North Star Naturopathic Medicine

The Medical Practice of Dr. Christina Caselli, ND – Mount Shasta, California

Patient Information

Name	DOB	Gender M_____ F _____
	Email	

Address	Home Phone
	Mobile Phone

Mother's Name: Father's Name:

Emergency Contact

Name Relationship to child Phone

Preferred way to receive correspondence and messages: Mobile Phone_____ Home Phone_____ E-mail_____

How did you find us?
Doctor Referral _____Patient Referral _____Web search _____

If you were referred, please let us know by whom:

Have you or your child seen a doctor that practices natural or integrative medicine before? Yes____ No____
If so, what type of natural medicine-oriented clinicians have you visited?

Naturopathic Doctor_____ Holistic MD/DO_____ Acupuncturist_____ Chiropractor_____ Other:_____

Do you have questions about Naturopathic Medicine?

What are your health goals for your child?

Does your child have health insurance? Yes_____ No_____
If Yes, HMO or PPO? Who is the insurance carrier?

Please list other health care providers your child is currently working with:

Name	Specialty	Contact Info
1.		
2.		
3.		

Phone: 530-925-3221
Fax: 1-888-974-1834
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Mt. Shasta, CA 96067

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Current Health Concerns for Your Child

Please list by order of importance. (Attach another list if necessary)	How long has this been a problem?	Have you sought diagnosis or treatment for this issue before? If yes, please describe:
1.		
2.		
3.		

Personal & Family Health History

Date of last wellness exam?	Has your child had antibiotics? Y_____ N_____ If so, how many times?
Date of last blood work? Other tests or imaging?	Has your child ever had a blood transfusion? Y_____ N_____
Newborn Problems: Jaundice ❑ Hospitalization ❑ Other ❑	Siblings: Y_____ N_____ Number living: Number deceased: Gender: Age(s): Cause(s) if deceased: 1. 2. 3.
Prenatal history: Did the mother have any problems or illness during pregnancy? Y_____ N_____ If yes, describe: Birth History: Vaginal ❑ Cesarean Section ❑ Forceps ❑ Vacuum ❑ Trauma ❑ On Time ❑ Before 37 weeks of pregnancy ❑ After 42 weeks of pregnancy ❑ Born in: Hospital ❑ Birth Center ❑ Home ❑ Other ❑	Vaccination plan: CDC Standard Schedule ❑ Alternative Schedule ❑ No Vaccinations ❑ Doctor who performed vaccinations:

Drug Allergies

Any known medication allergies? Yes_____ No_____

If Yes, which medications:

What allergic reaction symptoms did your child experience?

Past Medical History

Please list any hospitalizations and any major past illnesses or injuries (e.g., broken bones, surgeries, etc.):

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Prescribed medications and over the counter medications – attach a separate list if necessary

Medication Name	Dose	When started?	Why?
1.			
2.			
3.			

Supplements – please list all vitamins/botanicals, homeopathics, etc.

Please include vendor if the product is a proprietary blend/combo product – attach a separate list if necessary.

Product name	Dose	When started?	Why?
1.			
2.			
3.			

Diet

Special diet or restrictions?	Food cravings?
Food allergies?	Breast Fed ❑ Formula Fed ❑ Both ❑ If formula, what kind?
Eating solid foods? Y_____ N____	Number of meals per day? _____

How much water per day? _____

How much juice per day? _____ What kind of juice?

Please list typical foods consumed daily – specify typical times of day for each:

Breakfast	
Lunch	
Dinner	
Snacks	
Sweets	

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Please check the appropriate box below to indicate the frequency of consumption:

	Daily	Weekly	Monthly	Occasionally (1-2 x per month)	Rarely (1-2 x per year)	Never
Sugar						
Artificial sweeteners						
Fast food						
Fried food						
Processed food						
Flour/baked goods						
Caffeine						
Soda						

Sleep

How many hours of sleep is your child getting each night?		Time in bed?
Does he or she fall asleep easily? Y_____ N_____	Does he or she sleep soundly? Y_____ N_____	Time gets up?
Does he or she wake rested? Y_____ N_____	What is your child's AM mood like?	

Co-sleeping ❑ Sleeping in own bed ❑ Sleeping in own room ❑

Exercise

Does he or she exercise regularly? Y_____ N_____	How often?	For how long?

What type of exercise(s) does your child do?

Do your child play any organized sports?

Social History and Development

What adults live with your child?	Child's Birth Order? (ex. 3rd of 4)
How many children in your home?	Any foster or adopted children?

School Age Children:
- Grade: _____
- Held back or had to repeat a grade? Y_____ N_____
- Does your child like school? Y_____ N_____
- Are you concerned about your child's attention span? Y_____ N_____ If yes, what?
- Any concerns about your child's behavior in school? Y_____ N_____ If yes, what?
- Any concerns about his or her academic abilities? Y_____ N_____ If yes, what?

Preschool or Daycare?
How often?
With whom?

Potty trained? Y_____ N_____ For how long? Nighttime bed wetting

Child & Family Diagnosed Health Conditions	YES	Who? Indicate child or specific family member	Notes:
ADD/ADHD	❑		
Alcohol/Drug Addiction	❑		
Anemia	❑		
Asthma	❑		
Autoimmune Diseases	❑		
Blood Disorder	❑		
Cancer	❑		What kind? Age diagnosed?
Cardiovascular Disease	❑		
Chicken Pox	❑		
Constipation	❑		
Depression	❑		
Diabetes Type 2	❑		
Ear Infections	❑		
Eczema	❑		
Epilepsy/Seizure Disorder	❑		
Gout	❑		
Hearing Problems	❑		
High Cholesterol	❑		
HIV/Aids	❑		
Hypertension	❑		
Inflammatory Bowel Disease	❑		
Learning Disability	❑		
Mental Illness – If Yes, specify:	❑		
Neurologic Disorder	❑		
Psoriasis	❑		
Stroke	❑		
Seasonal Allergies	❑		
Thyroid Disease	❑		
Others:	❑		Explain:

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