Wellspring Homeopathic Care **Linda J. Baker MD**

Registration Today's Date ___________

Name__________________________ Birth Date_____________ Sex: M F

Child's Parent's Names ____

Address:

Home Phone _______________________ Cell# _______________________

Work # ________________________ E-mail __________________________

Do you wish to receive informational newsletters via E-mail? Yes No

Occupation ____

SSN # ______________________________________

Health Insurance Carrier ____

Primary Physician ____

Other Health Providers Seen Regularly (including alternative/complementary providers)

Name __________________________ Specialty ________________________

__________________________ ________________________

__________________________ ________________________

Referred By ____

Note: All information is confidential and will be released only with your signed consent

Health History - Child

Name ______________________________ Birth date __________________

Please list your main concerns:

____
____
____
____

What diagnoses or explanations have been given to you about your child? ________________

____
____
____
____

Was there any event or illness that you or others feel brought on your child's symptoms? ___

____
____
____
____

Family History

Check if family history is unknown ☐

	Age	Health Problems		Age	Health Problems
Mother	_______	________________________________	Father	_______	________________________________
Sibling	_______	________________________________	Sibling	_______	________________________________
Sibling	_______	________________________________	Sibling	_______	________________________________
Maternal GM	_______	________________________________	Maternal GF	_______	________________________________
Paternal GM	_______	________________________________	Paternal GF	_______	________________________________

YES		RELATIONSHIP	YES		RELATIONSHIP	YES		RELATIONSHIP
	Alcohol/Drug Problem			Endocrine/Hormonal Imbalance			Gastro intestinal Disease	
	Allergy/Asthma			High Blood Pressure			Skin Disease	
	Anemia			High Cholasterol/ Fat			ADD/ADHD	
	Arteriosclerosis			Kidney Disease			Anxiety	
	Arthritis			Liver Disease			Depression	
	Binge Eating/Bulimia			Mental Illness			Other...	
	Bleeding Problem			Obesity				
	Cancer			Stroke				
	Diabetes			Suicide				
	Epilepsy/Seizure			Thyroid Disease				
	Heart Disease			Tuberculosis				

Health History

Name_______________________________ Birth date ____________

Pregnancy: Any illnesses/complications? ____________________________
____
____

Medications: ____
____
____

Any stressful life events during pregnancy? __________________________
____
____

Labor and Delivery: Any complications?______________________________
____
____
____

Mode Of Delivery: Vaginal spontaneous __ Vaginal w/ forceps __ Vaginal w/ suction__
C-Section __________ Reason _______________________
____
____

Medications during Labor and Delivery: ____________________________
____
____
____

Full Term ___________ Premature ___________ Weeks _________

Apgar Scores _________ 1 min. _________ 5 min. _________

Complications in newborn period: ____________________________________
____
____
____

Medications given to baby during hospital stay? _________________________
____
____
____

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Past History Of Illness And Medical Problems

Surgery: List all surgery and approximate dates ____
____
____
____

Other hospitalizations and dates ____
____
____
____

Broken bones and other traumatic injuries (include all car accidents or concussions) ______________________
____
____
____

Emergency room visits (dates) ____
____
____
____

YES		WHEN	YES		WHEN	YES		WHEN	YES		WHEN
	abdominal pain -chronic			cancer			endometriosis			menstrual prob-lem	
	acne			cataract			hay fever/aller-gies			mental disease	
	AIDS			chemical sensitivity			hearing problem			migraine	
	allergies			chicken pox			heparitis			mononucleosis	
	amalgams/silver gfillings			chronic diarrhea			herpes			nervous condi-tion	
	anemia			chronic fatigue			hiatal hernia			neurologic problem	
	antibiotics more than once a year			colds, frequen			high blood pres-sure			overweight (20 lbs.)	
	anorexia			colic			high cholester-ol/triglycerides			panic attacks	
	anxiety			colitis			hives			pelvic infection	
	arthritis			congenital defect			hypoglycemia			peptic ulcer	
	asthma			constipation			hyperactivity			pneumonia	
	attantion problem			counseling			insomnia			premenstrual tension	
	back pain/strain			croup			jaundice			psychotherapy	
	bed wetting			depression			kidney infection			reactions to vac-cinations	
	blood clots			diabetes			kidney stones			reflux	
	breast lump			dyslexia			kidney problem			rheumatic fever	
	bronchitis			ear infection			learning dis-ability			root canal	
	bulimia (self in-duced vomiting			eczema			liver disease			scoliosis	
	scarlet fever			seizures			sexually trans-mitted disease			sinusitis	
	skin problem			sleep disorder			suicide attempt			syphilis	
	taken steroid (cortisone/predni-sone)			thrush			thyroid problem			tics	
	tonsillitis			tooth problems			urine problem			vaginitis	
	vision problem			warts			whooping cough				

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Signs And Symptoms

Please check any sign and symptoms which your child demonstrates.

YES		YES		YES		YES		YES		YES	
	excessive fatigue		chills		flushing (external ears)		leg cramps		anal itching		low self-esteem
	cold intolerance		headaches		sensitive to sounds		joint pain		frequent urination		always fidgeting in seat
	heat intolerance		poor memory		ringing/buzzing in ears		joint swelling		pain with urination		difficulty falling asleep
	cold hands and feet		difficulty concentrating		nosebleeds		shortness of breath w/ exertion		foul odor to urine		obsessive compulsive behaviors
	flushing		clumsiness		nose itching		belching		rocking		bed-wetting
	dizziness		numbness/ tingling		excessive sneezing		food cravings		mood swings		night waking
	light-headedness		twitching		snoaring		Pica (eating non-food		head banging		nightmares/ terrors
	excessive sweating		blinking		sleep apnea		sensitive to food texture		self-mutilation		difficulty waking
	easy bruising/bleeding		eye pain		hoarsness		canker sorss		nail biting		cradle cap
	change in hair growth/ loss		excessive tearing		chronic nasal congestion		irregular heartbeat/palpitations		aggressiveness (hitting, biting, etc.)		daytime wetting/soiling
	change in skin/nails		eyes itching		frequent soar throats		nausea/ vomiting		rubbing genitals		itchy skin
	balance problem		dark circles under eyes		dry mouth		bloating of abdomen		irritability/ tantrums		dry skin
	weakness		visual complaints		grinding teeth		bowel gas		fears/anxieties		other rashes
	faintness		fevers		chest pain		diarrhea		impulsive		warts
	restlessness		nightblindness		difficulty swallowing		constipation		breath holding		molluscum
	swollen glands		hearing complaints		chronic cough		abdominal pain		sensitive to crowds		sensitivity to insect bites

YES		FOR GIRLS			
	nail problems		menses yet?	YES	NO
	frequent diaper rashes		date of first		
			check any symptoms		
				irregular menses	
				cramps	
				heavy bleeding	
				prolonged bleeding (>10 days)	
				premenstrual irritability	

# of school days missed this year due to illness: _______________

Medication Allergies

My child is allergic to these medications:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

☐ Check if none

Current medications

List all prescriptions and over-the-counter medications with dosages:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Vitamins, Herbs and Nutritional Supplements

List all supplements with dosages.

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Vaccines

Please attach a copy of your child's immunization record.
Have there been adverse reactions to any vaccines? _____ Please describe: _

____
____
____
____

Diagnostic Studies

Has your child had any laboratory studies (blood, urine, stool tests, etc.), x-rays or other studies done?_________ Please list and attach copy of results:

____
____
____
____
____
____

Social History

Who lives in the home with your child?____________________________________
____

Are any children in family adopted? _______ Pets in house? _______
Caregivers besides parents ____
____

List the people who are most important in your child's life: __________________
____
____

Recent changes, losses, births, deaths, divorce, remarriage or move? _______
____
____
____

Recent travel? ____
____

Is your child involved in any sports, music or other activities?_______________
Please describe: ____
____

What exercise does your child get on a regular basis? _____________________
____
____

Time spent watching TV _____ hours per week.
Time spent playing electronic games _____ hours per week.
Child's preferred free-time activities: ___________________________________
____
____

Our family spends time together regularly in these activities: _______________
____
____

Do you, your child, or any family members practice any relaxation/stress management techniques? _____ If yes, Please describe: _________________
____

Developmental History

Please give age when skills were mastered.

Sitting up	_____	Running	_____	Ride two-wheeler	_____
Crawling	_____	Jumping	_____	Put on clothing	_____
Pull to stand	_____	Walk down steps	_____	First words	_____
Walking	_____	Pedal	_____	Sentences	_____

Describe any problems with the above skills: ____________________________
____
____
____

Current school grade _______ Repeated any grades? ____________________
Class placement: Mainstream _____ Special Ed. _____ Other ____________
Describe any Special Education services _________________________________
____
____

Dietery / Nutritional History

Breast-fed? Yes No If yes, how long? ________________________
Bottle-fed? Yes No Began at what age? ________________________
Brand(s) formula ________________________________
Foods begun at what age? ________________________________
Cow's milk? Yes No Begun at what age? ________________________
Known allergies to food? (list) ________________________________
____
____

Suspected allergies to food? (list) ________________________________
____
____
____

Food cravings? (list) ________________________________
____
____
____

Current Foods My Child Eats (place a check mark in appropriate column)

FOODS/BEVERAGES	DAILY	3-5 TIMES/WEEK	1-2 TIMES/WEEK	NEVER OR ALMOST NEVER	USED TO EAT
fresh vegetables					
fresh fruits					
meats/poultry					
fish					
whole grains					
legumes					
bread-white					
bread-whole grain					
pasta					
nuts and seeds					
cookies/cakes					
candy					
milk					
cheese					
yogurt					
ice cream					
salty foods					
chocolate					
caffeine(soda/tea)					
soda					
soy products/milk					

How much water is drunk each day? ____________ Fruit juice? ____________

Environmental History

CIRCLE THE APPROPRIATE ANSWERS TO THE FOLLOWING QUESTIONS:

Location of home: City / Suburban / Wooded / Farm   Other (describe):

Water: City / Well   Purification system: Yes / No   If other, please describe:

Type of heat: Electric / Gas / Oil / Other   If other, please describe:

Do you live near: Power lines / Woods / Industrial areas / Water?

If you live near water, list type: Swamp / River / Ocean / Other   If other, please describe:

Does your home have a lot of: Dust / mold / Down or feather items (pillows, upholstery, stuffed animals?)
If so, please give details:

Describe your child's bedroom (circle appropriate response):

Bedding: Synthetic / Down / Feather?   Mattress cover? Yes / No   Crib/junior bed/adult bed

Flooring: Carpet: Wall-to-wall or area rug?   Wood?   Glued down?   Synthetic pad?

Window treatment: Shades / blinds / thin curtain / heavy curtain / valance / Other?
If other, describe:

Other items in room including furniture, toys, stuffed animals:

Flooring in other rooms:

Child's bathroom

Living room

Family room/play room

Is your child bothered by or sensitive to any of the following? Please check where appropriate and list specific products if possible:

_____ Perfumes/cosmetics
_____ Cleaning products
_____ Soaps
_____ Detergents
_____ Dust
_____ Mold
_____ Pollens/grasses
_____ Animals (dander)
_____ Gasoline
_____ Paint

_____Other

Please list known allergies: