics**	**___**	**___**
Tylenol	**___**	**___**	**Anti-histamine**	**___**	**___**
Decongestant	**___**	**___**	**Other**	**___**	**___**

Ibuprofen ___ ___

List all medicines currently taken:

_____
_____
_____

SUPPLEMENTS List all currently taken:

_____
_____
_____

ALLERGIES to medicines, food, pets, pollens etc:

_____
_____

Has your child ever had any of the following tests?

	When?	Results?
EKG		
EEG		
Psychological Evaluation		
Hearing Evaluation		
Speech/Language Evaluation		

IMMUNIZATIONS

__Measles __Polio __MMR __Smallpox __Diphtheria ___Hepatitis B
__Mumps __DPT __Tetanus __Influenza __ Pneumonia ___Other (list)

FAMILY HISTORY: any parents, grandparents, siblings, aunts, uncles, cousins with:

__Heart disease __Diabetes __Birth defects __Hypertension __ Asthma __ Eczema __ Arthritis
__Tuberculosis __Cancer __Allergies __Mental Illness

Birth mother's previous pregnancies: miscarriages or complications? _____

Birth mother's age at child's birth? _____

Birth mother's health during pregnancy? check all that apply.

__ Bleeding __Physical or emotional trauma
__ Nausea __Cigarettes, alcohol, drug consumption
__Illnesses __Medications
__ Hypertension __Thyroid problems
__ Obesity __Diabetes

BIRTH HISTORY

Term: ____Full ____Premature ____Late Birth Weight: _____lbs _____oz

Length of labor: _____hours; complications:_____

Has your child ever had any of the following problems?

__Jaundice	__Diarrhea	__Birth defects	__Rashes
__Colic	__Fever	__Cerebral Palsy	__Allergies
__Blue baby	__Seizures	__Birth injuries	__other(explain) _____

Child's sleep pattern (first year)_____

Feeding: Breast fed? _____ How long? _____ Formula: Milk Cow ____ Goat ____ Soy ___ Other _____

Age child began: solid foods _____ sitting _____ crawling _____ walking _____ teething _____

first words _____ exposed to indoor pets _____ day care outside the home _____

SYMPTOMS

__Hives
__Eczema
__Bleeding of gums
__Nose bleeds
__Acne
__High fevers
__Chronic rash
__Hearing loss
__Diarrhea
__Sore throat
__Frequent headaches
__Frequent colds
__Wheezing
__Cough
__Burning of urine
__Frequent urination
__Heart murmur
__Vomiting spells
__Anemia
__Stomach aches
__Jaundice
__Easy bruising
__Flat feet
__Constipation
__Gas
__Bleeding tendency
__Joint pain
__Dizzy spells
__Bloody urine
__Cries easily
__Nervous
__Sleep problems
__Night sweats

SYMPTOMS

__Sensitive to light _____
__Body/breath odor _____
__Motion/car sickness _____
__No appetite _____
__Nightmares _____
__Canker sores _____
__Unusual fears _____
__Excessive fatigue _____
__Hair loss _____

DIET

Please describe your child's typical daily/weekly diet.

_____

_____

_____nnnn_____

_____

_____

_____

_____

_____

_____

_____

_____

_____