

*Queen Anne Naturopathic Center, Ltd.*

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**CONFIDENTIAL PATIENT PROFILE – CHILD/TEENAGER**

*Please print clearly!*

NAME \_\_\_\_\_ Sex \_\_\_\_\_ Today's date: \_\_\_\_\_  
ADDRESS \_\_\_\_\_ Height: \_\_\_\_\_  
CITY/STATE/ZIP \_\_\_\_\_ Weight: \_\_\_\_\_  
AGE \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ PHONE (home) (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

PARENT NAME \_\_\_\_\_ work phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
cell phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
PARENT NAME \_\_\_\_\_ work phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
cell phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Please tell us how you found out about our office or who you were referred by:

Are you currently being seen by other health practitioners? (Please list names & phone # if avail.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Social History:**

School grade \_\_\_\_\_  
Siblings? (if yes, list name(s) & ages) \_\_\_\_\_  
Pets? (if yes, list name(s) and type) \_\_\_\_\_

**Physical History:** (This is a confidential medical record and will not be released without legal authorization)

What is the reason for your visit? Please list your most important present health concerns in order of significance.

- |          |          |
|----------|----------|
| 1) _____ | 4) _____ |
| 2) _____ | 5) _____ |
| 3) _____ | 6) _____ |

List prescription (Rx) and non-prescription medications presently taking, with dosage:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List Vitamins, minerals, herbs, homeopathic remedies presently taking, with dosage:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Birth History: \_\_\_ Normal \_\_\_ Premature Birth Weight & Inches: \_\_\_\_\_

Birth Complications? \_\_\_\_\_

Hospitalizations: (List reason and approximate age or year it occurred)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE COMPLETE INFORMATION ON REVERSE**

Other accidents or serious illnesses?  
\_\_\_\_\_

Childhood illnesses:

\_\_\_\_\_ Chicken Pox      \_\_\_\_\_ Measles      \_\_\_\_\_ Mumps/Rubella  
\_\_\_\_\_ other: \_\_\_\_\_

Any complications? \_\_\_\_\_

Vaccination history: \_\_\_\_\_ DPT      \_\_\_\_\_ Hepatitis      \_\_\_\_\_ Chicken Pox

**Are you allergic to any medications or supplements?** \_\_\_\_\_ **YES**      \_\_\_\_\_ **NO**

If YES, list drug/supplement and reaction: \_\_\_\_\_

Are you allergic to any foods? Are there any foods that don't agree with you? (list food and reaction)  
\_\_\_\_\_

Any environmental allergies? \_\_\_\_\_

**Lifestyle History:**

Average hours of sleep/night \_\_\_\_\_ Do you awake easily? \_\_\_\_\_

Describe any difficulties or patterns with your sleep \_\_\_\_\_

Freq. of bowel movements: \_\_\_\_\_ per day or \_\_\_\_\_ per week,    \_\_\_ loose \_\_\_ normal \_\_\_ hard

**Diet History:**

I eat on average # servings per day (/d) or week (/w):

\_\_\_\_\_ meat      \_\_\_\_\_ vegetables      \_\_\_\_\_ fruit      \_\_\_\_\_ whole grains

What do you drink daily? (?glasses/day) \_\_\_\_\_ Milk      \_\_\_\_\_ Soda pop      \_\_\_\_\_ Juice      \_\_\_\_\_ Water

Do you drink diet sodas or other foods/liquids with NutraSweet/Aspartame? \_\_\_\_\_

Describe your appetite: \_\_\_\_\_

What are your favorite foods that you eat frequently? \_\_\_\_\_

**Family History** (blood relatives): List major illnesses/health challenges. Also, list age. If deceased, circle the age.

Father : (age \_\_\_\_\_)

Grandfather: (age \_\_\_\_\_)

Grandmother: (age \_\_\_\_\_)

Mother: (age \_\_\_\_\_)

Grandfather: (age \_\_\_\_\_)

Grandmother: (age \_\_\_\_\_)

Aunts/Uncles/Siblings: