VITALIA HEALTH CARE

PATIENT PROFILE

Date: _____ Full Name: _____

Birthdate: _____ Age: _____ Gender: ❒ Male ❒ Female

Address: _____

_____Email address: _____

Phone # (Primary): _____ Phone # (Secondary): _____

Primary Physician: _____ Phone #: _____

Mother's name and Phone number: _____

Father's name and Phone number: _____

Known Allergies (Foods, Drugs, Vaccines, or Environmental): _____

_____

How did you hear about our clinic? _____

Please list any diagnosis or health concerns:

1) _____

2) _____

3) _____

4 _____

Current Medications (Prescription, Over The Counter Drugs, Vitamins, Herbs, Homeopathic Remedies, Etc...)

1)_____ Dosage _____ 6)_____ Dosage _____

2)_____ Dosage _____ 7)_____ Dosage _____

3)_____ Dosage _____ 8)_____ Dosage _____

4)_____ Dosage _____ 9)_____ Dosage _____

5)_____ Dosage _____ 10)_____ Dosage _____

Hospitalization (when, for what, and how long):

_____

_____

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Development:

What age did your child start to talk? _____

Did your child's speech regress? _____ If yes, what age? _____

Was your child breastfed? _____. If yes, how long? _____

DIET

Describe your child's average meals:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

List foods that they crave: _____

Describe any diet restrictions or regimens that they follow: _____

How many glasses of water does your child drink per day? _____

Is child a picky eater? Y N

Average hours of sleep per night: _____ Do you give pills or herbs to help sleep? ❒ No ❒ Yes

Does your child have difficulty sleeping? ❒ Daily ❒ Often ❒ Sometimes ❒ Never

FAMILY HISTORY:

REVIEW OF SYTEMS

For each of the following symptoms/illnesses, please circle the appropriate letter or fill in the information.

Y = Presently Have P = Had In The Past N = Never Had

GENERAL

Allergies	Y	P	N	Unusual Weight Loss	Y	P	N
Unusual Weight Gain	Y	P	N	Night Sweat	Y	P	N
Swollen Lymph Nodes	Y	P	N	Weakness Or Lethargy	Y	P	N

SKIN

White tongue	Y	P	N	Red cheeks	Y	P	N
Eczema	Y	P	N	Dark circles under eyes	Y	P	N
Rashes	Y	P	N	Unusually Dry	Y	P	N

HEAD/EYES/EAR/NOSE/THROAT

Ear Infection	Y	P	N	Ear Discharge	Y	P	N
Frequent Colds	Y	P	N	Nasal Stuffiness	Y	P	N
Nosebleeds	Y	P	N	Nasal Discharge	Y	P	N

RESPIRATORY

Cough	Y	P	N
Asthma	Y	P	N
Shortness of breath	Y	P	N

GASTROINTESTINAL

Bad breath	Y	P	N
Loose Stool	Y	P	N
Too Much Gas	Y	P	N
Abdominal Pain	Y	P	N
Fatty Food Intolerance	Y	P	N
Constipation	Y	P	N
Diarrhea	Y	P	N

BEHAVIOUR

Biting	Y	P	N
Teeth Grinding	Y	P	N
Spinning	Y	P	N
Obsessive interests	Y	P	N
Aggression	Y	P	N

UNDERSTANDING/AWARENESS

Limited understanding	Y	P	N
Follows commands	Y	P	N
Normal understanding for age	Y	P	N

NEUROPSYCHOLOGICAL

Seizures	Y	P	N	Depression	Y	P	N
Screaming/ crying	Y	P	N	Stressed Easily	Y	P	N
Easily Anxious	Y	P	N	Mood Swings	Y	P	N
Sensitive to sound	Y	P	N	Insomnia	Y	P	N

PLAY SKILLS

Appropriate for age	Y	N	Interactive with others	Y	N
Repetitive	Y	N	Eye Contact?	Y	N
Pretend/ Imaginative Play	Y	N			

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MOTOR SKILLS

Delayed gross motor (climbing, running)	Y	N
Delayed fine motor (writing)	Y	N
Uncoordinated/clumsy	Y	N
Toe walking	Y	N

ANTIBIOTIC USE *(HOW MANY COURSES HAS YOUR CHILD RECEIVED?)(check)*

___0-5 ___5-10 ___10-15 ___ 15-20 ___20+

Reason for antibiotic use? _____

How many colds/flus/infections per year? _____

MUSCULOSKELETAL

Muscle Pain	Y	P	N
Joint Pain/Stiffness	Y	P	N
Muscle Atrophy	Y	P	N

History of Strep infection?	Y	N
History of fungal or yeast infections?	Y	N
Chronic nasal congestion or discharge?	Y	N
Has child had any allergy testing done?	Y	N

If yes, list type _____

MOTHER'S PREGNANCY AND LABOUR

Was your child delivered _____vaginal _____C-section Forceps _____Suction used

Was birth premature	Y	N	If Yes, at how many weeks _____
Is child a twin?	Y	N	
Any birth trauma?	Y	N	

Describe _____

Complications/infections of baby? _____

VACCINATIONS

Has child received all recommended vaccinations for their age? Y N

If no, has child received any of the following (check):

___DPT ___HIB ___Hep B ___Polio ___MMR ___Pneumococcal ___Varicella ___Meningococcal ___Flushot ___H1N1

Did your child receive any vaccinations when they were sick? Y N

Did your child have any vaccine reactions:

___Fever (circle) - Mild or High ___Rash ___Seizures ___Excessive fatigue ___Vomiting ___Swelling at injection site ___Behavior change ___Irritability/screaming ___Loss of eye contact/speech