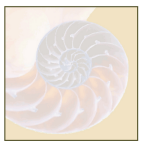

PATHWAYS
TO NATURAL HEALTH, INC.

Date _____

PATHWAYS TO NATURAL HEALTH
PEDIATRIC HEALTH HISTORY

Patient's Name: _____ Age: _____ Birthdate: _____ Blood Type: _____

Mother/Guardian's Name: _____ Father/Guardian's Name: _____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Parent's Work Phone: _____ Parent's Email

Address: _____ How did you hear about Dr. Clapham? _____

Name of Doctor: _____

Reason for referral or presenting problem: _____

Other health concerns: _____

_____

Medications:

	Now	Past		Now	Past
Aspirin	_____	_____	Antibiotics	_____	_____
Tylenol	_____	_____	Anti-histamine	_____	_____
Decongestant	_____	_____	Ibuprofen	_____	_____

Other (please list) _____ Allergies to medicine: _____

Medical History

Chicken pox _____ Strep throat _____ Tonsillitis (approx #) _____

Frequent colds _____ Colic _____ Ear infections (approx #) _____

Croup _____ Bronchitis _____ Asthma _____

Measles _____ Mumps _____ Rubella _____

Rheumatic fever _____ Scarlet Fever _____ Pneumonia _____

Allergies _____ Other (please list) _____

Has your child has any of the following tests?	When	Where	Results
Speech/Language			
Hearing			

Psychological evaluation _____

Electroencephalogram _____

Injuries/Surgeries/Hospitalizations (please list): _____

_____

Immunizations

Measles: _____ Mumps: _____ Rubella: _____

Diphtheria: _____ Pertussis: _____ Tetanus: _____

Polio: _____ Hepatitis B: _____ H. Flu: _____

Any adverse reactions: (please list) _____

Family History

Allergies _____	Anemia ____	Arthritis _____	Asthma/Hives/ Hay fever _____	Cancer _____
Cardiovascular disease _____	Cataracts _____	Depression ____	Diabetes _____	Addiction____
High blood pressure _____	Skin disease _____	Epilepsy or seizures _____	Stroke _____	Thyroid_____
Mental illness_____	Other relevant family history (use lines below)_____			

_____

_____

Please list age, health conditions, and causes of death, if appropriate

	Age	Health Conditions	Deceased (age)	Cause of death
Mother				
Father				
Brother				
Sister				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				

What is your family heritage? Please list all backgrounds and give approximate percentage

_____

Mother's Pregnancy History

Mother's age at child's birth _____ Previous pregnancies by natural mother, miscarriages or complications: _____

Mother's health during pregnancy

Bleeding _____ Physical or emotional trauma _____

Nausea _____ Cigarettes, alcohol, or drug consumption _____

Illnesses _____ Medication _____

Hypertension _____ Thyroid issues _____ Diabetes _____

Birth History

Term: Full _____Premature _____ Late _____ Weight at birth _____

Length of labor _____ Complications _____

Did your child have any of the following issues shortly after birth?

Birth defect _____ Birth injuries _____ Blue baby _____

Cerebral palsy _____ Seizures _____ Jaundice _____

Colic _____ Fever _____ Rashes _____

Other (please explain) _____

Child's sleep patterns (first year) _____

Feeding: Breast fed? _____ How long? _____ Formula? (what type) _____

Age began solids _____ Which foods? _____

Food intolerances _____

Age began: Sitting _____Crawling _____ Walking _____ Talking _____

Symptoms (mark **Y** if current, **P** for any significant past symptoms)

Hives _____ Burning of urine _____ Bloody urine _____

Eczema _____ Frequent urination _____ Cries easily _____

Bleeding gums _____Heart murmur _____ Anxiety _____

Nose bleeds _____ Vomiting spells _____ Sleep issues _____

Acne _____ Anemia _____ Night sweats _____

High fevers _____	Stomach aches _____	Sensitive to light _____
Chronic rash _____	Jaundice _____	Body/breath odor _____
Hearing loss _____	Easy bruising _____	Motion/car sickness _____
Diarrhea _____	Flat feet _____	No appetite _____
Sore throats _____	Constipation _____	Nightmares _____
Headaches _____	Gas _____	Canker sores _____
Frequent colds _____	Bleeding tendency _____	Unusual fears _____
Wheezing _____	Joint pains _____	Excessive fatigue _____
Cough _____	Dizzy spells _____	Hair loss _____

Diet (Please describe your child's typical daily diet)

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

Thank you. I look forward to helping your child in any way that I can.