Maine Family Natural Health

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**12 Priest Hill Road * Vassalboro, Maine**
**(207) 469-5534**

# PEDIATRIC PATIENT HEALTH HISTORY

Patient's Name: _____ _____
First Middle Last

Natural medicine healthcare is possible only when the doctor completely understands the patient's physical, mental, and emotional conditions. The information you provide helps your practitioner understand your child's needs and how to help him/her reach your health goals. Please write legibly and answer all questions thoroughly. Feel free to mark anything you may have questions about.

Address: _____

City:_____ State: _____ Zip code: _____

Telephone numbers: home _____ work/cell _____

Social Security #: _____ Email: _____ _____

Birth Date: _____ Age: _____ Gender: _____

Parent/Guardian Occupations: _____

Employer: _____ Employer Address: _____

Marital Status: ☐ Single ☐ Married ☐ Partnership ☐ Separated ☐ Divorced ☐ Widowed

With whom does the child live? ☐ Parents ☐ Grandparents ☐ Other Family ☐ Foster Care ☐ Group Home

Parent/Guardian name: _____ Parent/Guardian SS#: _____

Parent/Guardian phone: _____ Parent/Guardian birth date: _____

Parent/Guardian address (if different from child): _____

Emergency Contact: _____ Relationship: _____

Telephone numbers: _____

_____

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Maine Family Natural Health to release information necessary to secure payment.

Signature: _____ Date: _____

Name of responsible party: _____ Social Security #: _____

Relationship to patient: _____ Phone #: _____

Employer & address: _____

How did you hear about Maine Family Natural Health? _____

When did s/he last visit a doctor's office, medical clinic, or hospital? Please explain. _____
_____

Are you aware of any allergies to food, drugs, or other environmental allergens (cats, mold, dust)? If yes, please list and explain: _____
_____

## Pediatric and Family History

What hospitalizations or surgeries has s/he had? _____
_____
_____

What diagnostic imaging studies has s/he had? ☐ X-rays ☐ Other_____
☐ Electrocardiogram (EKG/ECG) ☐ Electroencephalogram ☐ Ultrasound ☐ CT scan ☐ MRI

### Medications and Supplements

Does s/he use any of the following, or did his/her mother use these during her pregnancy with this child?

- ☐ Pain relievers (aspirin, ibuprofen)
- ☐ Diet pills, appetite suppressants
- ☐ Cortisone (cream or pills)
- ☐ Thyroid medications
- ☐ Sleeping pills
- ☐ Antacids
- ☐ Laxatives
- ☐ Tranquilizers
- ☐ Antibiotics
- ☐ Recreational (Illegal) Drugs used by birth mother? (past or present use of any of the following: marijuana, LSD, cocaine, heroin, MDMA, PCP, methamphetamines, drugs not prescribed to her)

Please list any prescriptions medications, over-the-counter medications, vitamins, or other supplements s/he is taking:
_____
_____
_____

### General

What are his/her current health concerns? _____
_____

Height: _____ Weight: _____lbs. Weight at birth: _____lbs.

Maximum weight: _____lbs. When? _____

When during the day or night is his/her energy the highest? _____ The lowest? _____

Briefly describe your spiritual or religious practices: _____

Briefly describe his/her hobbies or special interests: _____

**Please provide the following information about THE CHILD'S FAMILY:**

## Family History

Does/did anyone in his/her family have any of the following conditions (please circle)?

| | | | |
|---|---|---|---|
| Anemia | Diabetes | Hayfever/hives | Liver disease |
| Arthritis | Epilepsy | Heart disease | Mental illness |
| Asthma | Gallbladder disease | Heart murmur | Stroke |
| Cancer (any kind) | Glaucoma | High Blood Pressure | Tuberculosis |
| Cataracts | Goiter | Kidney disease | |

Is his/her father still living? Yes; his age_____ No; age at time of death _____ Cause of death _____
Is his/her mother still living? Yes; her age _____ No; age at time of death _____ Cause of death _____

**Please provide the following information about THE CHILD:**

## Childhood Illnesses

Please circle if s/he had any of the following conditions as a child or adolescent:

| | |
|---|---|
| Diptheria | Mumps |
| German measles | Rheumatic fever |
| Measles | Scarlet fever |
| Chicken pox | Other _____ |

## Past Immunizations

Please circle any of the following immunizations s/he has had. If unsure, please write a question mark (?) beside the immunization.

| | | | |
|---|---|---|---|
| (DPT) | Diptheria | Pertussis | Tetanus |
| (MMR) | Measles | Mumps | Rubella |
| Polio | Hepatitis B | Chicken Pox | Other _____ |

