



Janene Martin, ND

410.433.4005
410.433.0909 fax

5801 Falls Road
Baltimore, MD 21209

Personal Information (Adolescent)
6–18 Years Old

Date _____
TODAY'S DATE

Patient's Name _____
FIRST MIDDLE LAST

Information _____
DATE OF BIRTH

Gender MALE FEMALE _____
AGE

Parent/Guardian _____
FATHER MOTHER GUARDIAN

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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Medications

Please check: Now = Medications currently taken Past = Medications taken at one time or another

Aspirin	<input type="checkbox"/> Now	<input type="checkbox"/> Past	Asthma medications	<input type="checkbox"/> Now	<input type="checkbox"/> Past
Ibuprofen	<input type="checkbox"/> Now	<input type="checkbox"/> Past	Decongestants	<input type="checkbox"/> Now	<input type="checkbox"/> Past
Inhalers	<input type="checkbox"/> Now	<input type="checkbox"/> Past	Topical steroids	<input type="checkbox"/> Now	<input type="checkbox"/> Past
Antibiotics	<input type="checkbox"/> Now	<input type="checkbox"/> Past	Tylenol (acetaminophen)	<input type="checkbox"/> Now	<input type="checkbox"/> Past
Antihistamine	<input type="checkbox"/> Now	<input type="checkbox"/> Past	Other	<input type="checkbox"/> Now	<input type="checkbox"/> 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:

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

<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Measles	<input type="checkbox"/> Rubella
<input type="checkbox"/> Frequent colds	<input type="checkbox"/> Croup
<input type="checkbox"/> Tonsillitis (how many times?) _____	<input type="checkbox"/> Ear infections (how many times?) _____
<input type="checkbox"/> Scarlet fever	<input type="checkbox"/> Asthma
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Mumps
<input type="checkbox"/> Eczema	<input type="checkbox"/> Other



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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:

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)

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
- Flat feet Y N P
- Nervous Y N P



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- | | | | | | | | |
|--------------------|----------------------------|----------------------------|----------------------------|-------------------|----------------------------|----------------------------|----------------------------|
| Sleep problems | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> P | Nightmares | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Night sweats | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> P | Wheezing | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Sensitive to light | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> P | Dizziness | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Body/breath odor | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> P | Frequent colds | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Motion/car sick | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> P | Excessive fatigue | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> P |
| No appetite | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> P | | | | |

Does your child have any other condition not mentioned?

Diet

Please describe your child's typical daily diet:

Breakfast _____

Lunch _____

Dinner _____

Beverages _____

Snacks _____



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

If yes, please list and explain:

Family History

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

- | | | |
|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hayfever/hives | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney disease | |
| <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Liver disease | |

Birth History

Previous pregnancies, miscarriages or complications of birth mother:



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Mother's health during pregnancy:

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Illness |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Cigarettes, alcohol, drugs |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Physical or emotional trauma |

Term of pregnancy and labor details:

- | | |
|---|--|
| <input type="checkbox"/> Full term | <input type="checkbox"/> Duration of labor _____ |
| <input type="checkbox"/> Premature | <input type="checkbox"/> Weight at birth _____ |
| <input type="checkbox"/> Late Complications | |

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