



Janene Martin, ND

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5801 Falls Road  
Baltimore, MD 21209

**Personal Information (Child)**  
Birth to 5 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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## Personal Information (Child) — *continued*

### 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:

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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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## 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)

### Symptoms

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

For each item listed, please check:

Y = Condition your child has now

N = Never had condition

P = Past condition

Vomiting spells	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> P
Anemia	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> P
Stomach aches	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> P
Jaundice	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> P
Easy bruising	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> P
Flat feet	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> P
Constipation	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> P
Canker sores	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> P
Persistent cough	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> P
Frequent headaches	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> P
Bloody urine	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> P
Cries easily	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> P
Bleeding tendency	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> P
Flat feet	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> P
Nervous	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> P



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

- |                    |                            |                            |                            |                   |                            |                            |                            |
|--------------------|----------------------------|----------------------------|----------------------------|-------------------|----------------------------|----------------------------|----------------------------|
| 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?

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**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:

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

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?

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