glow
NATURAL HEALTH CENTER, PLLC
2719 E. Madison St. Suite 203
Seattle, WA 98112
Phone: 206 568 7545 Fax: 206 568 8298

Date_____

Child's name (first) _____(last)_____Nickname_____

Mother's Name (first) _____(last)_____ phone_____

Father's Name (first) _____(last)_____ phone_____

Emergency Contact Name (first) _____(last)_____ phone_____

Primary Physician(first) _____(last)_____ _____phone_____

Mother's pregnancy (circle all that apply) Easy Difficult High blood pressure Bleeding Nausea Diabetes Trauma/injury Stress Alcohol consumption Drugs Smoking

Birth history Was your baby born early? (Y) (N) If yes, how many weeks?_____ Any complications? (Y) (N)
Vaginal Delivery Cesarean Section Induced Forceps Suction Anesthesia used
Weight at birth____ lb. _____oz.

Any problems shortly after birth? (Y) (N) If yes please describe_____
blue baby jaundice seizures colic fever rashes

Any feeding problems? (Y) (N) **Breastfed** (Y) (N) How long? **Formula** (Y) (N) How long? Cow's milk soy other
Age which solids were added? _____Which foods?_____Sensitivities?_____

Any problems in development? Height Weight Speech Hearing Vision
If yes describe_____

Do you feel your child learns: Quickly Average More slowly than others

How would you describe your child?_____

Is your child easy to care for? (Y) (N)

Appetite (please circle one) Low Overeating? Picky? **Has sweets?** Daily Occasionally

Sleep Does your child still nap? (Y) (N) How often? _____How many hours of sleep /night?_____

Activity Approximate number of hours of electronic usage per day (include school and play)_____
How often does your child spend time outdoors? _____hrs./ week

Vaccinations (Y)-indicates up to date (N)
Polio Measles/Mumps/ Rubella Tetanus Pertussis Diphtheria

Hep B Chicken Pox Hib Influenza Prevnar Other
Adverse Reactions (Y) (N) if yes please describe_____
Has your child has had any of the following?
Chicken pox Positive test for TB Measles Mumps Rubella Hepatitis

Significant diseases, Hospitalizations, Injuries, or Trauma (Car accidents, broken bones, burns, poisoning or cuts needing stitches, death in the family etc.)
Issue: _____ _____Outcome: _____Date: _____
Issue: _____ _____Outcome: _____Date: _____
Issue: _____ _____Outcome: _____Date: _____

Health Conditions : Does your child have any of the following? C=Current P=Past N= Never

Acne	**C P N**	Food sensitivities	**C P N**
Anxiety	**C P N**	Frequent colds/flu	**C P N**
Asthma	**C P N**	Frequent infections	**C P N**
Allergies if yes please describe	**C P N**	Headaches	**C P N**
Bed wetting	**C P N**	Hyperactivity	**C P N**
Birth defect	**C P N**	Insomnia/ sleeping problems	**C P N**
Colic	**C P N**	Jaundice	**C P N**
Constipation	**C P N**	Learning disorder	**C P N**
Cradle cap	**C P N**	Leg pain	**C P N**
Cough	**C P N**	Moodiness	**C P N**
Depression	**C P N**	Nightmares	**C P N**
Diarrhea	**C P N**	Pneumonia/ bronchitis	**C P N**
Ear aches/ infections	**C P N**	Snoring	**C P N**
Eczema	**C P N**	Stealing or lying	**C P N**
Fatigue	**C P N**	Stomach ache	**C P N**
		UTI	**C P N**

Any concerns you have about your child?_____
_____

Complete for children age 2 and above:

Activity
Does your child exercise / play sports?_____
Does your child have regular chores at home?_____
Any hobbies?_____

School
Age entered school____Current grade?____Does your child like school?_____Days missed / year_____
Have any problems been identified at school? _____
Does your child get along with other children?_____
How does your child do in school?_____

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