

PEDIATRIC HEALTH HISTORY QUESTIONNAIRE

By completely filling out this form you will help us to help you. All answers will be *absolutely confidential*. If you have any questions, please ask. Thank you.

Name _____ Today's Date _____

Age _____ Male Female Date of Birth (m/d/yy) _____

Home address _____

City/State _____ Zip Code _____

Home Phone No. _____ Email Address _____

Who referred you to our clinic? _____

PARENT/GUARDIAN INFORMATION

Mother's Name _____ Work Phone _____

Occupation _____ Employer _____

Father's Name _____ Work Phone _____

Occupation _____ Employer _____

Guardian's Name _____ Work Phone _____

Occupation _____ Employer _____

Medical Doctors: _____

Naturopathic Physician: _____

Chiropractor: _____

Other: _____

School Name: _____ Grade _____

Academic Performance: Excellent Average Poor

Areas of difficulty: _____

Sibling's Names/Ages _____

Current height _____ Current weight _____

Handedness Left Right

CHILD'S MAIN HEALTH CONCERNS

Please list the reasons for your visit and when the concerns began:

1. _____

2. _____

3. _____

4. _____

5. _____

Does your child have a contagious disease at this time? Yes No

If yes, what? _____

MOTHER'S PREGNANCY

- Uncomplicated
- Early labor
- Excessive vomiting
- Bleeding
- Physical or emotional trauma

- Diabetes
- Thyroid problems
- High blood pressure
- Smoking, alcohol or drug use

Medications during pregnancy:

- None
- Vitamins
- Other (list) _____

Birth History:

Birth weight (lbs.) _____ Weeks _____

- Full term
- Premature
- Past term
- Vaginal

C-Section

Reason for C-Section _____

Mother's age at childbirth _____

Birth complications or interventions used? Describe:

Post-natal complications

- | | | |
|--|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Cardiac | <input type="checkbox"/> Infections | <input type="checkbox"/> Gastrointestinal |
| <input type="checkbox"/> Birth defects | <input type="checkbox"/> Birth injuries | |

DEVELOPMENTAL HISTORY

Rolled over at _____ Sat at _____ Crawled at _____

Walked at _____ Talked at _____

Regression of speech No Yes

Difficulty being comforted? No Yes

Was child breast fed? No Yes If yes, for how long? _____

Difficulty nursing? No Yes

Formula used? No Yes

Colic? No Yes

When were solids begun? _____

IMMUNIZATIONS

Check immunizations given and circle how far in the series

HIB	2 mo.	4 mo.	6 mo.	18 mo.		
DPT	2 mo.	4 mo.	6 mo.	18 mo.	4-6 yrs.	14-16 yrs.
Polio	2 mo.	4 mo.	6-18 mo.	4-6 yrs.		
Hep-B	Birth-2 mo.	1-4 mo.	6-18 mo.	9-13 yrs.		
Varicella	12 mo.					
Pneumococcal	2 mo.	4 mo.	6 mo.	12-15 mo.		
Meningococcal	2 mo.	4 mo.	6 mo.	12 mo.	14-16 yrs.	
MMR	12 mo.	18 mo.	4-6 yrs.			
Influenza	6-23 mo.					

Any reactions to the immunizations? Describe:

CHILD'S MEDICAL HISTORY

Check current or past conditions:

General:

- | | | |
|---|--|---|
| <input type="checkbox"/> Easy bleeding/bruising | <input type="checkbox"/> Excessive fatigue | <input type="checkbox"/> Fainting/Dizziness |
| <input type="checkbox"/> Heat/cold intolerance | <input type="checkbox"/> High fevers | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Motion/car sickness | <input type="checkbox"/> Body/breath odor |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart murmur |

Skin:

- | | | |
|---------------------------------|---------------------------------|-------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Eczema | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Hives | | |

Head/Eyes/Ears/Nose/Throat:

- | | | |
|--|--|---|
| <input type="checkbox"/> Tooth/mouth pain | <input type="checkbox"/> Mercury amalgam fillings | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Head injuries | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Meningitis/encephalitis | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Sore throats |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Eye pain or blurry vision | |

Respiratory:

- | | | |
|-------------------------------------|--|------------------------------------|
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Wheezing | |

Digestion:

- | | | |
|--|--|--|
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Nausea/vomiting |
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Excessive thirst/hunger | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Belching/gas | <input type="checkbox"/> Reflux | |

Brain/Nervous system:

- Anxiety
- Autism

- Seizures/Epilepsy
- ADHD

- Depression
- Suicidal thoughts

Musculoskeletal:

- Joint pain

- Muscle spasms/cramps

- Broken bones

Infections/Immune system:

- Measles
- Diphtheria
- Whooping cough
- Scarlet fever

- Chicken pox
- Rubella
- Urinary tract infections
- Frequent colds/flu

- Mumps
- Strep infections
- Rheumatic fever
- Hayfever

Behavior:

- Excellent
- Variable
- Disruptive

Is there a concern with or history of:

- Biting
- Head banging
- Stuttering
- Hyperactivity
- Mood swings
- Excessive spinning

- Bed wetting
- Aggressiveness
- Teeth grinding
- Breath holding
- Irritability
- Hand flapping

- Hitting
- Odd fascinations
- Pulling own hair
- Cries easily
- Difficulty concentrating
- Tics

Sensitivity to

- Sound
- Touch
- Smell
- Light

Play skills

- Appropriate
- Inappropriate

Interaction with other children

- Leader
- Follower
- Plays alone

Sleep Normal Difficulty falling asleep Frequent waking Nightmares
 Bedtime _____ Number of hours of sleep _____

Excessive fears:

- Water
- Being alone
- Dark
- Thunder
- Strangers
- Animals

Which ones? _____

Other _____

Has your child had any of the following tests? State when and the results.

- Electroencephalogram (EEG) _____
- Psychological evaluation _____
- Hearing _____
- Speech/Language _____
- Vision _____

Allergies/Sensitivities: Is your child hypersensitive or allergic to any

- Drugs? _____
- Foods? _____
- Environmental substances or chemicals? _____

Medications: Please list all prescription, non-prescription and supplements/vitamins taken, including doses.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Hospitalizations/Surgeries/Injuries: Please list with dates.

Diet:

- Good eater Picky eater Snacker

Please describe your child's typical daily diet:

Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Drinks _____

Cravings/Favorite foods _____

Bowl movements (number per day) _____

FAMILY MEDICAL HISTORY

Check if your blood relatives had any of the following, and describe their relationship to you.

- Addiction _____
- Alzheimer's _____
- Aneurysms _____
- Anxiety _____
- Arthritis _____
- Asthma _____
- Autism _____
- Brain tumors _____
- Cancer _____
- Cerebral palsy _____
- Depression _____
- Epilepsy/Seizures _____

