ARTHRITIS Health
Comprehensive Care

Rheumatology
Paul F. Howard, MD, FACP, FACR
Matthew Mustain, PA-C
Audrey Bressor, ANP

Naturopathy & Acupuncture
Leslie Axelrod, NMD, L.Ac.
Keith Wilkinson, NMD

Yoga Therapy
Ginnie Livingston, RN, MSN, CYT
Ellen Martinoni, CYI, RYT
Kimberly Howard, CYT
Sherry Petersen, CYT

Dear Child/Parent/Guardian,

Thank you for your interest in naturopathic care at Arthritis Health and the opportunity to work with you. Naturopathic medicine is an approach to health care that provides an array of treatment options. However, more importantly, I believe naturopathic medicine offers a distinctly different way of thinking about health.

The following pages are the start of our comprehensive discussion to learn about you. This form is somewhat long, but I appreciate your time to thoughtfully answer these questions.

The first office visit is where we gather the largest amount of information. Accordingly, this visit can last 1 to 1 ½ hours. In order for me to prepare for this visit, I kindly request that this form be mailed or faxed to Arthritis Health at least 2 days prior to your first appointment. This will give me ample time to review your information before you arrive. Additionally, if you are taking any supplementation/medications, have recent laboratory work or pertinent medical records, please bring these to the visit.

Thank you again for your interest in working with me. I look forward to meeting you.

Sincerely,

C. Keith Wilkinson, NMD
Naturopathic Physician

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Scottsdale, Arizona 85260

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ARTHRITIS Health

Comprehensive Care

Rheumatology • Naturopathy • Acupuncture • Yoga Therapy

New Patient Form – CHILD (0-5 years)

Date: _____

Patient Information

Child's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Age: _____ DOB: _____ Gender: ☐ M ☐ F

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

Parent's # Home: _____ Cell: _____ Work: _____

Parent's E-mail address: _____

Child Lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other: _____

Additional Information

Primary Care Physician: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____

Relationship to Child: _____ Contact #: _____

Referral Information

How did you hear about Dr. Wilkinson? _____

Were You Referred by a Physician? ☐ Y ☐ N

If yes, could you provide us with information for the referring physician?

Referring Physician's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____

The following questions will help me understand your expectations.

1. Why did you choose to come to Arthritis Health?

2. What do you know about naturopathic medicine?

3. What expectations do you and your child have from this initial visit?

4. What long term expectations do you and your child have regarding your child's health?

5. Any other expectations you or your child have that I should know about?

What are your child's health concerns? List in order of importance.

1. _____

2. _____

3. _____

4. _____

5. _____

Childhood Illnesses/Immunizations

Did your child have the following - **D**isease (**D**), **I**mmunized (**I**), or **N**either (**N**):

Hepatitis (A / B)	D I N	Varicella (Chicken Pox)	D I N	Hemophilus (Hib)	D I N
Rotavirus	D I N	Diptheria (DTaP)	D I N	Measles (MMR)	D I N
Pneumococcal (PCV)	D I N	Tetanus (DTaP)	D I N	Mumps (MMR)	D I N
Polio (IPV)	D I N	Pertussis (DTaP)	D I N	Rubella (MMR)	D I N

Did your child follow the standard immunization schedule? ☐ Y ☐ N

If no, explain: _____

_____

Did your child have any significant reaction to any immunization? ☐ Y ☐ N

If yes, explain: _____

_____

When was the last time your child went to the doctor? _____

What was the reason? _____

_____

List any other major illness, trauma, medical interventions in your child's health history:

_____

_____

_____

Allergies

Is your child hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any substances in the environment or chemicals? _____

Have you ever had allergy testing? If yes, indicate when and details. _____

Current Medications / Supplements

Please list any prescription, over the counter meds, or vitamins/supplements your child is taking and dosages.

Prescription Medications	**OTC Medications** (Ibuprofen, allergy, aspirin, decongestant, etc.)	**Vitamins/Supplements**
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.

Past Medications

Has your child taken any of these medications in the past?
If so, list type and duration (ie, days, weeks, months, 1x, 2x, etc)

☐ Aspirin _____ ☐ Antibiotics _____ ☐ Tylenol _____

☐ Decongestant _____ ☐ Antihistamine _____ Other _____

Environmental Exposure

Does your child live near industrial areas such as chemical factories, refineries, agriculture, etc.? ☐ Y ☐ N

If yes, name the type of industry._____

_____

Is your child ever in an environment where they are exposed to solvents, fumes, paint, chemicals etc.? ☐ Y ☐ N

If yes, provide detail. _____

_____

Do you use pesticides, herbicides, or other chemicals around your home? ☐ Y ☐ N

If yes, provide detail. _____

_____

PRE / BIRTH / POST NATAL HISTORY

Term: ☐ Full ☐ Premature ☐ Late Weight: _____

Length of Labor: _____ Complications: _____

Did the child have any of the following complications after birth?

☐ Birth Defects ☐ Birth Injuries ☐ Blue Baby ☐ Jaundice ☐ Colic

☐ Rashes ☐ Seizures ☐ Cerebral Palsy ☐ Fever ☐ Other

Explain _____

_____

Feeding: ☐ Breast Fed, duration _____ ☐ Formula, milk/soy/_____ duration _____

Age began solids: _____ What Foods? _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS

Indicate your child's symptoms:

note - Y = a condition you have now **N =** Never had **P =** Significant problem in the past

Eczema	Y N P	Stomach Ache	Y N P	Joint Pain	Y N P
Ear Aches	Y N P	Diarrhea	Y N P	Stiffness	Y N P
Frequent Colds	Y N P	Constipation (< 1 BM/day)	Y N P	Fevers	Y N P
Asthma	Y N P	Vomiting	Y N P	Joint Swelling	Y N P
Wheezing	Y N P	Gas	Y N P	Fatigue	Y N P
Rash	Y N P	No Appetite	Y N P	Bleeding Gums	Y N P
Sore Throat	Y N P	Jaundice	Y N P	Anxiety/Nervousness	Y N P
Cough	Y N P	Body/Breath Odor	Y N P	Sleep Difficulty	Y N P
Conjunctivitis	Y N P	Weight Gain / Loss	Y N P	Irritability	Y N P
Nose Bleeds	Y N P	Acne	Y N P	Attention Deficit	Y N P

Other_____

_____

_____

DIET

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

Is there anything else you would like to add or comment on?

_____

_____

_____

_____

_____

Thank you for completing this form. See you at Arthritis Health.