

stephanie kaplan, nd  
4031 se hawthorne boulevard portland, oregon 97214  
[503-546-7663](tel:503-546-7663)

### Pediatric/Adolescent History

Patient Name \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Parent's Name \_\_\_\_\_ Parent's Name \_\_\_\_\_

Phone (home) \_\_\_\_\_ Work/Cell \_\_\_\_\_ mother/father/other

Is there someone I may thank for your referral? \_\_\_\_\_

Emergency contact, if different from parent above \_\_\_\_\_

**Please list your child's most important health concerns, including what brings you in today:**

**Medications and Supplements:** Please check any of the following your child has taken or is currently taking:

|               |          |           |          |          |           |
|---------------|----------|-----------|----------|----------|-----------|
| Aspirin       | _____now | _____past | Vitamins | _____now | _____past |
| Tylenol       | _____now | _____past | Minerals | _____now | _____past |
| Antibiotics   | _____now | _____past | Herbs:   | _____now | _____past |
| Decongestants | _____now | _____past |          |          |           |
| Other list):  | _____now | _____past |          |          |           |

**Allergies to medications:** Please list all know reactions

**Childhood Illnesses:** Please check all that apply

|                    |                     |                    |
|--------------------|---------------------|--------------------|
| ___ Chicken Pox    | ___ Scarlet fever   | ___ Mononucleosis  |
| ___ Measles        | ___ Rheumatic fever | ___ Ear infections |
| ___ Mumps          | ___ Strept throat   | ___ Tonsillitis    |
| ___ Rubella        | ___ Pneumonia       | ___ Croup          |
| ___ Whooping cough | ___ Asthma          | ___ Other: _____   |

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**Family History: Please identify all family members who have or have had any of the following:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Alcoholism    | <input type="checkbox"/> Cancer        | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Allergies     | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Hypoglycemia        |
| <input type="checkbox"/> Anemia        | <input type="checkbox"/> Eczema        | <input type="checkbox"/> Mental illness      |
| <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> Obesity             |
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Birth defects | <input type="checkbox"/> Hearing loss  | <input type="checkbox"/> Thyroid disorder    |

Other, please describe:

**Infant's/Child's/Adolescent's Health History: Please check all that apply**

- |                                  |                               |               |                                  |                               |                     |
|----------------------------------|-------------------------------|---------------|----------------------------------|-------------------------------|---------------------|
| <input type="checkbox"/> present | <input type="checkbox"/> past | Acne          | <input type="checkbox"/> present | <input type="checkbox"/> past | Eczema              |
| <input type="checkbox"/> present | <input type="checkbox"/> past | Allergies     | <input type="checkbox"/> present | <input type="checkbox"/> past | Epilepsy/seizure    |
| <input type="checkbox"/> present | <input type="checkbox"/> past | Anemia        | <input type="checkbox"/> present | <input type="checkbox"/> past | Fatigue             |
| <input type="checkbox"/> present | <input type="checkbox"/> past | Asthma        | <input type="checkbox"/> present | <input type="checkbox"/> past | Frequent infections |
| <input type="checkbox"/> present | <input type="checkbox"/> past | Bed wetting   | <input type="checkbox"/> present | <input type="checkbox"/> past | Headaches           |
| <input type="checkbox"/> present | <input type="checkbox"/> past | Birth defects | <input type="checkbox"/> present | <input type="checkbox"/> past | Heart murmur        |
| <input type="checkbox"/> present | <input type="checkbox"/> past | Colic         | <input type="checkbox"/> present | <input type="checkbox"/> past | Insomnia            |
| <input type="checkbox"/> present | <input type="checkbox"/> past | Constipation  | <input type="checkbox"/> present | <input type="checkbox"/> past | Jaundice            |
| <input type="checkbox"/> present | <input type="checkbox"/> past | Cough/wheeze  | <input type="checkbox"/> present | <input type="checkbox"/> past | Learning disorder   |
| <input type="checkbox"/> present | <input type="checkbox"/> past | Cradle cap    | <input type="checkbox"/> present | <input type="checkbox"/> past | Moodiness           |
| <input type="checkbox"/> present | <input type="checkbox"/> past | Depression    | <input type="checkbox"/> present | <input type="checkbox"/> past | Stuffy nose         |
| <input type="checkbox"/> present | <input type="checkbox"/> past | Diarrhea      | <input type="checkbox"/> present | <input type="checkbox"/> past | Thrush              |
| <input type="checkbox"/> present | <input type="checkbox"/> past | Dizzy spells  | <input type="checkbox"/> present | <input type="checkbox"/> past | Vomiting spells     |
| <input type="checkbox"/> present | <input type="checkbox"/> past | Earaches      | <input type="checkbox"/> present | <input type="checkbox"/> past | Eczema              |

**Immunizations:** Please list types, dates given and any adverse reactions

**Hospitalizations/Surgeries/Accidents/Serious Injuries:** Please list the date and describe each incident

**What is your child's disposition?**

**Please describe a typical day of eating for your child:**