



Childhood Health History

Name _____ Age _____ Birth date _____

Nickname/Preferred Name you would like us to call you: _____

Address _____ City _____ State _____ Zip _____

Telephone (home) _____ (cell) _____

Is it ok to leave a personal detailed message at one of these numbers? Y N
Which one? _____

Would you like to receive communications by unsecured email? Y N
If yes, what is your email address? _____

Who lives with your child? _____

Names of Parents: _____

Emergency contact: _____ Relationship: _____

Address: _____ Telephone: _____

How did you hear about us? Phone book ___ Insurance ___ Internet ___ Other _____

Referred by _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGN BENEFITS

I hereby authorize the release of any medical information necessary to in the processing of my medical claim. I also authorize payment directly to Integrative Primary Care Associates for the medical benefits.

I authorize my practitioner to examine and treat me, to consult with another healthcare practitioner in regards to continuing my care.

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.

Signed _____ Date _____
Patient, parent or guardian of minor

How would you rate your child's overall health? Poor Fair Good Excellent

What are your child's top 3 health concerns today?

1. _____
2. _____
3. _____

Prescription Medications Child is Currently Taking

(both regularly scheduled and ones taken as needed. There is additional space at end of form if you need it)

Name of Medicine	Dose	How Often You Take It	What You Take It For
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Non-Prescription Medications, Vitamins, Herbs, Supplements, Homeopathic Remedies Child is Currently Taking

(both regularly scheduled and ones taken as needed)

Name	Dose	How Often You Take It	What You Take It For
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is your child allergic to any foods or medications? _____

Do parents currently smoke? _____ If yes: In the house? _____ In the car? _____

Immunizations:

What are your thoughts on vaccinations for your child? _____

Has your child had the following vaccines?

Polio:	Y N	Pertussis	Y N
Tetanus/Diphtheria	Y N	Hepatitis B	Y N
Measles/Mumps/Rubella	Y N	Hepatitis A	Y N
Hemophilus Influenza	Y N	Meningitis	Y N
Pneumococcal (Prevnar)	Y N	Varicella (Chicken Pox)	Y N
Rotavirus	Y N	Other: _____	

Your child's past medical history:

Were there any problems with your child's birth or the mother's pregnancy? _____

Has your child ever been in the hospital overnight? If so, why and when was it? _____

Has your child ever had any of the following? (✓ if yes)

	Now	Past	Never		Now	Past	Never
Allergies				Anemia			
Headache				Heart Murmur			
Asthma				High Blood Pressure			
Injury(serious)				Bleeding Problems			
Kidney Disease				Cancer			
Liver Disease				Candida(yeast)			
Overweight				Eczema/rashes			
Pneumonia				Behavior Problems			

Other _____

Is your child currently seeing any other health practitioners? _____

Family History:

Please list the ages and if deceased, what they died from and at what age.

Mother's side

Father's side

Grandfather: _____ Grandfather: _____

Grandmother _____ Grandmother: _____

Mother: _____ Father: _____

Sisters: _____

Brothers: _____

Is there anything else you would like to let us know about your child to help us care for him/her better?
