

GIG HARBOR NATUROPATHIC MEDICINE, PS  
DR. LESLIE CHARLES, ND

**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, OSTEOARTHRITIS, ETC.

MOM: \_\_\_\_\_

MATERNAL GMA: \_\_\_\_\_

MATERNAL GPA: \_\_\_\_\_

DAD: \_\_\_\_\_

PATERNAL GPA: \_\_\_\_\_

PATERNAL GMA: \_\_\_\_\_

BROTHER(S): \_\_\_\_\_

SISTER(S): \_\_\_\_\_

AUNTS/UNCLES: \_\_\_\_\_