

Whole Health Clinic

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Date: _____

PEDIATRIC/ADOLESCENT PATIENT PROFILE

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

Address: _____

Mother's Name: _____ Father's Name: _____ Other: _____

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

How did you hear about us? _____

Child's Primary Care Physician: _____

Person To Be Notified

In Case of Emergency: Name: _____ Relationship: _____

Insurance information: Name of the insurance company? _____

Subscriber's name (This could be the child or his/her parents)? _____

Subscriber's employer? _____

Subscriber's date of birth? _____

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	___	___	_____

Allergies to drugs or medications: _____

SUPPLEMENTS:

	now	past	dose
Vitamins	___	___	___
Minerals	___	___	___
Fluoride	___	___	___
Herbs:	___	___	___

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:

- Parents: Single _____ Married _____ Separated _____ Divorced _____
Mother's Occupation _____ Full Time _____ Part Time _____
Father's Occupation _____ Full Time _____ Part Time _____
 - Other Guardian: _____ Relationship _____
 - Others Residing in Home: _____ Relationship _____
 - Daycare/Preschool/School: _____ Where _____
How Many Hours Each Day? _____ How Many Days Of The Week? _____
 - Siblings: NAME AGE HEALTH PROBLEMS
1)
2)
3)
 - Interaction With Relatives: Who? _____ How Often? _____
-

CHILD'S HEALTH HISTORY (please check)

NOW	PAST	NEVER	NOW	PAST	NEVER
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___

Acne
Allergies
Anemia
Asthma
Epilepsy/Seizures
Fatigue
Frequent Infections
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

HABITS:

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?
