

Confidential Patient History

Legal Name _____ Name you preferred to be called _____

Address _____ City _____ State _____ Zip _____

Home (_____) _____ Work (_____) _____ Mobile (_____) _____

Sex: Male Female Age _____ DOB _____ Social Security _____ - _____ - _____

Email _____

Name of Emergency Contact _____ Relationship _____

Best Number to Contact Them Mobile Home Work Other (_____) _____

How did you hear about Dr. Hamel? _____

Do you have health insurance? Yes No If you checked yes, please provide us with a copy of your insurance ID card(s).

Name of the insured _____ Insured's date of birth _____

What is their relationship to you? Spouse Child Other _____

Do they live at the same address as you? Yes No

If you checked no, what is their address _____ City _____ State _____

Zip _____ Phone Number (_____) _____ Do you want to be added to Dr. Hamel's

Newsletter? Y N

Nutritional, Metabolic & Structural Evaluation

Please complete the following information as completely as possible. This helps us to address your concerns and needs, and to build a health program personally designed for you.

Complaints | Please rank the child's health complaints and rate their severity (on a scale from 1-10, 10 being the worst).

Other Information | Please tell us any additional information or concerns about their health.

Medical History | Please describe any conditions which are under the care of a physician.

Diagnosis _____

Date of onset _____ Duration of current symptoms _____

Doctor(s) involved, their specialty _____

How diagnosed (what tests)? _____

Current treatment (medication, etc.) _____

Treatment received in past, if any, and how it worked _____

Medications | Please list any medications you (the child) are taking, or have taken in the past, and for how long. State the reason for taking it.

Surgeries/Hospitalizations | What surgeries, operations, traumas, fractures, car accidents, etc. have you (the child) had?

(please list all with brief details such as date, outcome, etc.) _____

Family History | Check those that apply and indicate the outcome and age of onset.

	Maternal		Paternal		Mother	Father	Brother	Sister	Onset	Outcome
	Grandma	Grandpa	Grandma	Grandpa						
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Arthritis (type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cancer (type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mental Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Thyroid Imbalance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other	_____									

Review of Systems | Please check the “NOW ” box for all conditions that you(the child) are now experiencing and mark the “PAST” box for any condition or symptoms experienced at any time in your life.

	N	P		N	P		N	P		N	P			
General			Nose			G-I System			Neurologic			Conditions		
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Gas	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Strokes	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Head			Lungs			Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Tingling sensation	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid condition	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Heart condition	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting/Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Head trauma	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty walking	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Poor coordination	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Blacking out	<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Muscle/Bone			Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Eyes			Coughing phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumor	<input type="checkbox"/>	<input type="checkbox"/>
Change in vision	<input type="checkbox"/>	<input type="checkbox"/>	Coughing blood	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder disease	<input type="checkbox"/>	<input type="checkbox"/>	Muscle ache	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's	<input type="checkbox"/>	<input type="checkbox"/>
Light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Vascular			Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Flashes in vision	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	G-U System			Bone pain	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Spots in vision	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Mouth			Ankle swelling	<input type="checkbox"/>	<input type="checkbox"/>	Pain urinating	<input type="checkbox"/>	<input type="checkbox"/>	Dislocations	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	Cold feet/hands	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	Skin			Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
Cold sores	<input type="checkbox"/>	<input type="checkbox"/>	Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Dentures	<input type="checkbox"/>	<input type="checkbox"/>	Calf pain	<input type="checkbox"/>	<input type="checkbox"/>	Foul odor of urine	<input type="checkbox"/>	<input type="checkbox"/>	Bruising	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	Increased urination	<input type="checkbox"/>	<input type="checkbox"/>	Brittle nails	<input type="checkbox"/>	<input type="checkbox"/>	TIA's	<input type="checkbox"/>	<input type="checkbox"/>
Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Decreased urination	<input type="checkbox"/>	<input type="checkbox"/>	Changes in moles	<input type="checkbox"/>	<input type="checkbox"/>	Headache unlike	<input type="checkbox"/>	<input type="checkbox"/>
Changes in taste	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Urinary infection	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	any previously	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness						Genital infection	<input type="checkbox"/>	<input type="checkbox"/>	Peeling	<input type="checkbox"/>	<input type="checkbox"/>	experienced		

Bowel Movements | Please circle those that apply.

