Janene Martin, ND

410.296.4005 Tel
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6302 Falls Road
Suite C
Baltimore, MD 21209

Personal Information (Adolescent) 6 -18 Years Old

Date _____
TODAY'S DATE

Patient's Name _____ _____ _____
FIRST MIDDLE LAST

Information: Gender ☐ MALE ☐ FEMALE _____ _____
DATE OF BIRTH AGE

Parent/Guardian _____ _____ _____
FATHER MOTHER GUARDIAN

Address _____
STREET 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	☐ Now ☐ Past	Asthma medications	☐ Now ☐ Past
Ibuprofen	☐ Now ☐ Past	Decongestants	☐ Now ☐ Past
Inhalers	☐ Now ☐ Past	Topical steroids	☐ Now ☐ Past
Antibiotics	☐ Now ☐ Past	Tylenol (acetaminophen)	☐ Now ☐ Past
Antihistamine	☐ Now ☐ Past	Other	☐ Now ☐ 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.)

☐ Chicken Pox	☐ Bronchitis
☐ Measles	☐ Rubella
☐ Frequent colds	☐ Croup
☐ Tonsillitis (how many times?) _____	☐ Ear infections (how many times?) _____
☐ Scarlet fever	☐ Asthma
☐ Pneumonia	☐ Mumps
☐ Eczema	☐ Other

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X-Rays and Special Studies

☐ Electroencephalogram

	WHEN	WHERE	RESULTS
☐ X-Ray			
☐ Psychological evaluation			
☐ Hearing evaluation			
☐ Speech/language evaluation			

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

For each item listed, please check:

Y = Condition your child has now
N = Never had condition
P = Past condition

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

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
Nervous	☐ Y	☐ N	☐ P

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Sleep problems	☐ Y	☐ N	☐ P	Nightmares	☐ Y	☐ N	☐ P
Night sweats	☐ Y	☐ N	☐ P	Wheezing	☐ Y	☐ N	☐ P
Sensitive to light	☐ Y	☐ N	☐ P	Dizziness	☐ Y	☐ N	☐ P
Body/breath odor	☐ Y	☐ N	☐ P	Frequent colds	☐ Y	☐ N	☐ P
Motion/car sick	☐ Y	☐ N	☐ P	Excessive fatigue	☐ Y	☐ N	☐ P
No appetite	☐ Y	☐ N	☐ 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?

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Cataracts
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Gallbladder disease
- ☐ Glaucoma
- ☐ Goiter
- ☐ Hay fever/hives
- ☐ Heart disease
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mental illness
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Suicide
- ☐ Thyroid disease
- ☐ Tuberculosis

Birth History

Previous pregnancies, miscarriages or complications of birth mother:

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Mother's health during pregnancy:

- ☐ Bleeding
- ☐ Nausea
- ☐ Hypertension
- ☐ Diabetes
- ☐ Illness
- ☐ Thyroid problems
- ☐ Cigarettes, alcohol, drugs
- ☐ Physical or emotional trauma

Term of pregnancy and labor details:

- ☐ Full term
- ☐ Premature
- ☐ Late Complications
- ☐ Duration of labor _____
- ☐ Weight at birth _____

Other Current Providers

Name	Contact Information
_____	_____
_____	_____
_____	_____

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

_____

_____

_____