



Morgan J. Titus Rau, ND
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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?

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

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:

Diphtheria	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)	Diphtheria	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

Hypothyroid	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 _____
Date of last GYN exam or pap smear _____
Painful menses Y P N
Ovarian cysts Y P N
Cervical Dysplasia Y P N
Breast tenderness Y P N
Nipple discharge Y P N
Irregular cycles Y P N
Birth control Y P N if yes, what types? _____
PMS symptoms: _____
Number of pregnancies _____
Number of miscarriages _____
Difficulties of pregnancy or labor? _____

Duration of menses _____	Does she do self breast exams? _____	How often? _____
Endometriosis Y P N	Heavy flow Y P N	Abnormal pap smear Y P N
Breast mass/lump Y P N	Spotting Y P N	Absence of menses Y P N

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.

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