

Anne Hill, ND, AHG  
Rising Tide Medicine, PC  
503-313-3605

Parent's names \_\_\_\_\_ Phone(am) \_\_\_\_\_

Address \_\_\_\_\_ Phone(pm) \_\_\_\_\_

E-mail address \_\_\_\_\_ Patient's name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Place of Birth \_\_\_\_\_

Ethnicity/Nationality \_\_\_\_\_ Gender: female \_\_\_\_\_ male \_\_\_\_\_

Name of Pediatrician and Hospitals or Clinics where your child's health records are kept.

\_\_\_\_\_

What are the reasons you are bringing your child in today?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Please list medications, vitamins and any supplements your child is on:

\_\_\_\_\_

Any allergies to medicines, vitamins or supplements? Please list which ones?

\_\_\_\_\_

**Medical History:** please check if the patient has had any of the following: Please indicate at what age.

\_\_\_\_\_ Chicken pox \_\_\_\_\_ Scarlet fever \_\_\_\_\_ Tonsillitis  
\_\_\_\_\_ Measles \_\_\_\_\_ Pneumonia \_\_\_\_\_ Ear infections  
\_\_\_\_\_ Eczema \_\_\_\_\_ Frequent colds \_\_\_\_\_ other (please list) \_\_\_\_\_  
\_\_\_\_\_ Whooping Cough \_\_\_\_\_ Rheumatic fever

Any Injuries/Surgeries/Hospitalizations? Please list: \_\_\_\_\_

\_\_\_\_\_

What Immunizations has your child had? At what age?

\_\_\_\_\_ MMR \_\_\_\_\_ Polio \_\_\_\_\_ Smallpox \_\_\_\_\_ Chicken Pox  
\_\_\_\_\_ DTP \_\_\_\_\_ Hep B \_\_\_\_\_ TB \_\_\_\_\_ Influenza

Others (list) \_\_\_\_\_

Any adverse reactions? Y N Describe \_\_\_\_\_

**Prenatal History**

Previous pregnancies by natural mother, miscarriages, or complications?

Mother's age at child's birth? \_\_\_\_\_

Mother's health during pregnancy?

- |                    |   |                |
|--------------------|---|----------------|
| _____ Bleeding     | _____ Physical or emotional trauma          |                |
| _____ Nausea       | _____ Cigarettes, alcohol, drug consumption |                |
| _____ Illnesses    | _____ Medications                           |                |
| _____ Hypertension | _____ Thyroid problems                      | _____ Diabetes |

**Birth History**

Term: Full \_\_\_\_\_ Premature \_\_\_\_\_ Late \_\_\_\_\_ Weight at birth \_\_\_\_\_

Length of labor \_\_\_\_\_ Complications? \_\_\_\_\_

Were forceps or suction used? \_\_\_\_\_ Was a C-section performed? \_\_\_\_\_

Did your child have any of the following problems shortly after birth?

- |                      |                      |                 |
|----------------------|----------------------|-----------------|
| _____ Birth defects  | _____ Birth injuries | _____ Blue baby |
| _____ Cerebral palsy | _____ Seizures       | _____ Jaundice  |
| _____ Colic          | _____ Fever          | _____ Rashes    |

Other (explain) \_\_\_\_\_

Describe child's sleep patterns (first year and current)

List food intolerances (if any)

Feeding: Breastfed? \_\_\_\_ how long? \_\_\_\_\_ Formula? \_\_ milk / soy \_\_\_\_\_

Age began solids \_\_\_\_\_ Which foods? \_\_\_\_\_

Age began: Sitting \_\_\_\_\_ Crawling \_\_\_\_\_ Walking \_\_\_\_\_ Talking \_\_\_\_\_

**Symptoms** (mark Y if current, P for past symptoms)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Hives          | <input type="checkbox"/> Burning of urine   | <input type="checkbox"/> Bloody urine        |
| <input type="checkbox"/> Eczema         | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Cries easily        |
| <input type="checkbox"/> Bleeding gums  | <input type="checkbox"/> Heart murmur       | <input type="checkbox"/> Nervous             |
| <input type="checkbox"/> Nose bleeds    | <input type="checkbox"/> Vomiting spells    | <input type="checkbox"/> Sleep problems      |
| <input type="checkbox"/> Acne           | <input type="checkbox"/> Anemia             | <input type="checkbox"/> Night sweats        |
| <input type="checkbox"/> High fevers    | <input type="checkbox"/> Stomach aches      | <input type="checkbox"/> Sensitive to light  |
| <input type="checkbox"/> Chronic rash   | <input type="checkbox"/> Jaundice           | <input type="checkbox"/> Body/breath odor    |
| <input type="checkbox"/> Hearing loss   | <input type="checkbox"/> Easy bruising      | <input type="checkbox"/> Motion/car sickness |
| <input type="checkbox"/> Diarrhea       | <input type="checkbox"/> Flat feet          | <input type="checkbox"/> No appetite         |
| <input type="checkbox"/> Sore throats   | <input type="checkbox"/> Constipation       | <input type="checkbox"/> Nightmares          |
| <input type="checkbox"/> Headaches      | <input type="checkbox"/> Gas                | <input type="checkbox"/> Canker sores        |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Bleeding tendency  | <input type="checkbox"/> Unusual fears       |
| <input type="checkbox"/> Wheezing       | <input type="checkbox"/> Joint pains        | <input type="checkbox"/> Excessive fatigue   |
| <input type="checkbox"/> Cough          | <input type="checkbox"/> Dizzy spells       | <input type="checkbox"/> Hair loss           |

**Initial cranial evaluation:**

\_\_\_\_\_, ND