GIG HARBOR NATUROPATHIC MEDICINE, PS

DR. LESLIE CHARLES DR. DIANA DUNCAN

CONFIDENTIAL PEDIATRIC PATIENT INFORMATION

NAME_____ SEX_____ DATE_____

ADDRESS_____CITY_____STATE_____ZIP_____

PHONE (HOME)_____(MOM CELL)_____ (DAD CELL)_____

MAY WE LEAVE A HEALTH-RELATED MESSAGE ON THE HOME PHONE? YES NO CELL? YES NO

BIRTHDATE ___/____/_____ AGE ____ BIRTH HEIGHT/WEIGHT:_____ NO. OF SIBLINGS: ____

LIVES WITH: BOTH PARENTS MOM DAD GRANDPARENTS FOSTER FAMILY OTHER

DATE OF LAST PHYSICAL EXAM?_____WHERE?_____

NAME IN CASE OF EMERGENCY_____PHONE_____

WHAT OTHER HEALTH CARE ARE YOU PRESENTLY RECEIVING? _____

NAME OF PEDIATRICIAN:_____

WHERE DID YOU HEAR ABOUT OUR CLINIC?_____

PRESENT HEALTH CONCERNS: IN YOUR OPINION, WHAT ARE YOUR MOST IMPORTANT HEALTH CONCERNS IN THEIR ORDER OF SIGNIFICANCE? PLEASE INDICATE THE PROBLEM THAT MOTIVATED YOU TO COME IN TODAY.

1._____ 4._____
2._____ 5._____

MEDICATIONS: SUPPLEMENTS, PRESCRIPTION & NON-PRESCRIPTION DRUGS.

1._____ 5._____
2._____ 6._____

INSURANCE INFORMATION:

INSURANCE COMPANY _____
ID #_____GROUP#_____
INSURED NAME_____RELATIONSHIP_____

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT DR. CHARLES WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY. I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME THAT MY INSURANCE CARRIER DOES NOT COVER I AM PERSONALLY RESPONSIBLE TO PAY. I FURTHER AGREE TO A FINANCE CHARGE OF 1% MONTHLY ON ALL PAST DUE ACCOUNTS. PAYMENT IS EXPECTED AT TIME OF VISIT.

PATIENT SIGNATURE _____ DATE_____/_____/_____

PARENT OR GUARDIAN SIGNATURE_____

YOUR HEALTH HISTORY

MOM'S PREGNANCY: GOOD FAIR POOR MOM'S WEIGHT GAIN IN PREGNANCY: _____LBS.

MEDICATIONS/ILLNESSES/COMPLICATIONS IN PREGNANCY:_____

BIRTH: HOSPITAL/BIRTH CENTER/HOME VAGINAL/C-SECTION PITOCIN/PAIN MEDS/ANTIBIOTICS

WERE YOU BREASTFED? YES NO FOR HOW LONG?____MOS. FORMULA INTRODUCED AT_____

HOSPITALIZATIONS (YEAR & REASON)_____

SERIOUS ILLNESSES OR INJURY (YEAR & CAUSE)_____

VACCINATIONS: UP-TO-DATE PARTIAL ADVERSE REACTION

ALLERGIES: LIST ANY ALLERGIES YOU HAVE TO FOODS/DRUGS/ENVIRONMENTALS AND TYPE OF REACTION:
1. _____
2. _____
3. _____

HABITS:
DIET: WHAT DID YOU EAT YESTERDAY? PLEASE PROVIDE A SAMPLE OF YOUR DAILY DIET:
BREAKFAST: _____
LUNCH/SNACKS: _____
DINNER/DESSERT:_____
HOW IS YOUR SLEEP?_____ AVERAGE HRS OF SLEEP/DAY: _____
WHAT TYPE OF PHYSICAL ACTIVITY DO YOU GET? _____

FAMILY MEDICAL HISTORY

PLEASE LIST ANY PERTINENT HEALTH HISTORY FOR YOUR FAMILY: ECZEMA, ASTHMA, HEART DISEASE, CANCER, DIABETES, ANXIETY, DEPRESSION, MENTAL HEALTH ISSUES, LEARNING DISABILITIES, AUTOIMMUNE DISEASES, DIGESTIVE ISSUES, PSORIASIS, PARKINSONS, EPILEPSY, FIBROMYALGIA, OSTEOARTHRTIS, ETC.

MOM:_____

MATERNAL GMA:_____

MATERNAL GPA:_____

DAD:_____

PATERNAL GPA:_____

PATERNAL GMA:_____

BROTHER(S):_____

SISTER(S):_____

AUNTS/UNCLES: _____