



Anderson Natural Health Clinic

607 Market Street, Kirkland, WA 98033
425-822-8356/fax: 425-822-7842

Child Patient Profile

Please complete the following questionnaire as thoroughly as possible to aid your clinician in their diagnosis and treatment. This will become a part of your child's confidential medical record and will not be released unless you have authorized us to do so. Please write "NA" in those sections which do not apply. PLEASE PRINT CLEARLY.

Patient Information

Name:		Sex: M F	Date:	Birthdate:	SS#:
Address:		City:	State:	Zip Code:	Home Phone:
Place of Birth:	Grade in School:	Emergency Contact:		Phone:	Relation:
Names of Parents:			Parent's Occupation:		
1.			1.		
2.			2.		

Present Health Concerns

List the reasons for this appointment in order of importance:	Duration:
1.	1.
2.	2.
3.	3.
4.	4.
Name of last Doctor consulted:	Date of last check-up:

What level of change to your living habits are you willing to make to improve your child's health? (circle one):

Whatever it takes Significant Change Some Change No Change

Vitamins/Herbs/Supplements that your child is taking now:

Name / type	Reason for taking	Dose/day	For how long	Who prescribed

Drugs (prescription and over-the-counter, that your child is taking now):

Name of drug	Reason for drug	Dose	For how long	Doctor

Allergies (drugs, food, environmental). Please circle any which are life-threatening):

Is your child sensitive to chemical smells? _____

List any chemicals, fumes, and dusts etc. that your child is or has been repeatedly exposed to:

Medical / Health History:

Primary Care Doctor/Provider (if any): _____ Date last seen: _____

Reason for seeing: _____

Clinic Name: _____ Phone #: _____ Fax #: _____

Address of Clinic: _____

Other Current Health Providers: Type: Phone: Fax:

How would you describe your child's general health? _____

Date of last full physical exam: _____ Results: normal other _____

Date of last urine test: _____ Results: normal other _____

Date of last blood work: _____ Results: normal other _____

Childhood diseases: _____

Immunizations:

Type:	Date/Age	Adverse Reaction:	Type:	Date/Age	Adverse Reaction:
Hep B			Pneum.		
DTaP			Varicella		
Polio			Meningitis		
MMR			Hep A		
Hib			TB		
Flu			Small Pox		

Outpatient Procedures / Hospitalizations (surgeries/special diagnostic studies):

Type: _____ Date: _____ Reason for procedure/admission: _____ Outcome/Results: _____

Major Illness/Emotional or Physical Trauma/Accidents (not already listed):

Type: _____ Date: _____ Treatment received: _____ Outcome: _____

Family History: Using the following key, designate which family members have had the following. List type where parentheses are present.

M=Mother F=Father B=Brother S=Sister G=Grandparent C=Child

Condition	M	F	B	S	G	C	Condition	M	F	B	S	G	C
Alcoholism							Hearing Loss						
Allergies							Heart Disease						
Anemia							High Blood Pressure						
Arthritis (Rheumatoid)							High Cholesterol						
Arthritis (Osteo)							Hypoglycemia						
Asthma							Kidney Disease						
Auto Immune Disease							Mental Disorder						
Bleeding Tendency							Obesity						
Cancer ()							Stroke						
Cancer ()							Thyroid (low/high)						
Diabetes							Tuberculosis (TB)						
Drug Addiction							Other:()						
Epilepsy							Other:()						
Headache							Other:()						

Speech: (please circle all that apply)

Stuttering hesitation baby talk lisping

Approximate number of words in vocabulary: _____

Eliminations:

Bowel movement habits

Urine habits

Frequency: (how often) Per day, times per week		Frequency: (how often in 24 hours)	
Color: (black, brown, yellow, green, white)		Color: (dark yellow, lt. yellow, green, colorless)	
Consistency: (hard, formed, soft, watery)		Character: (clear, cloudy, dilute, etc.)	
Any mucus or blood? (which)		Blood or sediment? (which)	
Does stool pass easily?		Any pain, incontinence, other symptoms?	
Does child not want to defecate?		Any bed wetting?	

Digestion: Any stomach upset, bloating, burping, flatulence (gas), nausea, or rectal itching after food? (circle or specify): _____

Review of Systems Has your child suffered from any of the following? **P=Past N=Now**

	P	N		P	N		P	N		P	N
Rashes			Hay fever			Hypertension			Abdominal pain		
Lumps			Sinus trouble			Heart murmur			Bloating		
Sores			Chronic colds			Palpitations			Constipation		
Itching/dryness			Dry mouth			Rheumatic fever			Diarrhea		
Hair/nail changes			Gums bleed			Breathing trouble			Heartburn		
Anemia			Sore Tongue			Blood in urine			Excess gas		
Easy Bruising			Stiff neck			Urinary infect.			Nausea		
Slow Healing			Swollen glands			Excess urination			Vomiting		
Nose Bleeds			Goiter			Pain on urination			Rectal Itching		
Headaches			Discharge			Urination at night			Nervousness		
Head Injury			Excess thirst			Incontinence			Mood changes		
Eye Pain			Cold intolerance			Urinary hesitance			Muscle pain		
Vision change			Excess sweating			Vaginal Discharge			Joint pain		
Flashing Lights			Excess hunger			Leg cramps			Back pain		
Hearing Loss			Fatigue			Eczema			Stiffness		
Earaches			Cough			Hives			Weakness		
Ringling Ears			Spitting blood			Runny nose			Tremors		
Dizziness			Wheezing			Asthma			Paralysis		
Ear Infections			Chest pain			Food intolerance			Numbness		

Any thing else we need to know about your child?