Abernathy Naturopathic Family Health Care
Dr. Crystal Abernathy, N.D.
10008 Red Bluff Court, Charlotte, NC 28269
(704) 562-9705

Patient Information (Child)

To the parent or guardian: please take some time to fill out this form about your child as completely and accurately as possible. It will help me to best address your child's health. Thank you.

Child's Full Name___________________________ Child's age_____ Today's Date__________
Child's Address____________________________
____
Home Phone #(______)___________Date of Birth_______ Place of Birth________ Gender: M F

Mother's Full Name________________________ **Father's** Full Name______________________
Mother's Social Security #__________________ Father's Social Security #__________________
Mother's Address__________________________ Father's Address__________________________
__________________________ __________________________
Mother's phone #s: (______)___________Home Father's phone #s: (______)___________Home
(______)___________Work (______)___________Work
(______)___________Cell (______)___________Cell

Who does your child live with?_____________________________
Who does this office have permission to release medical information to?_____________________
Siblings' name and ages:____
Medical doctor's name, address, and phone #____

Emergency Contact: Name__________________________ Relationship____________________
Address__________________________ Phone #s:(______)__________Home
__________________________ (______)__________Work
__________________________ (______)__________Cell

Source of referral? (please circle one): medical doctor, naturopathic doctor, chiropractor, relative, friend, yellow pages, health food store, newspaper or magazine ad, AANP website, other website
**Please list name of the person/business who referred you so that I can thank them_____________

Chief Health Concerns Today:
(1)____
(2)____
(3)____
(4)____

Allergies: Please list any allergies to drugs, foods, animals, or other allergens: _____________
____
____

List all natural supplements (vitamins, minerals, herbs, homeopathics, etc. that your child takes:

Supplement Name	Brand name	Mgs./IU per dose	# doses per day	Total Mgs./IU per day
Example: calcium	*Brand X*	*200 mg*	*4 capsules*	*800 mg*

List all drugs, medications, or over-the-counter drugs that your child takes:

Drug (generic name)	Brand name	Mgs./IU per dose	# doses per day	Total Mgs./IU per day
methylphenadate HCL	*Ritalin*	*10 mg*	*2 tablets*	*20 mg*

Family Medical History:

Does anyone *in your child's family* have any of the following conditions? (please circle)
Diabetes, gastrointestinal disease, celiac disease, ADD/ADHD, cancer, asthma, psychological illnesses, allergies (please list):____

Prenatal Health/Childbirth:

Were there any unusual events or abnormalities during pregnancy or labor? Please circle: Yes No (If yes, please explain):____

Infancy:

Birth weight:___________
Breastfed or bottle fed? (please circle one)
If breastfed, how long?___________
If bottle fed, what kind of formula? Cow's milk based, soy based or other?___________________
Were there abnormalities in your child's sleeping habits or appetite as an infant?
Please circle: Yes No (If yes, please explain):____
____

Vaccinations:

Was your child vaccinated? Please circle: Yes No______________________________________
Any unusual reactions to vaccinations? Please circle: Yes No (If yes, please explain):__________
____

Infancy Illnesses:

Did your child have any illnesses or diseases besides a cold in their first 2 years?
Please circle: Yes No (If yes, please explain):____

First foods:

At what age was your child fed food other than breast milk or formula?____________
Any unusual reactions? Please circle: Yes No (If yes, please explain):______________________
____

Medical History:
Has your child ever been diagnosed with any ***disease***?
Please circle: Yes No (If yes, please explain):

____

____

Has your child ever had any ***allergy testing***?
Please circle: Yes No (If yes, please explain):

____

____

Has your child ever had any ***surgery***?
Please circle: Yes No (If yes, please explain):

____

____

Psychological Concerns: (please circle Yes or No; if Yes give details):

ADD	Yes	No	______________________________
ADHD	Yes	No	______________________________
Anxiety	Yes	No	______________________________
Bipolar disorder	Yes	No	______________________________
Eating disorders	Yes	No	______________________________
Depression	Yes	No	______________________________
OCD	Yes	No	______________________________
Schizophrenia	Yes	No	______________________________
Sexual Abuse	Yes	No	______________________________
Other	Yes	No	______________________________

