CHILD New Client - Christine McGrew Blair - (804) 747-3993

www.herbchick.com | feelinggood4life@yahoo.com

Child's Name: _____ Today's date: _____

Date of Birth: _____ Gender: _____ Blood Type: _____ Race: _____

Eye color: _____ Hair color: _____ Age _____ Weight: _____ Height: _____

Mother's Name_____

Father's Name: _____

Address:_____

_____

Home Phone: _____ Cell Phone: _____

Work/Other Phone: _____

Mother's occupation: _____

Father's occupation: _____

Describe the pregnancy and delivery: _____

_____

Child's siblings (gender and ages) … Pets?

_____

Child's Medical History: _____

_____

_____

Please list any prescriptions and/or over the counter medications:

_____

_____

***ON THE BACK, PLEASE SHARE FAMILY HEALTH HISTORY**

Please list any supplements:

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_____

_____

Immunizations/Vaccinations (give dates if known) : Oral Polio_____

TB_____ DPT/DT/dT _____ MMR_____ Hem.InfluenzaB _____

Hep B_____ Varicella (Chicken Pox) _____ Pneumo vax _____ Flu_____

Other _____

Known Allergies…food, environment, medicine etc…

Any Emotional or Behavioral Issues:

Any Emotional, Physical or Mental Traumas the child may have experienced:

Pure Water Intake… Amount and Frequency

Describe his/her Activity Level …

Describe his/her Sleeping Patterns …

Describe his/her Bowel Movements. How often?

Describe his/her Eating Habits ***Attach Food Journal***

What are the concerns that have brought you for your visit?