

PPEDIATRIC HEALTH HISTORY FORM

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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

Gender:

M

F

Date of birth

Home address

City

ZipCode _____

Home telephone

Work/cell: #

Email address: (optional)

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:

Names of Healthcare Providers:

Medical Doctor(s)

Naturopathic Physician

Chiropractor

Other

School Grade

School Name _____

Siblings Name(s)/Age(s)

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?

No

Yes

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 (name) _____ |
| Birth History Birth weight (lbs) Weeks gestation Vaginal C-section Reason for C- section Mother's age at child's birth? Birth complications or interventions used? Describe: _____ _____ | |

Post-natal Complications

- None**
- Jaundice**
- Respiratory**
- Cardiac**
- Infections**
- Gastrointestinal**
- Birth defects**
- Birth injuries**

Developmental History

Rolled over at

Sat at
Crawled at _____
Was child breastfed?
No
Yes, if so how long?
Difficulty nursing?
No
Yes
Formula used? No
Yes
When were solids begun?
Colic?
No
Yes

| Immunizations | | | | | | |
|--|------------------|--------------|---------------|----------------|-----------------|-----------------|
| Check immunizations given and circle how far in the series. | | | | | | |
| HIB | 2mo | 4mo | 6mo | 18mo | | |
| DPT | 2mo | 4mo | 6mo | 18mo | 4-6yrs | 14-16yrs |
| Polio | 2mo | 4mo | 6mo | 18mo | 4-6yrs | |
| Hep B | birth-2mo | 1-4mo | 6-18mo | 9-13yrs | | |
| Varicella | 12mo | | | | | |
| Polio | 2mo | 4mo | 6-18mo | 4-6yrs | | |
| Pneumococcal | 2mo | 4mo | 6mo | 12-15mo | | |
| Meningococcal | 2mo | 4mo | 6mo | 12mo | 14-16yrs | |
| MMR | 12mo | 18 mo | 4-6yrs | | | |
| Influenza | 6-23mo | | | | | |
| Any reactions to immunizations? Describe: _____ | | | | | | |

Height
Weight lbs

| |
|--|
| Medical History: Put an "X" by all current or past conditions |
|--|

General

Easy bleeding/bruising
Excessive fatigue
Fainting/ Dizziness
Heat/cold intolerance
High fevers
Itching Night sweats
Motion/ car sickness
Body/breath odor
Frequent urination
Anemia
Heart murmur

Skin

Rashes
Eczema
Acne
Hives

Head/ Eyes/ Ears/ Nose / Throat

Tooth/ mouth pain
Mercury amalgam fillings
Sinus problems
Head injuries
Headaches
Eye pain or blurry vision
Nose bleeds
Meningitis/ Encephalitis
Ear infections
Sore throats
Tonsillitis

Respiratory

Bronchitis
Chronic cough
Pneumonia
Asthma
Wheezing

Digestion

Constipation
Diarrhea
Nausea/Vomiting
Poor appetite
Excessive thirst or hunger
Stomach aches
Belching/ gas
Reflux

Brain/Nervous system

| | | |
|---|------------------------------|-------------------------------|
| <p>Anxiety Seizures/ Epilepsy Depression Suicidal thoughts Autism spectrum ADHD</p> <p>Musculoskeletal Joint pain Muscle spasms/cramps Broken bones/fractures</p> <p>Infections/Immune system Measles Rubella</p> <p>Chicken pox Mumps Diphtheria Strep infections Frequent colds/flu Scarlet fever Urinary tract infections Hayfever</p> | <p>Whooping cough</p> | <p>Rheumatic fever</p> |
|---|------------------------------|-------------------------------|

Behavior

- Excellent**
- Variable**
- Disruptive**

Is there a concern with or history of (Put an X by any that apply):

- Biting**
- Bed Wetting**
- Hitting**
- Head banging**
- Aggressiveness**
- Odd fascinations**

Stuttering
Teeth grinding
Pulling own hair
Hyperactivity
Breath-holding
Cries easily
Mood swings
Irritability
Difficulty concentrating
Excessive spinning
Hand flapping
Tics

Sensitivity or aversion to:

Sound
Touch
Smells
Lights
Food textures
Clothing tags/textures

Play skills:

Appropriate
Inappropriate

Sleep:

Frequent waking
Nightmares
Bedtime
Number of hours of sleep

Hospitalizations/ Surgeries / Injuries: **Please list with dates.**

—

Bowel movements: #/day

Family 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 _____
Tics _____

Tuberculosis _____

Heart Disease _____
High Blood Pressure _____
Kidney Disease _____
Learning Disabilities _____
Bipolar Disorder _____

Gonorrhea _____
Headaches/Migraines _____

Mental Retardation _____
Muscular Disease _____
Obsessive Compulsive _____

Schizophrenia _____
Syphilis _____
Stroke _____

Other Infectious Disease _____