Fox Valley
NATURAL MEDICINE

PEDIATRIC PATIENT PROFILE

Date:_____

Last Name: _____ First Name:_____

Date of Birth:_____ Sex: M F Email:_____

Address:_____

Home/Work Telephone:_____Mobile/Work Telephone:_____Circle Preference

Referred By?_____

Please fill out the following information. This is a confidential health record and will not be released unless Fox Valley Natural Medicine receives written permission.

Chief Complaint and Present Health Concerns

List the most important health concerns in their order of significance	Prior Diagnosis of the problem

What are your goals for today?_____

_____

Please list prescription medications that you are taking, with dosages and prescribing physician:_____

_____

List any vitamins or nutritional supplements that you are taking:_____

_____

List any severe or life-threatening allergies. Please explain:_____

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Personal Habits

Any dietary restrictions or food sensitivities? If Yes please explain:_____

_____

Exercise? Yes No What Type/ How Often:_____

_____

Past Medical History

Hospitalizations:_____

Serious Illnesses and Injuries:_____

Date of last physical Exam:_____ Date of Last Blood Test:_____

Prenatal History: Mother's health during pregnancy with this child

Age	Trauma	Alcohol
Bleeding	Stress	Drugs
Nausea	High blood pressure	Smoking
Illness	Radiation	Antibiotics
Toxemia	medications	Gestational diabetes

First Year

Term age _____ birth weight _____ place of birth _____

Breastfed Y / N Duration _____ Formula Y / N Duration _____

Food Introduction Age _____ What Food _____

Vaccination history: please not any adverse reaction

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Childhood Diseases History

Condition	Yes	Complication	Condition	Yes	Complication
Chicken pox			Scarlet fever		
Measles			Rheumatic fever		
Mumps			Strep throat		
Rubella			Pneumonia		
Whooping cough			Asthma		
Tonsillitis			Croup		

Family History: Please check yes if the condition applies a family member. Please use P for past and C for current.

Condition	Yes	Relation	P / C	Condition	Yes	Relation	P / C
Alcoholism				Headaches			
Allergies				Heart disease			
Anemia				Hepatitis			
Arthritis				High blood pressure			
Asthma				Kidney disease			
Cancer				Mental illness			
Depression				Stroke			
Eczema				Tuberculosis			
Epilepsy				Diabetes			
drug addiction				Other			

Social History

Parents: Married / Significant Other/ Divorced

Mother's Occupation _____ Father's Occupation _____

Do you have siblings? Yes No List their ages:_____

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CONSENT TO TREATMENT OF MINOR CHILD

I, being the parent of legal guardian, hereby authorize Dr. _____ and whomever s/he may designate as assistants to administer treatment as deemed necessary to:

Full name of child _____

Child's address _____

Signature _____ Date _____

Printed name _____ Relationship to child _____

Witness _____

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