

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?

- | | | | |
|------------------------------------|-----------------------------------|---|---|
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Birth defects | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Fever | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Blue baby | <input type="checkbox"/> Seizures | <input type="checkbox"/> Birth injuries | <input type="checkbox"/> 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.

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