How often: daily | more than once a day | skip days Consistency: normal | too hard | too soft | diarrhea alternating with hard

Amount: normal | too little Color: brown | black | yellow | whitish Other: mucus | foul smell | lots of gas

Comments: _____

Any Acid reflux? _____

Nutrition | Circle one.

Breastfed | Formula | Foods (describe): _____

Birth | Please circle those that apply.

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Normal/vaginal | Forceps | Vacuum Extraction | Cesarean Section | Hematoma | Delayed (baby in birth canal for extended period) | Breech | Brow/Face Presentation | Shoulder Presentation | Erb's/ Klumpke's Palsy | broken clavicle

At Birth, any presence of: Jaundice, Meconium, Cyanosis??? Y N

Obstetrician/Midwife _____ Pediatrician _____

Milestones: Infant is able to (circle all that apply):

Respond to sound | Sit alone | Walk assisted | Says 5 or more words | Stands on one leg | Follow an object with his/her eyes | Crawl | Walk without assistance | Makes a tower of three objects | Walks on tiptoe | Holds head up | Stand | unintelligible babble | Copies a vertical line | Hops

Vaccinations | Has the child been vaccinated? Y N If yes, how old were they when they got them, and how many have they had?

Are they on a delayed schedule? Y N How many more are left? _____ Have they had any adverse reactions to any? Y N if yes, explain _____

Sleep | How many hours of sleep is the child getting? What is the quality of the sleep? Is the sleep schedule consistent? Please explain.

Exercise | Is the child getting daily exercise? Y N Organized sports? Y N Explain _____
Is the child experiencing any stress? Y N Are they allowed time to relax and have fun? Y N Explain _____

Toxic Inventory / Personal Care Products | Please list any toxins, chemicals, or solvents you (child) have had exposure to or use of. These can include products for the yard, work, furniture, art, building/carpentry, etc. (list the brand names in the space provided):

- | | | |
|--|--|--|
| <input type="checkbox"/> Shampoo _____ | <input type="checkbox"/> Deodorant _____ | <input type="checkbox"/> Toothpaste _____ |
| <input type="checkbox"/> Body Soap _____ | <input type="checkbox"/> Hand/Body Lotion _____ | <input type="checkbox"/> Laundry Soap _____ |
| <input type="checkbox"/> Dish Soap _____ | <input type="checkbox"/> Household Cleaner _____ | <input type="checkbox"/> Hairspray/Gel _____ |
| <input type="checkbox"/> Nail Polish _____ | <input type="checkbox"/> Hair Coloring _____ | <input type="checkbox"/> Air Freshener _____ |
| <input type="checkbox"/> Ant/Roach Spray _____ | <input type="checkbox"/> Pesticides _____ | <input type="checkbox"/> Other _____ |

Water/Hydration | How many glasses or bottles is the child drinking in an average day? ____ Do they drink tap water? ____
What brand(s) of drinking water do you use? _____

Do you cook with tap, bottled, or filtered water on a regular basis? _____
If you have a home water purifier, when was the last time you changed the cartridge? _____

Diets | Please check any applicable diet that you (the child) are currently on.

- | | | | | |
|---|---------------------------------------|-------------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Allergy rotation/desensitization | <input type="checkbox"/> No dairy | <input type="checkbox"/> Vegan | <input type="checkbox"/> Low fat | <input type="checkbox"/> Any other diet _____ |
| <input type="checkbox"/> Atkins/Zone diet | <input type="checkbox"/> Vegetarian | <input type="checkbox"/> Yeast-free | <input type="checkbox"/> Diabetic | |
| | <input type="checkbox"/> Candida diet | <input type="checkbox"/> Low salt | | |

Signature _____ Date _____