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Date: _____

Pediatric/Adolescent Client Registration Form

Name: _____ Age: _____ Sex: _____ Birthdate: _____

Address: _____

Parents or Legal Guardians: _____

Phone (home): _____ (work): _____ mother/father/other

How did you hear about Dr. Anderson? _____

Child's Primary Care Physician: _____

Person To Be Notified In Case of Emergency:

Name: _____ Phone: _____ Relationship: _____

Please List Child's Health Concerns in Order of Importance to You:

1. _____ 2. _____
3. _____ 4. _____

1. Has the child received any treatment for the above concerns? Yes No

If yes, what?

2. Has child ever had these concerns in the past? Yes No

If yes, when?

3. How long has he/she had these concerns?

Medications: Please list all medications including aspirin, Tylenol, antibiotics, decongestants along with the dosage and frequency given.

1. _____ 2. _____
3. _____ 4. _____

Supplements: Please list all supplements including vitamins, minerals, herbs, and homeopathic medicines along with the dosage and frequency given.

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Allergies to drugs or medications: _____

Hospitalizations, Serious Illness, Serious Injuries, Surgeries:

Please describe each incident and give date & age:

Client Name: _____	Date of Birth: _____
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Medications Taken in the Past 5 Years: Please include dates and duration.

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

Social History:

1. Parents: Single _____ Married _____ Separated _____ Divorced _____

Mother's Occupation _____ Full Time _____ Part Time _____

Father's Occupation _____ Full Time _____ Part Time _____

2. Other Guardian: _____ Relationship _____

3. Others Residing in Home: _____ Relationship _____

4. Daycare/Preschool/School: _____ Where _____
 How Many Hours Each Day? _____ How Many Days Of The Week? _____

5. Siblings: Please list names, ages, and any health concerns.

- 1.
- 2.
- 3.
- 4.
- 5.

6. Any relatives/other persons the child spends time with regularly?

Who? _____
 How frequently? _____

Prenatal/Birth History:

MOTHER'S health during the pregnancy with this INFANT/ CHILD/ ADOLESCENT (check and describe)
 :

_____ Age	_____ Nausea	_____ Medications
_____ Trauma/Injury	_____ Drugs	_____ Gestational Diabetes
_____ Alcohol use	_____ Smoking	_____ Pre-eclampsia
_____ Illness	_____ X-rays	_____ Other
_____ Bleeding	_____ High Blood Pressure	please describe:
_____ Stress	_____ Toxemia	

TERM: Full _____ Premature _____ Late _____ Birth Weight: ___ LBS ___ OZ

Was birth / pregnancy: Easy? _____ Difficult? _____

Place of Birth: ___ Hospital ___ Home ___ Clinic ___ Other ___ Method

Client Name:	Date of Birth:
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Child's Health History

Health Problem	Never	Past	Current	Doctor's Notes
Acne				
Allergies				
Anemia				
Asthma				
Bed Wetting				
Birth Defects				
Colic				
Constipation				
Cough/Wheeze				
Cradle Cap				
Depression				
Diarrhea				
Dizziness				
Earaches				
Eczema/Rash				
Epilepsy/Seizures				
Fatigue				
Frequent Infection				
Headaches				
Heart Murmur				
High Fever				
Hyperactivity				
Insomnia				
Jaundice				
Learning Difficulty				
Moodiness				
Stuffy Nose				
Thrush				
Urinary Infection				
Vomiting				
Other				

Childhood Illnesses (Please check and indicate at what age)

- | | | |
|------------------------------------------|---------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Mumps | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Strep Throat | <input type="checkbox"/> Other |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tonsillitis | |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Rubella | |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Croup | |

Client Name:	Date of Birth:
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Family History: Please identify all family members who have or have had any of the following:

Has any family member had:	Yes	Which relative and age of onset?	Doctor's Notes
Alcoholism/Drug Addiction			
Allergies			
Anemia			
Arthritis			
Asthma			
Birth Defects			
Cancer			
Diabetes			
Eczema			
Epilepsy/Seizures			
Hearing Loss			
Heart Disease			
High Blood Pressure			
Hypoglycemia			
Mental Illness			
Obesity			
Stroke			
Thyroid Disorder			
Other:			

Lifestyle and Habits:

- Does your child eat a special diet?
- What are your child's favorite foods?
- What is your child's general disposition?
- How much does your child sleep?
- Date of last check-up _____ with Dr. _____
- List any chemicals, metals, dusts, smoke or fumes your child has been repeatedly exposed to:
- Does your child react to environmental allergens or foods? Which ones?
- Does your child have any unusual behaviors or personality quirks? Please describe.

Client Name:	Date of Birth:
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Feeding

Food	Never	Rarely	Often	Weekly	1x daily	2x daily	3x daily	4x daily	5x daily
Mother's Milk (or weaned when? _____)									
Milk or Formula Kind? _____									
Sweets (cookies, candy, cake, ice cream, etc.)									
Fruit Sweets (jelly, jam, dried fruit, fruit juice)									
White flour products (bread, pasta, crackers, cookies)									
Protein foods (meat, beans, fish, tofu, etc.)									
Dairy products (milk, cheese, ice cream, yogurt)									
Eggs									
Vegetables (excluding white potato and corn)									

Are you willing to change your habits and your family's habits to improve your child's health?

Does your child have any other problems you would like to discuss with the doctor?

I, the undersigned attest that I have the authority to make medical decisions for the child in question and that the above information is true and correct to the best of my knowledge.

Signature of Parent or Legal Guardian

Date