Development:
Please rate your child's development in the following areas:

Physical development:	below average	average	above average
Mental development/intelligence:	below average	average	above average
Emotional/social development:	below average	average	above average

Please list any details in this area you feel are important:

____

____

Personality:
Please describe your child's personality:______________________________

____

____

Lifestyle:

Is your child exposed to tobacco smoke in your home or elsewhere? Please circle: Yes No

Is your child under excess stress? Please circle: Yes No

Does your child have any of the following?:

Item			
Tea?	Yes	No	How much per day or week?____________
Coffee?	Yes	No	How much per day or week?____________
Soda?	Yes	No	How much per day or week?____________
Diet Soda?	Yes	No	How much per day or week?____________
Candy/sweets?	Yes	No	How much per day or week?____________
Sweet-n-low?	Yes	No	How much per day or week?____________
Nutrasweet/Equal	Yes	No	How much per day or week?____________
Sugar gum?	Yes	No	How much per day or week?____________
Sugar-free gum?	Yes	No	How much per day or week?____________
Fast foods?	Yes	No	How much per day or week?____________
Antacids?	Yes	No	How much per day or week?____________
Laxatives?	Yes	No	How much per day or week?____________
Margarine?	Yes	No	How much per day or week?____________
Excess salt?	Yes	No	How much per day or week?____________

What type of water does your child drink? (circle) tap filtered distilled reverse osmosis spring

How much water does your child drink daily?______________

Height?________ Weight?__________

Sleep:

How many hours per night does your child sleep?______________

How many naps does your child take & how many hours each?____________________

Who does your child sleep with?____________________

Does your child have any sleep problems? (nightmares, bedwetting, sleepwalking, etc.)

Please circle: Yes No (If yes, please explain):______________________________

____

Physical activity level: none/sedentary moderately active very active extremely athletic

Your child's energy level: low average high hyperactive

Other:

Is there anything else which hasn't been covered which you feel may be impacting your child's health? (please describe)______________________________

____

____

____

____

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Declaration & Consent to Treatment

This is to acknowledge that I have read and understand the following:

I. Crystal Abernathy, N.D. is not a medical doctor (M.D.), and the treatment or therapies rendered or recommended by her may differ from those usually offered by a medical doctor or other health care providers.
PLEASE INITIAL HERE______

II. Any treatment or advice provided to me by Crystal Abernathy, N.D. is not mutually exclusive from any treatment or advice that I may now be receiving or may in the future receive from another health care provider. I am at liberty to seek or continue medical care from a medical doctor and/or other health care provider(s) of my choice. Crystal Abernathy, N.D. will not suggest or recommend that I refrain from seeking or following the advice of another health care provider. However, she welcomes teamwork with M.D.s, chiropractors, and other health care providers.
PLEASE INITIAL HERE______

III. I understand that the ultimate responsibility for my health is my own, and that Crystal Abernathy, N.D. will be acting as a guide and coach in this process. Lifestyle changes can be important as any other treatments.
PLEASE INITIAL HERE______

IV. I will receive a full and complete explanation of the treatment and/or services that I may receive, including risks of following or not following advice given. I accept this care of my own free will and choice, and hereby authorize and give consent to treatment by Crystal Abernathy, N.D.
PLEASE INITIAL HERE______

V. My health records will be held in the strictest of confidence at all times. However, they may be used in research [your name & other identifying information will not be revealed.]
PLEASE INITIAL HERE______

VI. I am not an agent of any private, local, county, state, or federal agency attempting to gather information without so stating my intentions.
PLEASE INITIAL HERE______

VII. **I agree to pay my account in full at the end of each visit, including fee for services, cost of supplements, remedies, laboratory tests, and other fees.**
→ *****I understand that 24 hours notice must be given in order to cancel an appointment (including phone consults), and that failure to do so, or failure to keep an appointment, will result in a charge of the full fee.*
PLEASE INITIAL HERE______

VIII. This office does not file insurance forms, and an official receipt with codes will be given only on request. [*However, this does not ensure that your insurance company will reimburse you. Please address inquiries about coverage to your insurance company.]
PLEASE INITIAL HERE______

Patient's Name (please print)________________________________ Date________________

Patient/Parent/Legal Guardian signature