Ashland Natural Medicine

Nm 97520

Dr. Chris Chlebowski

Pediatric Patient Information

Name _____ Today's Date _____

Gender M F Date of Birth _____/_____/_____
Email Address_____

Address_____

City _____ State _____ Zip_____

Phone _____

Emergency Contacts:

_____ Phone_____

_____ Phone_____

Is patient under the care of another physician? Yes / No Who?

Pediatrician's Name _____Phone number _____

Responsible Party:

Name_____

Address: _____

Phone: _____ Relationship to Patient: _____

Phone: _____ Work Phone: _____

Marital status of child's parents _____ With whom does the child reside? _____

How did you hear about Ashland Natural Medicine?

☐ Referral from a friend/family ☐ Referral from your primary care physician ☐ Word of mouth
☐ Website ☐ Newspaper Advertisement ☐ Google Search ☐ YouTube Channel
☐ Enrolled in our classes ☐ Flier ☐Art Walk ☐ Other _____

Has your child been to a Chiropractor, Naturopath or Homeopath before? ☐ Yes ☐ No

Is your child under the care of another physician? ☐ Yes ☐ No
If Yes, who?_____
For what reason/s?

_____

Infant Health History:
What are your reasons for bringing your child to our clinic today?

_____

_____

Has your child seen other physicians for stated condition/s? Yes No

Name of Physician and prior treatments:_____

_____

When did complaints begin?_____

(X) any of the following conditions your child has suffered from:

____Asthma	**____Cradle Cap**	**____Bed wetting**	**____Breast feeding issues**	**___Scoliosis**
____Constipation	**____Diarrhea**	**____Fever**	**____Measles**	**___Seizures**
____Rubella	**____Chicken Pox**	**____Meningitis**	**____Ear Infections**	**___Colic**
____Bruising	**____Jaundice**	**____Edema**	**____Chronic Colds**	**___Vomiting**
____Hip dislocation	**____Mumps**	**____Whooping cough**	**____Scarlet fever**	**___Rash**

Other_____

Car Accidents Yes / No (*Please explain and include dates)*

_____

_____

*The National Safety Council states that 50% of children have a fall during their first year of life (i.e. from a bed, changing table, stairs, etc.) Was this the case with your child? Yes / No

Traumas/Falls Yes / No (*Please explain and include dates)*

_____

_____

Hospitalizations/Surgeries Yes / No (*Please explain and include dates)*

Allergies Yes / No *Which ones and how did you discover them*?

_____

_____

Is there any family history of any of the following conditions (circle please)

Cancer / Tuberculosis / Psoriasis / Diabetes / Syphilis

Number of doses of **antibiotics** your child has taken
During the past six months _____ Total during her/his lifetime _____

Number of doses of other **prescription medications** your child has taken
During the past six months _____Total during her/his lifetime _____ List _____
_____

Please **list** all ***supplements / herbs/ homeopathics / vitamins*** your child has taken in the last six months:
_____

Pregnancy & Delivery History:

Prenatal History
Please describe the child's birth (at home, caesarean, hospital, adopted, etc.)
_____
_____

Birth Interventions
Forceps ____ Caesarean ____ (emergency or planned) Vacuum extraction ____
Labor induced ____ Other emergency procedures ____
How many ultrasounds during pregnancy? _____
How long was the delivery? _____
At how many weeks was the child born?_____

Name of Obstetrician/Midwife/Naturopath:
_____

Vaccinations or antibiotics by mother during pregnancy Y / N Age of Mother at delivery _____
Is the patient's mother currently pregnant? Y / N Number of siblings_____
Any major health problems with either birth parent? Y / N
If yes, please explain_____
_____

Major heath problems with the child's siblings? Y / N
If yes, please explain_____
_____
Please **check** if there was a history
Maternal Hypertension ____ **Proteinuria ____** **Gestational diabetes ____**
Cigarette during pregnancy Y / N **Alcohol during pregnancy** Y / N
Recreational drugs Y / N **Medications during pregnancy** Y / N
If yes please list: _____
_____

Other Conditions
Child's Birth Weight_____ Child's Birth Length_____ APGAR Scores_____/_____
Did your child come out head or feet first? _____

Which way was your child facing when they were delivered? (Circle one)
Towards the front / Towards the back

To the best of your knowledge please list all of the vaccinations your child has received and when.

_____
_____
_____

Any reactions from above vaccines? Y N If yes please explain_____
_____

Breast Fed Y / N How long?_____
Formula Fed Y / N How long?_____ Type:_____
Introduced to solids at _____ Months Cows milk _____months Goats milk _____

At what age was your child able to:
Respond to sound _____ Respond to visual stimuli _____ Hold head up _____
Sit up _____ Cross Crawl _____ Stand alone_____ Walk Alone _____
Speak simple words_____

Authorization for Care:

I have read the above information and certify it to be true and correct and to the best of my knowledge. I will not hold Dr. Chlebowski &/or Dr. Miki or any staff member of Ashland Natural Medicine responsible for any errors or omissions that I may have made in the completion of this form. I hereby authorize this office to provide my child with naturopathic, homeopathic, chiropractic care, and/or acupuncture in accordance with this state's statutes.

We are here to serve you and your child and we encourage you to ask questions. Your participation is vital.

Parents Signature _____ Date _____

We offer phone, FaceTime and Skype Appointments, so no matter where you travel, we can be there for you and your family.

***Policy Reminders:** Refills for prescriptions and custom tinctures require 72 hours' notice. Refills can be picked up during our normal clinic hours: Monday and Thursday, 10:00 AM – 5:00 PM or on Tuesday, Wednesday, and Friday, 9:00 AM - 5:30 PM. We are closed 12:30 – 1:30 PM for lunch.

Please remember, we require 72 hour cancellation notice, as charges will apply. Thank you.