BLUE SPARK HEALTH
NATUROPATHIC MEDICINE

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Pediatric Holistic Health Record

Patient Name:_____ Preferred Name: _____

Date of Birth: _____ Age: _____ Gender or Orientation: _____

Reason for visit: _____

_____

Address: _____ City: _____ State: _____ Zip: _____

Working age? _____ Where do you work? _____

I Authorize Blue Spark Health, PLLC to contact me at the following:

Phone: _____ Leave message on phone: Yes: ____☐____ No: ____☐____

Child email (if applicable): _____Child cell (if applicable): _____

Parent/legal guardian: _____

Phone: _____

Parent email address: _____

Pediatrician: _____

Specialists: _____

Whom may we thank for referring you to Blue Spark Health? _____

Current medications/supplements: please list all names and doses of medication(s)/supplement(s) taken:

Medication/Supplement	Dose	How often	Condition

1. Did you know energy medicine can provide profound healing even in children? ☐Yes ☐No
2. If you could wave a magic wand what would you change about your child's health? _____

Please check any of the following needed by your child on a regualr or frequent basis:					
Aspirin	Tylenol	Ibuprofen	Decongestant	Antihistamine	Antibiotics
☐	☐	☐	☐	☐	☐

Medical History: _____

Childhood Illness: Has your child had any of the following illnesses?

Chicken Pox: ☐	Measles ☐	Mumps ☐	Rubella ☐

Scarlet Fever ☐	Pneumonia ☐	Frequent Colds ☐	Rheumatic Fever ☐

Has he/she ever had:

Tonsillitis	Number of Times?	Ear Infections	Number of Times?
☐Yes ☐No		☐Yes ☐No	

Allergies to medication; list drug and type of reaction:

Medication	Reaction

Are you interested in having food intolerances assessed? ○Yes ○No

Other known allergies (Foods or Environmental):	

Electroencephalogram Psychological Evaluation:

Hearing _____ Speech _____ Language _____ Vision _____

Have you chosen to vaccinate? Which ones?

☐ COV-mRNA	☐ Polio	☐ DPT(Tdap)	☐ MMR	☐ Hep A	☐ Hep B	☐ RV	☐ VAR
Dates of vaccinations							
☐ Hib	☐ DtaP	☐ Influenza	☐ PCV	☐ IPV	☐ HPV	☐ MCV	☐ HPV
Dates of vaccinations							

Any adverse reactions to vaccinations?

_____

_____

_____

_____

Family History ☐ Heart Disease ☐ Hypoglycemia ☐ Tuberculosis ☐ Allergies ☐ Diabetes

☐ Hypertension ☐ Mental Illness ☐ Arthritis ☐ Cancer

Mother's history:	Mother's age at childbirth _____ Number of pregnancies by birth mother _____
Mother's health during pregnancy:	☐ Bleeding ☐ Nausea ☐ Illness ☐ Hypertension ☐ Anxiety ☐ Depression
Consumption during pregnancy?	☐ Alcohol ☐ Tobacco/Nicotine ☐ Drugs ☐ Other _____
Please list any medications taken during pregnancy	
Gestational health conditions?	
Injuries/Surgeries/Hospitalizations:	
Add brief history of what your pregnancy was like while carrying this child? ie stressors, major, life events, mood, etc.	

Child's Birth History	Check if yes	Explain
Physical or emotional trauma	☐	
Birth injuries	☐	
Birth defects	☐	
Term: ☐Preemie ☐Weeks ☐Full ☐Late ☐Vaginal ☐C-Section		Length of Labor:
Weight at birth	Complications:	
NICU stay? _____How long? _____weeks		

Has your child had any of the following problems:

Jaundice: _☐__ Colic: _☐__ Blue Baby: _☐_

Any injuries, traumas, surgeries, hospitalizations:

_____

_____

_____

Child's sleep patterns (first year): _____

Feedings:

_____Breast fed How long? _____ Age began eating solid food _____

_____Formula Milk _____ Soy _____ Other _____

Rashes _____ Allergies _____ Other _____

Developmental:

Any developmental delays? _____

Age began walking _____

Age begal crawling _____

Age he/she spoke first word _____

Diet: Please describe your child's typical daily diet

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Favorite food/snacks: _____

Physical Activity

How many hours per week does your child engage in physical activity? (baseball, running, swimming, dancing, etc.).

Hours _____

On average, how many minutes of the activity does your child get at this level each time? _____

On average, how much time does your child spend on screens daily? _____

SYMPTOMS		
Fever	☐ Now	☐ Past
Eczema	☐ Now	☐ Past
Acne	☐ Now	☐ Past
Chronic rash	☐ Now	☐ Past
Jaundice	☐ Now	☐ Past
Bleeding gums	☐ Now	☐ Past
Canker sores	☐ Now	☐ Past
Teeth problems	☐ Now	☐ Past
Nose bleeds	☐ Now	☐ Past
Frequent colds	☐ Now	☐ Past
Sore throats	☐ Now	☐ Past
Hay fever	☐ Now	☐ Past
Night sweats	☐ Now	☐ Past
Easy bruising	☐ Now	☐ Past
Motion sickness	☐ Now	☐ Past
Fever	☐ Now	☐ Past
Seizures	☐ Now	☐ Past
Cough	☐ Now	☐ Past
Hearing loss	☐ Now	☐ Past
Stomach aches	☐ Now	☐ Past
Diarrhea	☐ Now	☐ Past
Constipation	☐ Now	☐ Past
Excessive fatigue	☐ Now	☐ Past
Bleeding tendency	☐ Now	☐ Past
Depression	☐ Now	☐ Past
Anxiety / ADD / ADHD mood disorder	☐ Now	☐ Past
Substance abuse/use	☐ Now	☐ Past
Kidney diseases or reoccurring UTI	☐ Now	☐ Past

SYMPTOMS		
Sensitive to light	☐ Now	☐ Past
Joint pains	☐ Now	☐ Past
Flat feet	☐ Now	☐ Past
Muscle/bone pain	☐ Now	☐ Past
Dizzy spells	☐ Now	☐ Past
Hair loss	☐ Now	☐ Past
Body/breath odor	☐ Now	☐ Past
Cries easily	☐ Now	☐ Past
Unusual fears	☐ Now	☐ Past
Nevousness	☐ Now	☐ Past
Sleep problems	☐ Now	☐ Past
Anemia	☐ Now	☐ Past
Nightmares	☐ Now	☐ Past
Frequent headaches / migraines	☐ Now	☐ Past
Runny nose	☐ Now	☐ Past
Heart murmur / heart disorder	☐ Now	☐ Past
Bloody urine	☐ Now	☐ Past
Burning urination	☐ Now	☐ Past
Vomiting spells	☐ Now	☐ Past
Lack of appetite	☐ Now	☐ Past
Diarrhea	☐ Now	☐ Past
Gas / colic	☐ Now	☐ Past
Wheezing / asthma	☐ Now	☐ Past
History of head injury or concussion	☐ Now	☐ Past
Snoring / obstructive sleep apnea	☐ Now	☐ Past

Reset form

Thank you for your time. Your child's medical history is important to us!