Center for Innovative Medicine
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Patient's Name *

First Name Last Name

Date *

Month Day Year

Age

Date of Birth

Month Day Year

Gender

Parent/Guardians Name

Phone Number (Home) *

Phone Number (Parents work)

Parents Email Address

example@example.com

How did you hear about this clinic?

Has any other family member already been a patient at this clinic?

Name of doctor's office/hospital/clinic where your child's health records are kept:

Reason for referral or presenting problems:

Medications

Type a question

- ☐ Aspirin
- ☐ Antibiotics
- ☐ Decongestants
- ☐ Tylenol
- ☐ Ibuprofen
- ☐ Antihistamines

Other

Allergies to Medicines:

Medical History

Type a question

- ☐ Chicken Pox
- ☐ Measles
- ☐ Rubella
- ☐ Frequent colds
- ☐ Scarlet fever
- ☐ Mumps
- ☐ Pneumonia
- ☐ Rheumatic fever

Tonsilitis, approx. no. of times:

Ear infections, approx. no of times:

Strep throat, approx. no. of times:

Other:

Has your child ever had any of the following?

Electroencephalogram (EEG):

Psychological evaluation:

Hearing test:

Speech/language test:

Injuries/Surgeries/Hospitalizations (please list):

IMMUNIZATIONS

- ☐ Chicken pox
- ☐ Measles
- ☐ Mumps
- ☐ Diphtheria
- ☐ Tetanus
- ☐ H. influenza
- ☐ Smallpox
- ☐ MMR
- ☐ Rubella
- ☐ DPT
- ☐ Polio

Others

Adverse reactions? If yes, what?

FAMILY HISTORY

*

- ☐ Heart disease
- ☐ Hypertension
- ☐ Cancer
- ☐ Mental illness
- ☐ Birth defects
- ☐ Asthma
- ☐ Diabetes
- ☐ Arthritis
- ☐ Allergies
- ☐ Osteoporosis
- ☐ Tuberculosis

Other significant:

PARENTAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications?

Mother's age at child's birth

Mother's health during pregnancy *

- ☐ Bleeding
- ☐ Illness
- ☐ Nausea
- ☐ Physical or emotional trauma
- ☐ Cigarettes, alcohol, drug consumption
- ☐ Medications
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Hypertension

BIRTH HISTORY (Term)

Other

Complications

Birth city & state

Birth time

Birth weight

Did your child have any of the following problems shortly after birth?

- ☐ Rashes
- ☐ Birth injuries
- ☐ Seizures
- ☐ Colic
- ☐ Birth defects
- ☐ Jaundice
- ☐ Blue baby
- ☐ Cerebral palsy
- ☐ Fever
- ☐

Child's sleep patterns (1st year):

Food intolerances:

Breast fed: Y/N

- ☐ Yes
- ☐ No

How long:

Formula Y/N Type (milk, soy):

Age began solids:

Which foods:

Age began: Sitting

Crawling

Walking

Talking

Symptons

Y =a condition now P=significant problem in the past N=never had S=Sometimes a problem

	Hives	Burning urine	Bloody urine	Eczema	Cries easily	Bleeding gums	Heart murmur
Y							
P							
N							
S							

	Nervous	Nose bleeds	Vomiting spells	Sleep problems	Asthma	Acne	Anemia
Y							
P							
N							
S							

	Night sweats	High fevers	Jaundice	Sensitive to light	Chronic rash	Stomach aches	Diarrhea
Y							
P							
N							
S							

	Hearing loss	Easy bruising	Sore throats	Flat feet	No appetite	Body/breath odor	Constipation
Y							
P							
N							
S							

	Nightmares	Frequent colds	Bleeding tendency	Unusual fears	Wheezing	Joint pains	Dizzy spells
Y							
P							
N							
S							

	Hair loss	Excessive fatigue	Cough	Allergies	Frequent urination
Y					
P					
N					
S					

DIET

Please describe your child's typical daily diet: