TRUE HEALTH INTEGRATIVE MEDICAL CENTER

Dr. Adrienne Wilson, NMD
4525 S. Lakeshore Dr. #103, Tempe AZ, 85282
Tel: 480-779-0873

CONFIDENTIAL PATIENT INFORMATION (CHILD)

DATE:_____________

Patient's Name:_________________________________ Age:_______ Sex:______ Birth date:_______________

Name of Parent or Guardian:____

Address:____ City:________________ State:______ Zip:_________

Phone (home):___________________ (cell):__________________ E-mail:__________________________________

Emergency contact:____ Relationship:______________________

Address:____Phone:______________________

Patient's Pediatrician:____Phone:______________________

How did you hear about Dr. Wilson?____

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PLEASE LIST THE HEALTH CONCERNS THAT BRING YOU IN TODAY

1.

2.

3.

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MEDICATIONS

	now	past	frequency
Pain Relievers (List types used)	_____	_____	____________
Antibiotics	_____	_____	____________
Decongestants	_____	_____	____________
All Others:			
_________________________	_____	_____	____________
_________________________	_____	_____	____________

____

____

Please list all prescription medications and dosages: ____

____

____

Please list all vitamins, herbs, homeopathic, or other supplements that you are taking:___________________

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ALLERGIES (to medications, supplements, foods, or environment):__________________________________

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PAST SURGERIES/HOSPITALIZATIONS

Please list dates and reason for any surgeries or hospitalizations:

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HEALTH HISTORY

Please put an N if you have the condition now; P for in the past; B for both:

___ Measles	___ Scarlet Fever	___ Shortness of Breath
___ Mumps	___ Frequent Runny Nose	___ Heart Murmur
___ Influenza	___ Bronchitis	___ Fatigue
___ Mononucleosis	___ Recurring Ear Infections	___ Muscle Weakness
___ Hay Fever	___ Oral Lesions	___ Diarrhea
___ Headaches	___ Shingles	___ Constipation
___ Dizziness	___ Memory Loss	___ Cough/Wheezing
___ Hives/Rashes	___ Insomnia	___ Indigestion/Gas
___ Pneumonia	___ Jaundice	___ Anxiety
___ Colitis	___ Ringing in the Ears	___ Backaches
___ Joint Pain	___ Bladder Infection	___ Strep Throat
___ Frequent Infections	___ Bed Wetting	___ Behavioral Disorder

Other:____ ___

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FAMILY HISTORY

Please check Self if you have had any of the following. Also, please identify any family member(s) that have had any of the following:

	Self	Family Member(s)
Alcoholism	___	________________
Heart Arrhythmia	___	________________
Autoimmune Disorder	___	________________
Bleeding Disorder	___	________________
Cancer	___	________________
Diabetes	___	________________
Epilepsy	___	________________
Heart Disease	___	________________
Other:___________________	___	________________

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HEALTH & LIFESTYLE HABITS

Is your child exposed to cigarette smoke? __________________________

How much/often does the patient:

drink soda pop? ________________________ drink water? __________________________

have caffeine? (i.e. chocolate) __________________________ have sugar?_______________________________

Diet restrictions?____

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

____

Parent or Guardian Signature: ____ Date: ______________