



Rheumatology

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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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Comprehensive Care  
*Rheumatology • Naturopathy • Acupuncture • Yoga Therapy*

### New Patient Form – CHILD (6-12 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?

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2. What do you know about naturopathic medicine?

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

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

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

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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	Diphtheria (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 \_\_\_\_\_

## REVIEW OF SYSTEMS

### Mental / Emotional

Irritability?	Y N P	Depression?	Y N P
Mood Swings?	Y N P	Anxiety or nervousness?	Y N P
Considered/Attempted suicide?	Y N P	Hyperactivity?	Y N P
Poor concentration?	Y N P	Memory problems?	Y N P
Nightmares?	Y N P	Sleep Problems?	Y N P
Unusual Fears?	Y N P		

### Immune

Reactions to immunizations?	Y N P	Reactions to vaccinations?	Y N P
Chronic fatigue?	Y N P	Chronic infections?	Y N P
Chronically swollen glands?	Y N P	Slow wound healing?	Y N P

### Endocrine

Fatigue	Y N P	heat or cold intolerance?	Y N P
Hypoglycemia?	Y N P	Diabetes?	Y N P
Excessive thirst?	Y N P	Excessive hunger?	Y N P

### Neurologic

Seizures?	Y N P	Paralysis?	Y N P
Muscle weakness?	Y N P	Numbness or tingling?	Y N P
Loss of memory?	Y N P	Easily stressed?	Y N P
Vertigo or dizziness?	Y N P	Loss of balance?	Y N P

### Skin

Rashes?	Y N P	Eczema/Hives?	Y N P
Acne, Boils?	Y N P	Itching?	Y N P

### Head

Headaches?	Y N P	Head Injury?	Y N P
Dizzy Spells?	Y N P	Jaw/TMJ problems	Y N P

### Eyes

Tearing or dryness?	Y N P	Color blindness?	Y N P
Impaired vision?	Y N P	Glasses or contacts?	Y N P
Blurriness?	Y N P	Eye pain/strain?	Y N P

### Ears

Impaired hearing?	Y N P	ringing?	Y N P
Ear Aches?	Y N P	Dizziness?	Y N P

### Nose and Sinuses

Frequent colds?	Y N P	Nose Bleeds?	Y N P
Stiffness?	Y N P	Hayfever / Post Nasal Drip?	Y N P
Sinus problems?	Y N P	Loss of smell?	Y N P

### Mouth and Throat

Frequent sore throat?	Y N P	Bad Breath?	Y N P
Teeth grinding?	Y N P	Sore tongue/lips?	Y N P
Gum problems?	Y N P	Hoarseness?	Y N P
Cavities?	Y N P	Jaw clicks?	Y N P

<b>note - Y = a condition you have now    N = Never had    P = Significant problem in the past</b>
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**Neck**

Lumps? Y N P Swollen glands? Y N P  
Goiter? Y N P Pain or stiffness? Y N P

**Respiratory**

Cough? Y N P Pneumonia? Y N P  
Asthma? Y N P Wheezing Y N P  
Bronchitis? Y N P

**Cardiovascular**

Heart disease? Y N P Murmurs? Y N P  
Fainting Y N P Chest pain Y N P  
Palpitations/Fluttering Y N P

**Gastrointestinal**

Nausea/vomiting Y N P Heartburn? Y N P  
Jaundice (yellow skin)? Y N P Abdominal pain or cramps? Y N P  
Change in appetite? Y N P Belching or passing gas? Y N P  
Liver Disease? Y N P Constipation (<1 BM / day) Y N P  
Blood in stool? Y N P Diarrhea? Y N P  
Bowel Movements: How many per day? \_\_\_\_\_

**Urinary**

Pain on urination? Y N P Frequent urination? Y N P  
Frequent infections? Y N P Bed wetting? Y N P

**Musculoskeletal**

Joint pain? Y N P Arthritis? Y N P  
Broken bones? Y N P Weakness? Y N P  
Muscle spasms or cramps? Y N P Joint stiffness? Y N P  
Swelling in joints? Y N P Warm joints? Y N P  
Muscle fatigue? Y N P Malaise? Y N P  
Difficulty walking/running Y N P

**Blood / Peripheral Vascular**

Easy bleeding or bruising? Y N P Anemia? Y N P  
Cold hands/feet? Y N P

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

**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 the form. See you at Arthritis Health.**

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[www.arthritishealth.net](http://www.arthritishealth.net)