BRANNICK CLINIC
of Natural Medicine
WHOLE HEALTH PRIMARY CARE & WELLNESS

Today's Date: _____

PEDIATRIC / ADOLESCENT CASE HISTORY

Patient's Name:_____ Age:_____ Date of Birth:_____ Sex:_____

Address:_____ City / State / Zip:_____

Mother's Name:_____ Father's Name:_____

Phone (Home)_____ (Work)_____ (Mobile)_____ Mother/Father/Other

Referred by:_____

Person to be notified in case of Emergency: Name:_____ Relationship:_____
Address:_____ Phone:_____

PLEASE LIST MOST IMPORTANT HEALTH CONCERNS:

MEDICATIONS:

	Now	Past
Aspirin		
Tylenol		
Antibiotics		
Decongestants		
Other_____		

SUPPLEMENTS:

	Now	Past
Vitamins		
Minerals		
Herbs		
Other_____		
Other_____		

ALLERGIES TO DRUGS / MEDICATIONS:_____

CHILDHOOD ILLNESSES:

____Chicken Pox
____Measles
____Mumps
____Rubella
____Whooping Cough
___Scarlet Fever
___Rheumatic Fever
___Strep Throat
___Pneumonia
___Asthma
___Mononucleosis
___Ear Infection
___Tonsillitis
___Croup
___Other_____

IMMUNIZATIONS: (List types, dates given, and any adverse reactions)

HOSPITALIZATIONS / SURGERIES / ACCIDENTS / SERIOUS INJURIES (Describe each incident and give date):

FAMILY HISTORY (Identify all family members who have or have had any of the following):

_____Alcoholism	_____Cancer	_____High Blood Pressure
_____Allergies	_____Diabetes	_____Hypoglycemia
_____Anemia	_____Eczema	_____Mental Illness
_____Arthritis	_____Epilepsy	_____Obesity
_____Asthma	_____Heart Disease	_____Stroke
_____Birth Defects	_____Hearing Loss	_____Thyroid Disorder
_____Other (describe)		

INFANT'S / CHILD'S / ADOLESCENT'S HEALTH (Please check):

	Now	Past		Now	Past
Acne	_____	_____	Epilepsy / Seizure	_____	_____
Allergies	_____	_____	Fatigue	_____	_____
Anemia	_____	_____	Frequent Infections	_____	_____
Asthma	_____	_____	Headaches	_____	_____
Bed wetting	_____	_____	Heart Murmur	_____	_____
Birth Defects	_____	_____	High Fever	_____	_____
Colic	_____	_____	Hyperactivity	_____	_____
Constipation	_____	_____	Insomnia	_____	_____
Cough / Wheeze	_____	_____	Jaundice	_____	_____
Cradle Cap	_____	_____	Learning Disorder	_____	_____
Depression	_____	_____	Moodiness	_____	_____
Diarrhea	_____	_____	Stuffy Nose	_____	_____
Dizzy Spells	_____	_____	Thrush	_____	_____
Earaches	_____	_____	Vomiting Spells	_____	_____
Eczema	_____	_____			

WHAT IS YOUR INFANT'S / CHILD'S / ADOLESCENT'S DISPOSITION?

PRENATAL / BIRTH / FEEDING HISTORY:

MOTHER'S HEALTH DURING THE PREGNANCY WITH THIS INFANT / CHILD / ADOLESCENT:
(Please check and describe)

Age_____ Trauma / Injury_____ Alcohol Consumption_____
Bleeding_____ Stress_____ Drugs_____
Nausea_____ High Blood Pressure_____ Smoking_____
Illness_____ X---Rays_____ Other_____
Toxemia_____ Medications_____

Pregnancy Term: Full:_____ Premature_____Late_____Birth Weight

Was Pregnancy / Birth: Easy:_____ Difficult:_____

Place of Birth: Hospital:_____Home:_____Clinic:_____Other:_____

Feeding:
Breast Feeding_____ How long?_____
Formula (kind)_____ How long?_____
Age solid foods began_____ What Foods_____
Food Intolerances?_____
Favorite Foods_____

DIET EATEN YESTERDAY:

SOCIAL HISTORY:
Parents:
Married_____ Separated_____ Divorced_____

Mother's Occupation_____Full Time_____Part Time_____
Father's Occupation_____Full Time_____Part Time_____

Guardian:_____Relationship:_____
Others Residing in the Home?_____Relationship:_____
Daycare:_____Where?_____

SIBLINGS:

NAME	AGE	HEALTH PROBLEMS