Nutritional Direction, PA

Date _____

Child's Name _____D/O/B _____Age _____

Chief concerns about your child's health, and/or reason you have chosen to bring your child to Nutritional Direction, PA: _____
_____
_____

List any immunizations your child has had (including at birth):
_____
_____
_____
_____

Describe birth trauma, such as respiratory distress, if any:
_____
_____

Type of delivery: Vaginal _____ Caesarian _____ Hours in labor _____
Single birth? ____ Multiple birth? ____
List any drugs taken by mom during or immediately prior to delivery:
_____

List any drugs or over-the-counter medications taken by mom during pregnancy:
_____

Did Mom smoke during pregnancy? Yes ____ No ____
Did Mom consume alcohol during pregnancy? Yes ____ No ____
Did Mom consume recreational drugs during pregnancy? Yes ____ No ____
Did Mom breast-feed? Yes____ No____ If yes, how long?_____
Mom's weight pre-birth _____ post-birth _____
Was Mom exposed to X-rays during pregnancy? Yes _____ No _____
When did Mom discover that she was pregnant? _____ What was her reaction?
_____

Indicate child's history and/or diagnoses of the following, if applicable (include age of child and duration of illness):
Pneumonia _____
Colds/Flu _____
Bronchitis/Asthma/Other respiratory _____
Other Diagnoses _____

List any surgeries, including date, your child has had: _____
_____

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List child's historical usage of antibiotics or other pharmaceuticals
_____
_____

List any vitamins/supplements your child currently takes: _____
_____

List any dental issues (with age of child), including fluoride treatments:
_____
_____
_____

List parents' history of exposure to toxic chemicals, heavy metals, parasites etc. Check all that apply, using "M" for Mom and "D" for Dad
____ Mold/Fungus
____ Industrial Plant Pollutants
____ Work in chemical environment
____ Nuclear power plant
____ Parasites/Ringworm, other
____ Other _____

Chronic complaints of child:
____ Headaches
____ Tummy aches
____ Leg or other bone pain
____ Constipation/diarrhea
____ Recurrent infections
____ Other _____

Child's favorite food: _____
Child's favorite drink: _____
Child's favorite subject in school: _____
Is your child home-schooled now? Yes _____ No _____

How many bowel movements does your child have per day? _____
How much water does your child drink per day? _____

List any known (diagnosed) or suspected allergies: _____
_____
_____

Does your child sleep well? Yes ____ No ____ How many hours per night? _____

Does your child sleepwalk or have a problem with bed-wetting? Yes ____ No _____