## Review of Systems

Please circle. Y = yes, present condition N = no, never had the condition P = problem in the past

### Head

| | | | |
|---|---|---|---|
| Headaches | Y P N | Migraine headaches | Y P N |
| Head injury | Y P N | Jaw or TMJ problems | Y P N |

### Eyes

| | | | |
|---|---|---|---|
| Blurred vision | Y P N | Cataracts | Y P N |
| Glasses/contacts | Y P N | Eye pain/strain | Y P N |
| Glaucoma | Y P N | Tearing/dryness | Y P N |
| Spots in vision | Y P N | Color blindness | Y P N |
| Double vision | Y P N | Nystagmus/twitching | Y P N |

### Ears

| | | | |
|---|---|---|---|
| Ringing | Y P N | Frequent ear infections | Y P N |
| Earaches | Y P N | Impaired hearing | Y P N |

### Nose/Sinuses

| | | | |
|---|---|---|---|
| Stuffiness | Y P N | Loss of smell | Y P N |
| Sinus problems | Y P N | Hayfever | Y P N |
| Nose bleeds | Y P N | Frequent colds | Y P N |

**Mouth/Throat**

| | | | |
|---|---|---|---|
| Teething problems | Y P N | Gum problems | Y P N |
| Freq. sore throat | Y P N | Jaw clicking | Y P N |
| Dental cavities | Y P N | Sore lips/tongue | Y P N |

**Neck**

| | | | |
|---|---|---|---|
| Lumps | Y P N | Swollen glands | Y P N |
| Goiter | Y P N | Pain or stiffness | Y P N |

**Skin**

| | | | |
|---|---|---|---|
| Rashes | Y P N | Psoriasis | Y P N |
| Eczema, hives | Y P N | Lumps | Y P N |
| Acne, boils | Y P N | Color changes | Y P N |
| Itching | Y P N | Loss of hair | Y P N |
| Night sweats | Y P N | Dryness | Y P N |

**Musculoskeletal**

| | | | |
|---|---|---|---|
| Joint pain | Y P N | Muscle spasms | Y P N |
| Weakness | Y P N | Arthritis | Y P N |
| Broken bones | Y P N | Sciatica | Y P N |

What type of exercise does s/he do? _____ How often does s/he exercise? _____

**Respiratory**

| | | | |
|---|---|---|---|
| Asthma | Y P N | Wheezing | Y P N |
| Bronchitis | Y P N | Cough | Y P N |
| Spitting up blood | Y P N | Difficulty breathing | Y P N |
| Sputum/phlegm | Y P N | Pneumonia | Y P N |
| Pain with breathing | Y P N | Pleurisy | Y P N |
| Emphysema | Y P N | Tuberculosis | Y P N |
| Shortness of breath | Y P N | Second-hand smoke | Y P N How much, how often? _____ |

**Cardiovascular**

| | | | |
|---|---|---|---|
| Angina | Y P N | Chest pain | Y P N |
| Blood clots | Y P N | Heart murmur | Y P N |
| Heart disease | Y P N | Rheumatic fever | Y P N |
| Fainting | Y P N | Ankle swelling | Y P N |
| Low blood pressure | Y P N | High blood pressure | Y P N |
| Palpitations | Y P N | | |

**Gastrointestinal**

| | | | |
|---|---|---|---|
| Diarrhea | Y P N | Constipation | Y P N |
| Change in thirst/appetite | Y P N | Ulcers | Y P N |
| Black stool | Y P N | Coughing up blood | Y P N |
| Jaundice/yellow skin | Y P N | Hemorrhoids | Y P N |
| Gallbladder disease | Y P N | Heartburn | Y P N |
| Abdominal pain/Colic | Y P N | Blood in stool | Y P N |
| Liver disease | Y P N | How many bowel movements per day? _____ | |

**Urinary**

| | | | |
|---|---|---|---|
| Incontinence | Y P N | Frequent infections | Y P N |
| Painful urination | Y P N | Kidney stones | Y P N |
| Frequency at night | Y P N | Bed-wetting | Y P N |

**Blood/Vascular**

| | | | |
|---|---|---|---|
| Anemia | Y P N | Cold hands/feet | Y P N |
| Thrombophlebitis | Y P N | Leg pain | Y P N |
| Easy bruising | Y P N | Varicose veins | Y P N |

**Neurological**

| | | | |
|---|---|---|---|
| Fainting | Y P N | Paralysis | Y P N |
| Numbness/tingling | Y P N | Seizures | Y P N |
| Birth Trauma | Y P N _____ | Muscle weakness | Y P N |
| Absence of sensation | Y P N if yes, where?_____ | | |

