



Janene Martin, ND

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6302 Falls Road  
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Baltimore, MD 21209

**Personal Information**  
**(Child) Birth - 5 Years Old**

Date \_\_\_\_\_  
TODAY'S DATE

Patient's Name \_\_\_\_\_  
FIRST MIDDLE LAST

Information: Gender MALE FEMALE \_\_\_\_\_  
DATE OF BIRTH AGE

.....  
Parent/Guardian \_\_\_\_\_  
FATHER MOTHER GUARDIAN

Address \_\_\_\_\_  
STREET ADDRESS  
\_\_\_\_\_  
CITY STATE ZIP CODE

Phone Numbers \_\_\_\_\_  
HOME WORK CELL/MOBILE

Please **check box** to indicate preferred number for appointment reminders and messages.  
**No health information will be disclosed.**

Email Address \_\_\_\_\_  
EMAIL@ADDRESS

Name and address of doctor's office/hospital/clinic where your child's health records are kept:

\_\_\_\_\_  
OFFICE/HOSPITAL/CLINIC NAME

Address \_\_\_\_\_  
CITY STATE ZIP CODE

ALL RESPONSES WILL BE KEPT CONFIDENTIAL

What are your child's most important health problems?

1) \_\_\_\_\_ 3) \_\_\_\_\_

2) \_\_\_\_\_ 4) \_\_\_\_\_



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## Personal Information (Child) — *continued*

### Medications

Please check:

Now = Medications currently taken    Past = Medications taken at one time or another

Aspirin	Now	Past	Decongestants	Now	Past
Ibuprofen	Now	Past	Topical steroids	Now	Past
Inhalers	Now	Past	Tylenol (acetaminophen)	Now	Past
Antibiotics	Now	Past	Other	Now	Past
Antihistamine	Now	Past			
Asthma medications	Now	Past			

### Medical History

Does your child have any allergies to foods, drugs or other allergens in your environment (cats, mold, dust, etc.)

Yes    No    If yes, please list and explain:

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Has your child ever had: (Check all that are applicable.)

Chicken Pox	Bronchitis
Measles	Rubella
Frequent colds	Croup
Tonsillitis (how many times?) _____	Ear infections (how many times?) _____
Scarlet fever	Asthma
Pneumonia	Mumps
Eczema	Other



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**Personal Information (Child) — *continued***

**X-Rays and Special Studies**

Electroencephalogram

	WHEN	WHERE	RESULTS
X-Ray			

	WHEN	WHERE	RESULTS
Psychological evaluation			

	WHEN	WHERE	RESULTS
Hearing evaluation			

	WHEN	WHERE	RESULTS
Speech/language evaluation			

	WHEN	WHERE	RESULTS

**Injuries/Surgeries/Hospitalizations**

Please describe:

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**Immunizations**

Measles	MMR	Hepatitis B
Mumps	Tetanus	Diphtheria
Polio	Small Pox	Other _____
DPT	Influenza	



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Any adverse reactions to immunizations? (please specify)

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Symptoms

Hives	Y	N	P
Eczema	Y	N	P
Bleeding gums	Y	N	P
Nose bleeds	Y	N	P
Acne	Y	N	P
High fever	Y	N	P
Chronic rash	Y	N	P
Hearing loss	Y	N	P
Diarrhea	Y	N	P
Sore throats	Y	N	P
Gas	Y	N	P
Joint pains	Y	N	P
Hair loss	Y	N	P
Unusual fears	Y	N	P
Bruises easily	Y	N	P
Urination burning	Y	N	P
Frequent urination	Y	N	P
Heart murmur	Y	N	P

For each item listed, please check:  
 Y = Condition your child has now  
 N = Never had condition  
 P = Past condition

Vomiting spells	Y	N	P
Anemia	Y	N	P
Stomach aches	Y	N	P
Jaundice	Y	N	P
Easy bruising	Y	N	P
Flat feet	Y	N	P
Constipation	Y	N	P
Canker sores	Y	N	P
Persistent cough	Y	N	P
Frequent headaches	Y	N	P
Bloody urine	Y	N	P
Cries easily	Y	N	P
Bleeding tendency	Y	N	P
Nervous	Y	N	P



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Sleep problems	Y	N	P	No appetite	Y	N	P
Night sweats	Y	N	P	Nightmares	Y	N	P
Sensitive to light	Y	N	P	Wheezing	Y	N	P
Body/breath odor	Y	N	P	Dizziness	Y	N	P
Motion/car sick	Y	N	P	Frequent colds	Y	N	P
				Excessive fatigue	Y	N	P

Does your child have any other condition not mentioned?

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Diet

Please describe your child's typical daily diet:

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Beverages \_\_\_\_\_

Snacks \_\_\_\_\_



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### Personal Information (Child) — *continued*

Does your child have any food intolerances that you know of?      Yes      No

If yes, please list and explain:

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### Family History

Do you have a family history of any of the following?

- |                     |                     |                 |
|---------------------|---------------------|-----------------|
| Anemia              | Glaucoma            | Mental illness  |
| Arthritis           | Goiter              | Osteoporosis    |
| Asthma              | Hay fever/hives     | Stroke          |
| Cancer              | Heart disease       | Suicide         |
| Cataracts           | Heart murmur        | Thyroid disease |
| Diabetes            | High blood pressure | Tuberculosis    |
| Epilepsy            | Kidney disease      |                 |
| Gallbladder disease | Liver disease       |                 |

### Birth History

Previous pregnancies, miscarriages or complications of birth mother:

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### Personal Information (Child) — *continued*

#### Mother's health during pregnancy:

Bleeding

Nausea

Hypertension

Diabetes

Illness

Thyroid problems

Cigarettes, alcohol, drugs

Physical or emotional trauma

#### Term of pregnancy and labor details:

Full term

Premature

Late Complications

Duration of labor \_\_\_\_\_

Weight at birth \_\_\_\_\_

### Other Current Providers

Name

Contact Information

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is there anything else you would like me to know in order to serve you better?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_