

HIGH DESERT NATUROPATHIC CARE

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CONFIDENTIAL PATIENT INFORMATION (CHILD)

DATE _____

Patient's Name _____ Age: _____ Sex: _____ Birthdate: _____

Name of Parent or Guardian _____

Address: _____ City _____ State _____ Zip _____

Phone (home) _____ (work) _____ e-mail _____

Person to be contacted in case of Emergency _____ Relationship _____

Address _____ Phone _____

Patient's Primary Care Physician/ Pediatrician: _____

How did you hear about Dr. Keller? _____

PLEASE LIST THE HEALTH CONCERNS THAT BRING YOU IN TODAY

1. _____
2. _____
3. _____

MEDICATIONS

	now	past	frequency
Pain Relievers (List types used)	_____	_____	_____
Antibiotics	_____	_____	_____
Decongestants	_____	_____	_____
Other _____	_____	_____	_____

Please list all vitamins, herbs, homeopathic, or other supplements that the patient is taking

ALLERGIES (to medications, supplements, foods, or environment) _____

PAST SURGERIES/ HOSPITALIZATIONS:

Please list dates and reason for surgery or hospitalization:

HEALTH HISTORY

Please put an **N** if your child has the condition now, **P** for in the past; **B** for both

___ Measles

___ Dizziness

___ Jaundice

___ Mumps

___ Hives/ Rashes

___ Bladder Infection

___ Influenza

___ Pneumonia

___ Bed Wetting

___ Strep Throat

___ Colitis

___ Diarrhea

___ Mononucleosis

___ Frequent Infections

___ Constipation

___ Frequent Runny Nose

___ Recurring Ear Infections

___ Indigestion/Gas

___ Cough/Wheezing

___ Scarlet Fever

___ Anxiety

___ Headaches

___ Herpes (oral)

FAMILY HISTORY

Please check **Self** if your child has had any of the following; also, please identify any family member(s) that have had any of the following:

	Self	Family Member
Allergies	___	_____
Alcoholism	___	_____
Asthma	___	_____
Bleeding disorder	___	_____
Diabetes	___	_____
Epilepsy	___	_____

HEALTH & LIFESTYLE HABITS

Is your child exposed to cigarette smoke? _____

How often does the patient:

drink soda pop? _____ have caffeine? (i.e. chocolate) _____

drink water? _____

Diet restrictions? _____

List any chemicals, fumes, dust, etc. that your child is repeatedly exposed to _____