**Emotional**

| | | | |
|---|---|---|---|
| Mood swings | Y P N | Nervousness | Y P N |
| Anxiety | Y P N | Depression | Y P N |

**Endocrine**

| | | | |
|---|---|---|---|
| Hypothryoid | Y P N | Hyperthyroid | Y P N |
| Excessive thirst | Y P N | Excessive hunger | Y P N |
| Cold intolerance | Y P N | Heat intolerance | Y P N |

Known endocrine/hormonal disorders: _____

**General Reproductive (adolescent male and female)**

Sexually active Y P N
Discharge or sores Y P N
Sexually transmitted infections Y P N
Please circle those that apply: Herpes Syphilis Gonorrhea Chlamydia HPV HIV/AIDS Trichomonas Hepatitis (B, C, D, E)

**Male Reproductive**

| | | | |
|---|---|---|---|
| Hernia | Y P N | Testicular masses | Y P N |
| Testicular pain | Y P N | Penile Irregularities | Y P N |
| Difficult urination | Y P N | Un-descended Testicles | Y P N |

**Female Reproductive**

Age of first menses_____
Length of cycle _____ Duration of menses _____
Date of last GYN exam or pap smear _____ Does she do self breast exams? _____ How often? ____

| | | | |
|---|---|---|---|
| Painful menses | Y P N | Endometriosis | Y P N |
| Ovarian cysts | Y P N | Heavy flow | Y P N |
| Cervical Dysplasia | Y P N | Abnormal pap smear | Y P N |
| Breast tenderness | Y P N | Breast mass/lump | Y P N |
| Nipple discharge | Y P N | Spotting | Y P N |
| Irregular cycles | Y P N | Absence of menses | Y P N |
| Birth control | Y P N if yes, what types? _____ | | |

PMS symptoms: _____
Number of pregnancies _____ Number of live births _____
Number of miscarriages _____ Number of abortions _____
Difficulties of pregnancy or labor? _____

**Is there anything else you would like to include in the child's health history?** _____
_____

**HIPAA Notice of Privacy Practices and Consent:** I hereby consent to the use and disclosure of my child's protected health information by Maine Family Natural Health for the purposes of **treatment, payment, and healthcare operations,** or as otherwise required by law.

- Maine Family Natural Health has posted their Notice of Privacy Practices which provides more detailed information about the usage and disclosure of my child's protected health information. I have a right to review the Notice prior to signing this consent and to receive a printed copy of the Notice.
- I have the right to request restrictions to the usage and disclosure of my child's protected health information.
- I have the right to request an alternative to the standard method of communication of my child's protected health information.
- I have the right to revoke this consent, in writing, at any time. Revocations will be honored as of the date they are received by Maine Family Natural Health.
- I understand that while Maine Family Natural Health may honor these requests, they are not required by law to do so.
- I am aware that Maine Family Natural Health reserves the right to change the terms of their Notice of Privacy Practices and to make new Notice of Privacy Practices provisions effective for all protected health information that they maintain. In the event of amendments, Maine Family Natural Health will make available a revised Notice of Privacy Practice for my review.

Alternative Method of Communication Request:

As a courtesy, it is Maine Family Natural Health's policy to call your home on the working day prior to your child's scheduled appointment to remind of his/her appointment time. We may leave a reminder message on your voice-mail or with a person answering the phone – no personal health information will be disclosed.

☐ I agree with Maine Family Natural Health's standard method of communication.
☐ Please change as follows:
  ☐ Please contact me at the following telephone number: _____
  ☐ I prefer not to receive reminder calls.

**Statement of Financial Responsibility:** I understand and agree to the following:

- Payment for services rendered is my responsibility as the patient's responsible party.
- I am responsible for paying for all services, including lab tests, rendered at the time of service.
- If I am receiving a discount of any sort, I am responsible for providing accurate and thorough documentation supporting it and I am responsible for paying in full at the time of service.

**Consent for Treatment:**

I understand that my child's care as a patient at Maine Family Natural Health is directed by Dr. Morgan Titus Rau, a licensed naturopathic doctor. I consent to services rendered and provided to my child by Dr. Titus Rau.

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**I have fully read and understand the above agreements and authorizations. I hereby certify that I have completed this Pediatric Patient Health History truthfully and to the best of my knowledge.**

_____ _____
**Child's Name** **Date**

_____ _____
**Parent, Guardian, Responsible Party** **Date**