Dr. Christina Sahni Radie
1730 SW Skyline Blvd. Suite #110 Portland, OR 97221
(503) 404-2333

Today's Date _______________
Patient Name___________________________ Date of Birth ___/___/___ Age _____ Sex: M F
Address_______________________________ City_______________ State___________ Zip______

Parent/Guardian Contact Information:
Name________________________________ Relationship to child __________________________
Address_______________________________ City_______________ State___________ Zip______
Home Phone__________________ Cell/Work_________________ Email______________________
How did you hear about us?____

Health History
What is the main reason for seeing the doctor today? If there is a specific health condition, please describe in detail including the first time you noticed the condition. Please list any factors you suspect may have played a role in its onset and continuation.
____
____
____
____
How long has the main problem been an issue?____

List in order of importance other health problems that are an issue:
1.____ Length of time__________________
2.____ Length of time__________________
3.____Length of time_________________

Who is the child's pediatrician?
Name____ Phone____________________________

Has the child ever seen a naturopath or a chiropractor before? Y N
If so, who was the doctor and what were the results?
____
Does the child now, or in the past, experience(d) the following: (circle all that apply):

Anemia	Hepatitis	Bladder infections	Hernia	Blood disorders
Asthma	Epilepsy	Ear infections	Thyroid disease	Diabetes
Hives	Eczema	Acid reflux	Bedwetting	Hyperactivity

Any other condition:____

How would you describe your child's overall state of health? (please circle one)
Excellent Good Average Fair Poor

Previous hospitalizations/Surgeries/Serious Illnesses:
____ _________________Date___________________
____ Date___________________
Does the child have known allergies to any drugs, foods, animals, herbs or other substances?
Please list allergen and the reaction to it:
____
____
____

Medications: (please give full name, strength, dosage and how long child has been taking it)
____
____
____

Vitamins/Herbs: (please give full name, strength, dosage and how long child has been taking it)
____
____
____

Typical Food Intake:
Breakfast____
Lunch____
Dinner____
Snacks____
Drinks____

Birth History:
At how many weeks gestation was the child born?________ Circle one: Vaginal or C-Section
How much did he/she weigh?_________ How long in inches____________
Were there any birth complications?____
Was the child breast fed?___________ If yes, for how long?_________________________________
Were there difficulties introducing any foods? Which ones?________________________________
____

Immunization History:
Has the child had all immunizations? Y N
Please circle all administered:
Hep B DTaP/DTP Hib Polio MMR Varicella(Chicken Pox)
Other:______________
Any reactions/complications from any immunizations?____________________________________

Financial Policy:
Payment is due at time of service.
Upon request a bill can be provided to you to send to your insurance company in the event that the services provided at this clinic will be covered, so that you can be reimbursed.

Cancellation Policy:
At least 24 hour notice is required to cancel your appointment. If it is not cancelled at least 24 hours prior to your scheduled appointment, you may be charged up to 100% of the missed appointment.

All of the above information is true to the best of my knowledge and I agree to the financial and cancellation policies of this office as stated above.

______________________________________ _________________________
Patient Signature (or Parent/Legal Guardian if patient is under 18) Date

_______________________________________ _______________________________________

Patient Printed Name Parent/legal guardian Printed Name