



For Office Use Only:	
<input type="checkbox"/> Bloomington Natural Care Center <input type="checkbox"/> Burnsville Natural Care Center <input type="checkbox"/> Woodwinds Natural Care Center <input type="checkbox"/> Edith Davis Teaching Clinic <input type="checkbox"/> University Health Service	Date: _____ Account Number: _____

Child's Name: _____
(Last, First, Middle Initial)

Mother's Name: _____
(Last, First, Middle Initial)

Address: _____

Phone: _____ Occupation: _____

Father's Name: _____
(Last, First, Middle Initial)

Address: _____

Phone: _____ Occupation: _____

Sibling's Name: _____ Age: _____ Sex: _____

Sibling's Name: _____ Age: _____ Sex: _____

Sibling's Name: _____ Age: _____ Sex: _____

Sibling's Name: _____ Age: _____ Sex: _____

Primary Healthcare Provider and/or Clinic: _____

Address: _____

Phone: _____

Your answers to the following questions will help us learn more about your child's health. Please take a few minutes to complete this questionnaire; you may skip any questions you are uncomfortable answering.

1. What is your child's chief complaint today? _____

Check all that apply.

- 1Neck / Back / Joint pain
- 2Headaches
- 3Depression / Anxiety
- 4Respiratory Problems (e.g., asthma, allergies, sinus congestion)

5Digestive Problems (e.g., poor appetite, heartburn, constipation, diarrhea)

6Urinary Problems (e.g., difficult or painful urination, kidney stones)

7Fatigue or low energy

8Female reproductive health

9Male reproductive health

10.....Stress management

11.....General wellness

12Other: _____

2. Health History

Please list any health problems your child currently has or has had. Answer to the best of your knowledge.

Cancer (malignant or metastatic):

 Diabetes (Type I or II):

 Infectious Diseases (e.g. hepatitis, HIV):

 Heart, Lungs and Circulation (e.g. asthma, heart murmur):

 Digestive System (e.g. poor appetite, heartburn, constipation, diarrhea):

 Psychosocial Health (e.g. depression, anxiety, violence toward self or others):

 Skeleton and joints (e.g. arthritis, back or neck pain):

 Genitourinary System (e.g. difficult or painful urination, kidney stones, sexually transmitted diseases, painful menses):

 Nervous System (e.g. headache, dizziness):

 Eyes, ears, nose, and throat (e.g. loss of vision or hearing, ear infections, severe dental problems):

 Skin (e.g. rashes, sores, moles that have changed):

 Chronic Immune System deficiencies (e.g. colds, sinusitis, bronchitis):

 Other:

Family health History

Do/did any members of your immediate family (mother, father, sister, brother) have any serious health conditions?

No

Yes → Please describe your relation to this individual and their condition

3. PREGNANCY

Please check any areas that applied to the patient's mother during her pregnancy:

- | | | |
|----------------------------------------------|--------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Complications | <input type="checkbox"/> Vitamins/Minerals | <input type="checkbox"/> Toxic Exposures |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Any diagnosed illnesses | <input type="checkbox"/> Allergic Reactions |
| <input type="checkbox"/> Recreational drugs | <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Mental Trauma |
| <input type="checkbox"/> Smoking | <input type="checkbox"/> Immunization | <input type="checkbox"/> Physical Injury |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Prenatal Classes |
| <input type="checkbox"/> Caffeine: Cola | <input type="checkbox"/> Premature Contractions | <input type="checkbox"/> Chiropractic Care |
| <input type="checkbox"/> Caffeine: Coffee | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Prenatal Care |
| <input type="checkbox"/> Caffeine: Tea | <input type="checkbox"/> Other Pain | <input type="checkbox"/> Carried to Full Term |
| <input type="checkbox"/> Caffeine: Chocolate | <input type="checkbox"/> Excessive Weight Loss | <input type="checkbox"/> Attitude – Mostly Happy |
| <input type="checkbox"/> Caffeine: Other | <input type="checkbox"/> Excessive Weight Gain | <input type="checkbox"/> Attitude – Mostly Depressed |

4. LABOR AND DELIVERY

- | | |
|------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Greater than 12 Hours | <input type="checkbox"/> Caesarian |
| <input type="checkbox"/> Complications | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Fetal Monitor Used | <input type="checkbox"/> Home Birth |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Premature Delivery |
| <input type="checkbox"/> Forceps | <input type="checkbox"/> Vacuum Extraction |
| Other _____ | |

5. PERINATAL HISTORY – *If known please indicate*

The duration of the pregnancy was _____ weeks.
 The apgar score at birth was _____
 The apgar score at five minutes was _____
 The length at birth was _____
 The birth weight was _____

Please check any problems the patient had at birth:

- | | |
|-------------------------------------------------------|-----------------------------------|
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Nursing |
| <input type="checkbox"/> Coloring | <input type="checkbox"/> Sleeping |
| <input type="checkbox"/> Crying | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Choking | |
| <input type="checkbox"/> Other _____ (Please Explain) | |

Please check if any item(s) applied to the patient at birth:

- | | |
|-------------------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Medication | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Artificial Feeding | <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> Vitamin K | <input type="checkbox"/> Circumcision |
| <input type="checkbox"/> Other _____ (Please Explain) | |

Please list your child's allergies: _____

Please list any surgeries your child has had in the past, and their date: _____

Please list any traumas or injuries: _____

Please list current medications: _____

6. NUTRITION

Please check if the patient has received any of the following items:

- | | |
|---------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Breast Milk | <input type="checkbox"/> Sweets |
| <input type="checkbox"/> Commercial Formula | <input type="checkbox"/> Juice: Fruit |
| <input type="checkbox"/> Cow's Milk | <input type="checkbox"/> Juice: Vegetable |
| <input type="checkbox"/> Goat's Milk | <input type="checkbox"/> Vitamins |
| <input type="checkbox"/> Solid Foods | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Other _____ | (Please Explain) |

7. IMMUNIZATION

Please list any immunizations the patient has received along with the date it was received and any reactions observed: _____

Note foreign travel: _____

8. Please identify your race, as defined by the federal government. (Please check one)

- 1Asian or Pacific Islander
- 2Black/African American
- 3Hispanic
- 4American Indian or Alaskan Native
- 5White
- 6Other _____