Beacon Naturopathic Health Cetner
1842 Beacon St, Suite 203
Brookline, MA 02445
617 738 3300

Today's Date ______________

PEDIATRIC & ADOLESCENT CASE HISTORY

Patient's Name ______________________________ Age ____ Date of Birth _____________ Gender__

SSN# _____________________________________

Address ____

Mother's Name ___________________________ Father's Name _________________________________

Phone (Home) ___________________________ (Work) _____________________ mother/father/other

Referred by ____

Person to be Notified In case of Emergency: Name ______________________ Relationship: _____________________
Address ______________________ Phone _____________________

PLEASE LIST MOST IMPORTANT HEALTH CONCERNS / PROBLEMS

***MEDICATIONS*:**	Now	Past
Aspirin	________	________
Tylenol	________	________
Antibiotics	________	________
Decongestants	________	________
Other ___________	________	________

***SUPPLEMENTS*:**	Now	Past
Vitamins	______	________
Minerals	______	________
Herbs	______	________
___________	______	________
___________	______	________

ALLERGIES TO DRUGS/MEDICATIONS

CHILDHOOD ILLNESSES

Check all that apply

☐ Chicken Pox	☐ Scarlet Fever	☐ Mononucleosis
☐ Measles	☐ Rheumatic Fever	☐ Ear Infections
☐ Mumps	☐ Strep Throat	☐ Tonsillitis
☐ Rubella	☐ Pneumonia	☐ Croup
☐ Whooping Cough	☐ Asthma	☐ Other ________________

PRENATAL / BIRTH / FEEDING HISTORY:

MOTHER'S HEALTH DURING TILE PREGNANCY WITH THIS INFANT / CHILD / ADOLESCENT
Check and describe in space provided

☐ Age	☐ Trauma/Injury	☐ Alcohol Consumption
☐ Bleeding	☐ Stress	☐ Drugs
☐ Nausea	☐ High Blood Pressure	☐ Smoking
☐ Illness	☐ X-Rays	☐ Other __________________
☐ Toxemia	☐ Medications	☐

Decsribe:

____

TERM:
☐ Full ☐ Premature ☐ Late Birth Weight ________________

Was Pregnancy / Birth:
☐ Easy ☐ Difficult

Place of Birth
☐ Hospital ☐ Home ☐ Clinic Other ______________________

FEEDING:

☐ Breast Fed How Long? __________________________________
☐ Formula (Kind) ________ How Long?
Age solid foods began What Foods
Food Intolerances? ___________________________
Favorite foods ____

DIET EATEN YESTERDAY

____

SOCIAL HISTORY:

Parents:
☐ Married ☐ Separtated ☐ Divorced
Mother's Occupation ______________________________________ ☐ Full Time ☐ Part Time
Father's Occupation ______________________________________ ☐ Full Time ☐ Part Time

Guardian: ________________________________ Relationship: ________________________________
Others Residing in the Home: _________________ Relationship: ________________________________

DAYCARE ______________________ Where: _________________________

SIBLINGS	NAME	AGE	HEALTH PROBLEMS
1			
2			
3			
4			
5			

IMMUNIZATIONS: (List types, dates given, and any adverse reactions)

HOSPITALIZATIONS / SURGERIES /ACCIDENTS / SERIOUS INJURIES

Describe each incident and give date

FAMILY HISTORY: (Identify all family members who have or have had any of the following)

	Alcoholism		Cancer		High Blood Pressure
	Allergies		Diabetes		Hypoglycemia
	Anemia		Eczema		Mental Illness
	Arthritis		Epilepsy		Obesity
	Asthma		Heart Disease		Stroke
	Birth Defects		Hearing Loss		Thyroid Disorder
	Other (Describe)				

INFANT'S / CHILD 'S/ADOLESCENT'S HEALTH HISTORY (Check all that apply)

NOW	PAST		NOW	PAST		NOW	PAST	
		Acne			Depression			High Fever
		Allergies			Diarrhea			Hyperactivity
		Anemia			Dizzy Spells			Insomnia
		Asthma			Earaches			Jaundice
		Bed Wetting			Eczema			Learning Disorder
		Birth Defects			Epilepsy/Seizure			Moodiness
		Colic			Fatigue			Stuffy Nose
		Constipation			Frequent Infections			Thrush
		Cough/Wheeze			Headaches			Vomiting Spells
		Cradle Cap			Heart Murmur			

WHAT IS YOUR INFANT'S / CHILD'S / ADOLESCENT'S DISPOSITION?