Beacon Naturopathic Health Center
697 Cambridge Street
Brighton, Massachusetts 02135
(617) 783-3300

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
- [ ] Measles
- [ ] Mumps
- [ ] Rubella
- [ ] Whooping Cough
- [ ] Scarlet Fever
- [ ] Rheumatic Fever
- [ ] Strep Throat
- [ ] Pneumonia
- [ ] Asthma
- [ ] Mononucleosis
- [ ] Ear Infections
- [ ] Tonsillitis
- [ ] Croup
- [ ] Other ________________

PRENATAL / BIRTH / FEEDING HISTORY:

MOTHER'S HEALTH DURING TILE PREGNANCY WITH THIS INFANT / CHILD / ADOLESCENT

Check and describe in space provided

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

Decsribe:

____

TERM:

- [ ] Full
- [ ] Premature
- [ ] Late

Birth Weight ________________

Was Pregnancy / Birth:

- [ ] Easy
- [ ] Difficult

Place of Birth

- [ ] Hospital
- [ ] Home
- [ ] Clinic

Other ______________________

FEEDING:

- [ ] Breast Fed
- [ ] Formula (Kind) ________

How Long? __________________________________

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

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?