Krista Anderson Ross ND
Heartspace Center for Healing ~ 530 First St., Suite B-1 ~ Lake Oswego, OR 97034
503-804-0133 ~ kandersonrossnd@gmail.com

Patient Name: ____________________________________ Age: ______ D.O.B.:______

Parent/Guardian's Name:____

Address:____

Email Address:____

Home Phone:_______________________ Cell Phone:____________________________

What brings you into the office today?

____

____

____

What are your top health concerns, for the above named child, in order of importance?

____

____

____

General state of health is: __ Excellent __ Good __ Fair __ Poor

Date of last physical: ___________ Date of last dental exam if applicable: __________

Current Medications (including supplements, vitamins, and herbs):

____

____

____

Allergies (drugs, food, chemicals, etc):

____

____

Past operations / serious illnesses: _______________________________________

____

Medical History:
_ Chicken pox _ Measles _ Mumps _ Rubella _ Scarlet Fever
_ Strep throat _ Pneumonia _ Colic _ Croup _ Bronchitis
_ Tonsillitis _ Ear Infection _ Allergies _ Asthma

Immunization History: number received / number suggested
_ Diphtheria: /4 _ Pertussis: /4 _ Tetanus: /4 _ Polio: /4
_ Hepatitis B: /3 _ Measles: /2 _ Mumps: /2 _ Rubella: /2
_ H. Flu: /3

Family Medical History: Please note the diseases each family member has or had, their age at death, and cause of death if known:

Father: ____

Mother: ____

Paternal Grandfather: ____

Maternal Grandfather: ____

Paternal Grandmother: ____

Maternal Grandmother: ____

Siblings____

____

Mother's Pregnancy History:
Age at child's birth: ___________
_ Bleeding _ Drug/Alcohol Abuse _ Hypertension _ Medications
_ Physical Trauma _ Thyroid Problems _ Gestational Diabetes

Labor/Delivery History:
Pregnancy length: _ premature _ full term _ post term
Birth weight: ________________ Length: ________________
Any problems?
____
____

Feeding History:
Breast Fed? __________ How long? ___________
Formula Fed? __________ How long? ___________ What type? _______________
Solid Foods Introduced? ____________ What age Introduced? __________________
Food allergies/sensitivities: ____
____
____

Describe Child's Typical Daily Diet:
Breakfast:
____
Lunch:
____
Dinner:
____
Snacks:
____

Number of bottles given per day: ____ Number of ounces per bottle: _____________