Infant Registration & History

Ashland Natural Medicine
739 N Main Street
Ashland, Oregon 97520

Patient Information

Date_____ Birth Date _____
Patient Name _____
Sex M F
Address _____ City _____
State _____ Zipcode_____
Phone Number _____

Relationship to patient_____
Referred by _____
Is the patient under the care of a another Physician? Yes No
If yes Who?_____

Insurance Information

Insured's Name_____

Relationship to Patient_____

Insurance Carrier_____

Responsible Party Information

Name_____

Address_____
City _____State_____
Zipcode_____

Phone Numbers

Emergency contact_____
Emergency contact #_____
Pediatricians Name _____
Pediatrician's Number _____

Other Information

Marital status of child's parents_____

With whom does the child reside? _____
_____

Authorization for care of a minor

I hereby authorize this office to administer care for my daughter/son as they deem necessary. I clearly understand that I am responsible for all fees charged by this office

Parent or Guardian_____

Relationship to patient_____

Date_____

To help us serve you better please complete all of the following information. We look forward to working with you to build better health for your family

Infant Health History

Patient Name_____

What are your reasons for bringing your child into the office today?

_____

_____

_____

_____

Has your child seen any other physicians for this/these conditions? Y N

Name of Physician and prior treatments_____

_____

When did this/these complaints begin?_____

***Check* (X)** any of the following conditions your child has suffered from:

____**Asthma**	_____**Cradle Cap**	____**Bed wetting**	_____**Breast feeding issues**	____**Scoliosis**
____**Constipation**	_____**Diarrhea**	____**Fever**	_____**Measles**	____**Seizures**
____**Rubella**	_____**Chicken Pox**	____**Meningitis**	_____**Ear Infections**	____**Colic**
____**Bruising**	_____**Jaundice**	____**Edema**	_____**Chronic Colds**	____**Vomiting**
____**Hip dislocation**	_____**Mumps**	____**Whooping cough**	_____**Scarlet fever**	____**Rash**

____**Other**_____

_____**Car Accidents**: *Please explain in detail*_____

_____

____ **Traumas/Falls**: *Please explain in detail*_____

_____

____**Hospitalizations/Surgeries**: *Please explain in detail*_____

_____

____**Allergies**: *Which ones and how did you discover them*?_____

_____

Is there any family history of any of the following conditions (circle please) Cancer /Tuberculosis / Psoriasis / Diabetes / Syphillis

The National Safety Council states that 50% of children have a fall during their first year of life (i.e. from a bed, changing table, stairs, etc.) Was this the case with your child? ____Yes_____No

Number of doses of **antibiotics** your child has taken:

During the past six months:_____ Total during her/his lifetime:_____

Number of doses of other **prescription medications** your child has taken:

During the past six months: _____Total during her/his lifetime: _____List:_____

_____

Please **list** all ***supplements/herbs/homeopathics/vitamins*** your child has taken in the last six months

Pregnancy/Delivery History

Patient Name_____

Prenatal History

Please describe the child's birth (at home, caesarean, hospital, adopted, etc..)_____
_____
_____
_____

Birth Interventions

_____Forceps _____Caesarean: emergency or planned (please circle) _____Vacuum extraction
_____Labor induced with drugs _____Other emergency procedures
Number of ultrasounds during pregnancy _____
How long was the delivery?_____ At how many weeks was the child born?_____
Name of Obstetrician/Midwife/Naturopath:_____
Any vaccinations or antibiotics by mother during pregnancy Y N
Age of mother at delivery_____
Is the patient's mother currently pregnant? Y N Number of siblings_____
Any major health problems with either birth parent? Y N If yes, please explain_____
_____
Any major heath problems with the child's siblings? Y N If yes, please explain_____
_____

Please **check** if there was a history of…
____**Maternal Hypertension** _____ **Proteinuria** _____**Gestational diabetes**
____**Cigarette use during pregnancy** _____**Alcohol use during pregnancy** _____**Recreational drugs**
____**Medications used during pregnancy**: If yes please list_____
____**Other Condtions**_____

Child's Birth Weight_____ Child's Birth Length_____ APGAR Scores_____/_____
Did your child come out head or feet first? _____
Which way was your child facing when they were delivered? Towards the front or towards the back?
_____

To the best of your knowledge please list all of the vaccinations your child has received and when.
_____
_____
_____
Any reactions from above vaccines? Y N If yes please explain_____
_____

Breast fed: Y N How long?_____
Formula Fed: Y N How long?_____ Type:_____
Introduced to solids at:_____Months; Cows milk _____months

At what age was your child able to: _____Respond to sound_____Respond to visual stimuli
_____Hold head up _____Sit up _____Cross Crawl _____Stand alone
_____Walk Alone _____Speak simple words

We are here to serve you and your child and we encourage you to ask questions. Your participation is vital.