

Child's Name: _____ Child's Date of Birth: _____ Gender: _____
 Date of Appointment: _____

Parent's Names: _____
 Are parents: Married Living together Single Separated Divorced
 Legal Guardian, if not parents: _____ Relationship to child: _____
 Who lives in the house (include pets): _____

Current Concern(s):

	When did this start?	Current Treatment
1.		
2.		
3.		
4.		

Current Healthcare Providers (include pediatrician, any counselors, or non-traditional support):

Name of Provider	Dates	Type of Care Provided	Permission to discuss care if beneficial to child	
1.			Yes	No
2.			Yes	No
3.			Yes	No

Please list the medications, supplements and the doses for each that you are currently taking:

<u>Medication</u>	<u>Dose</u>	<u>Supplement</u>	<u>Dose</u>
1. _____		1. _____	
2. _____		2. _____	
3. _____		3. _____	
4. _____		4. _____	
5. _____		5. _____	

Any severe or life threatening allergy to medication or anything else? _____ Yes _____ No

Please list: _____

School attended or Daycare: _____

Current Grade: _____ Years at this school: _____

Hobbies or extra-curricular activities: _____

Time to Bed: _____ Time to rise: _____ Sleep issues? _____

Specific dietary guidelines?

___ Exclusively breast-fed (if weaned, for how many months was child nursed?) _____

Formula type if currently used: _____

___ Vegetarian ___ Vegan ___ Food allergy: _____

Other: _____

Health History:

Current height: _____ Current weight: _____

Was the pregnancy full term? Yes No If no, week delivered: _____

Any complications during pregnancy for mom or baby? _____

If yes, please describe: _____

Were any vaccinations given?

___ Yes, all vaccinations given according to the CDC schedule

___ Yes, but on a modified schedule.

___ All recommended vaccines given, but one per visit.

___ Not all vaccines given. If known, list vaccines given: _____

___ No vaccines given.

Any side effects noted from vaccines? _____

Any history of these common childhood/adolescent issues? (check all that apply)

- | | | | |
|-----------------------------|---------------------------|----------------------|-------------------|
| ___ Frequent Ear infections | ___ Stomach pains | ___ Anemia | ___ Acne |
| ___ Allergies | ___ Constipation | ___ Heart murmur | ___ Obesity |
| ___ Asthma | ___ Reflux | ___ Eczema | ___ Depression |
| ___ Frequent antibiotic use | ___ Diarrhea | ___ Autism | ___ PMS |
| ___ Recurrent strep | ___ Learning difficulties | ___ Emotional issues | ___ Mono |
| ___ Tonsillitis | ___ Developmental delay | ___ Headaches | ___ Night terrors |
| ___ Frequent colds | ___ Hyperactivity | ___ Seizures | ___ Frequent UTI |

Any other significant illnesses, diagnoses, hospitalizations, injuries or other health events:

Do any family members have a history of any of the following?

	Mother	Father	Sister	Brother	Grandparent
Anemia or blood disorders					
Allergies or Asthma					
Arthritis					
Autoimmune Disease, such as Lupus, Celiac's, Rheumatoid Arthritis...					
Bowel disease, such as Crohn's, Ulcerative Colitis...					
Cancer, list type					
Diabetes					
Epilepsy					
Heart Disease					
High Blood Pressure					
Kidney Disease					
Mental Illness					
Osteoporosis					
Stroke					
Thyroid Disease					
Other:					

Please mark any that apply and fill in any corresponding details:

_____ Exercise _____ hours per week

Activities: _____

_____ Combined screen time, computer + TV + video or other devices: _____ hours per week

_____ Smoke or use tobacco

_____ Alcohol intake _____ drinks per week

_____ Recreational drug use

Major life change in the past year: _____

What is your goal for treatment today? _____

What questions do you want to make sure you ask? _____

Please bring this completed form with you to your appointment.