

**BIG SKY INTEGRATIVE HEALTH, PLLC**

8707 N. JACKRABBIT LN. STE. A,

BELGRADE, MT 59714

(406)-388-6676

Name \_\_\_\_\_

Date \_\_\_\_\_

Age \_\_\_\_\_ Date of birth \_\_\_\_\_ Sex F M

S.S.# \_\_\_\_\_

Mother \_\_\_\_\_ Father \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_

(Work) \_\_\_\_\_

How did you hear about the clinic? \_\_\_\_\_

Name and address of Dr.'s office/hospital/clinic where your child's health records are kept.

What are your child's most important health problems? \_\_\_\_\_

**Medications**

	Now	Past
Aspirin	_____	_____
Antibiotics	_____	_____
Decongestant	_____	_____
Tylenol	_____	_____
Anti-histamine	_____	_____
Ibuprofin	_____	_____
Inhalers	_____	_____
Asthma meds	_____	_____

Topical steroids \_\_\_\_  
Others \_\_\_\_

Allergies to medications. \_\_\_\_\_  
\_\_\_\_\_

### Medical History

\_\_\_\_ chicken pox    \_\_\_\_ scarlet fever    \_\_\_\_ bronchitis  
\_\_\_\_ mumps        \_\_\_\_ frequent colds    \_\_\_\_ eczema  
\_\_\_\_ measles       \_\_\_\_ pneumonia        \_\_\_\_ croup  
\_\_\_\_ rubella        \_\_\_\_ mumps              \_\_\_\_ asthma

tonsillitis, number of times \_\_\_\_    ear infection, number of times \_\_\_\_

other \_\_\_\_\_

### X-rays and Special Studies

	When	Where	Results
Electroencephalogram	_____	_____	_____

Psychological evaluation \_\_\_\_\_  
\_\_\_\_\_

Hearing \_\_\_\_\_  
\_\_\_\_\_

Speech/Language \_\_\_\_\_  
\_\_\_\_\_

### Injuries/Surgeries/Hospitalizations

\_\_\_\_\_  
\_\_\_\_\_

### Immunizations

\_\_\_\_ measles    \_\_\_\_ polio    \_\_\_\_ MMR    \_\_\_\_ small pox    \_\_\_\_ diphtheria  
\_\_\_\_ mumps    \_\_\_\_ DPT    \_\_\_\_ tetanus    \_\_\_\_ influenza    \_\_\_\_ others \_\_\_\_\_

Any adverse reactions to immunizations? (Please specify)  
\_\_\_\_\_

**Family History**

heart disease     diabetes     hay fever  
 mental illness     hypertension     cancer  
 tuberculosis     allergies     arthritis  
 eczema     birth defects

Previous pregnancies by natural mother, miscarriages or complications: \_\_\_\_\_  
\_\_\_\_\_

Mother's age at child's birth \_\_\_\_\_

Mother's health during pregnancy:

bleeding     hypertension  
 cigarettes, alcohol, drugs     diabetes  
 nausea     thyroid problems  
 physical or emotional trauma     illness

**Birth History**

Term: Full     Premature     Late     Weight at birth \_\_\_\_\_

Length of labor \_\_\_\_\_

Complications \_\_\_\_\_  
\_\_\_\_\_

As a baby, did your child have any of the following problems?

jaundice     diarrhea     birth defects     rashes     colic  
 fever     cerebral palsy     allergies     blue baby  
 seizures     birth injuries  
 other \_\_\_\_\_

Feeding: Breast fed     How long? \_\_\_\_\_    Formula     Milk/soy

Age began: Solid foods \_\_\_\_\_    Sitting \_\_\_\_\_    Crawling \_\_\_\_\_

Walking \_\_\_\_\_    First words \_\_\_\_\_

Child's sleep patterns first year \_\_\_\_\_ -  
\_\_\_\_\_

**Symptoms**

Please circle: Y = current condition    N = never had.    P = past condition

Hives    Y N P    Burning of urine    Y N P    Dizzy spells    Y N P

Eczema	Y N P	Bloody urine	Y N P	Cries easily	Y N P
Flat feet	Y N P	Frequent urination	Y N P	Nervous	Y N P
Nose bleeds	Y N P	Motion/car sick	Y N P	Easy bruising	Y N P
Acne	Y N P	Vomiting spells	Y N P	Night sweats	Y N P
High fevers	Y N P	Sensitive to light	Y N P	Unusual fears	Y N P
Chronic rash	Y N P	Stomach aches	Y N P	Jaundice	Y N P
Hearing loss	Y N P	Body/breath odor	Y N P	Heart murmur	Y N P
Diarrhea	Y N P	Sleep problems	Y N P	No appetite	Y N P
Sore throats	Y N P	Bleeding gums	Y N P	Nightmares	Y N P
Gas	Y N P	Frequent headaches	Y N P	Canker sores	Y N P
Anemia	Y N P	Excessive fatigue	Y N P	Constipation	Y N P
Wheezing	Y N P	Bleeding tendency	Y N P	Joint pains	Y N P
Cough	Y N P	Frequent colds	Y N P	Hair loss	Y N P

Any other condition not mentioned? \_\_\_\_\_

### Diet

Please describe your child's typical daily diet: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Food intolerances (if known) \_\_\_\_\_