Illuminate
NATURAL HEALTH

New Patient Paperwork- Pediatric

NAME: _____ **DOB:** _____

Phone: _____ **Email:** _____

Address: _____

Parent(s) Name: _____

How did you hear about our clinic? _____

ARE YOU UNDER THE CARE OF A PHYSICIAN? _____

IF NOT, WHEN DID YOU LAST RECEIVE HEALTH CARE?_____

WHAT WAS THE REASON?_____

Height: _____ **Weight:** _____ **Blood Type:** _____ ❑ **Unknown**

ALLERGIES: _____

HEALTH HISTORY /PREVIOUS DIAGNOSES/ HOSPITALIZATIONS/SURGERY:

_____

_____

_____

VACCINATION STATUS: NONE DELAYED FULLY VACCINATED

FAMILY HISTORY:_____

❑ Cancer ❑ Kidney Disease ❑ Tuberculosis ❑ Asthma ❑ Diabetes

❑ Epilepsy ❑ Stroke ❑ Heart Disease ❑ High Blood Pressure ❑ Hay Fever

❑ Arthritis ❑ Anemia ❑ Hives ❑ Glaucoma ❑ Mental Health Illness

❑ Autoimmune disease

WHAT 3 EXPECTATIONS TO YOU HAVE FOR FOR THIS VISIT?

_____

_____

_____

WHAT LONG TERM EXPECTATIONS DO YOU HAVE FROM WORKING WITH THIS CLINIC?

_____

_____

_____

MEDICATIONS/SUPPLEMENTS:

MOTHER'S PREGNANCY STORY: (please include any health conditions, stressful situations ie: moving, divorce; nutrition, medications)

BIRTH STORY: (Please include how many weeks gestation, natural labor or induced, name of OB/ midwife, hospital/home/unassisted birth, how long, complications, trauma, vaginal or C-section, NICU, any medications at birth, surgical procedures soon after birth)

DUE DATE: _____ **ACTUAL BIRTH DATE:** _____

MILESTONES: (Please list when they reached the milestone, if it was equal Left to Right, anything unusual like abnormal crawl or toe walking)

Breastfeeding: _____
Rolling over: _____
Crawling: _____
Standing: _____
Walking: _____
Talking: _____
Eye contact: _____
Emotional Connection: _____
Responding socially appropriately: _____

DIET & LIFESTYLE

BREAST MILK:	**FORMULA- FED:**
BREASTFED OR PUMP?	REASON?
SINCE BIRTH?	BRAND?
FOR HOW LONG?	GAS, REFLUX, DIARRHEA, SLEEP ISSUES?
ANY SUPPLEMENTATION?	
GOOD OR POOR LATCH?	
TONGUE/LIP/CHEEK TIE?	
WHEN WAS VERY FIRST LATCH?	
PREFER ONE BREAST OVER THE OTHER?	

3-DAY DIET RECALL (For children eating solids)

	Breakfast	**Lunch**	**Dinner**	**Snacks**	**Beverages**	**Symptoms**: Mood/ Skin/ Bowels/ Sleep
Day 1						
Day 2						
Day 3						

Avoid any particular foods? _____

Bowel Movements: (circle what applies)

Well formed
Daily
Diarrhea
Constipation
Grey/Green/Black/Red
Undigested foods
Foul Smell
Greasy
Excessive gas

SLEEP

How many hours?_____Wake during night? _____
Hard to fall asleep?_____Awake rested?_____

Complete if applies:

Main interests or hobbies: _____

How many hours of TV per week?_____

EXERCISE? _____ What kind? _____ How often? _____

REVIEW OF SYSTEMS:

Circle/highlight if the condition or symptoms are a present concern.
*Mark **P** for those you have experienced in the past.*

IMMUNE
Chronic Fatigue
Swollen glands
Slow healing
Frequent colds
Hay fever
Seasonal allergies
Food reactions
Cancer

ENDOCRINE
Blood sugar dysregulation
Excessive thirst/hunger
Fatigue
Heat or Cold Intolerance

MENTAL/EMOTIONAL
Depression
Anxiety
Mental illness diagnosis
Counseling/therapy

NEUROLOGICAL
Seizures
Muscle Weakness
Spastic/rigid muscles
Poor memory
Head Injury
Vertigo/Dizziness
Poor balance
Numb/tingle
Paralysis
Headaches/ Migraines
Feeling of bugs crawling on skin
Delayed milestones
Toe walking
No eye contact
Cerebral Palsy
Horner's Syndrome
"lazy eye"

SKIN
Rashes
Acne
Lumps
Light spots
Eczema
Psoriasis
Hives
Itching
Hair loss

EYES
Color blindness
Impaired vision
Seeing spots
Double vision
Glasses
Tearing
Dryness

NOSE/SINUSES
Stuffiness
Nose bleeds
Loss of smell

MOUTH/ THROAT
Frequent sore throat
Hoarseness
Clear throat after eat
Cavities
Sores in mouth
Teeth grinding
TMJ pain/ clicks
Dry mouth
Excess saliva
Always thirty
Never thirsty

NECK
Pain/Stiffness
Swollen glands

RESPIRATORY
Cough
Sputum/Phlegm
Cough up blood
Asthma
Pneumonia
Pain with breathing
Shortness of breath (SOB)

CARDIOVASCULAR
High/Low blood pressure
Murmurs
Irregular heartbeat/ flutter/palpitations
Chest pain
Easy bleeding/bruising?

GASTROINTESTINAL
Poor latch
Gag with solids/ Trouble swallowing
Nausea/vomiting
Ulcers
Jaundice
Gall Bladder disease
Appendicitis
Liver disease
Hemorrhoids
Reflux
Heartburn
Abdominal pain
Belching/ passing gas
Bloating
How often bowel movements?

URINARY
Pain with Urination
Urinate at night
Frequent urination
Frequent infections
Incontinence
Other _____

MUSCULOSKELETAL
Pain or stiffness
Poor tone
Hight tone (spastic or rigid)
Broken bones
Muscle spasm or cramps
Weakness
Muscle twitching

FEMALE REPRODUCTIVE
Age of first menses
Length of cycle
Duration of menses
Painful menses/Clotting/ Heavy flow/PMS
Endometriosis
Ovarian cysts

MALE REPRODUCTIVE
Circumcised
Hernias
Testicular pain
Discharge/ sores
Testicular mass
Undescended testes

List your child's Diagnoses in Chronological order, and your thoughts about them.

List your concerns in order of importance:

Chief Concern 1: _____
(complete for up to 3 concerns)

Onset of illness: _____

Description: (location, radiation, severity)

Timeline of illness (how have things changed with time):

Treatments you have tried (conventional and Natural):

Treatments that have worked:

Chief Concern 2: _____

(complete for up to 3 concerns)

Onset of illness: _____

Description: (location, radiation, severity)

Timeline of illness (how have things changed with time):

Treatments you have tried (conventional and Natural):

Treatments that have worked:

Chief Concern 3: _____

(complete for up to 3 concerns)

Onset of illness: _____

Description: (location, radiation, severity)

Timeline of illness (how have things changed with time):

Treatments you have tried (conventional and Natural):

Treatments that have worked: