# CHILD'S HISTORY

## GENERAL INFORMATION

Child's Name _____ Today's Date _____
Age _____ DOB _____ Height _____ Weight _____ Sex ❑ M ❑F
Name of Parents/Guardians _____
Address _____ City _____ State _____ Zip _____
Phone _____ Email _____
Purpose for contacting us? _____
Have other doctors been see for this condition? q Y q N Who? _____
Pediatrician _____ Date of last visit _____ Reason _____
List hospitalizations and surguries _____

## COMPLAINTS/CONCERNS

Please check any of the following conditions your child has suffered from during the past six months:

❑ Ear Infections
❑ Asthma/Allergies
❑ Colic
❑ Scoliosis
❑ Digestive Problems
❑ Bed Wetting
❑ Seizures
❑ ADHD, ADD
❑ Auto Accident
❑ Chronic Colds
❑ Recurring Fevers
❑ Temper Tantrums
❑ Headaches
❑ Growing/Back Pains
❑ Other _____
❑ Other _____

Please list child's chief symptoms in order of decreasing severity, starting with the worst one. Please note when they started, how often they occur, and their severity.

| Problem | When did it start? | How often? | How severe is it? |
|---|---|---|---|
| 1. e.g. Headaches | June 2009 | 3 times per week | mild/moderate/severe |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |

## SLEEP/REST

Average number of hours you child sleeps per night _____ Quality of sleep ❑ Good ❑ Fair ❑ Poor
Does your child wake up tired? ❑ Yes ❑ No Does your child take naps? ❑ Yes ❑ No

## ALLERGIES

| Medication/Supplement/Food/Animal/Environmental | Reaction |
|---|---|
| | |
| | |
| | |
| | |

## IMMUNIZATION HISTORY

Has your child ever had any vaccinations? ❑ Yes ❑ No If yes, please list:

_____
_____
_____
_____
_____
_____

Healthy Happy You

# CHILD'S HISTORY 2

## MEDICATIONS

Please list all medications that you are taking or have taken in the last month, including prescription drugs, non-prescription drugs, antibiotics, vitamins, minerals and nutritional supplements:

| Medication or Supplement | Dosage | Any Side Effects? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## DENTAL HISTORY

Does your child currently have any amalgam, silver, metal, and/or gold fillings? ☐Yes ☐ No
If yes, which kind: _____ How many? _____
How long has your child had these fillings? _____

## PRENATAL HISTORY

Name of obstretrician/midwife _____ Pediatrician/Family MD _____
Birth intervention? ☐Yes ☐ No ☐ Forceps ☐ Vacuum Extraction ☐ C-Section ☐ Emergency ☐ Planned
Ultrasound during pregnancy? ☐Yes ☐ No If yes, how many? _____
Medications during pregnancy? ☐Yes ☐ No If yes, please list _____
Cigarettes or alcohold during pregnancy? ☐Yes ☐ No

## FEEDING HISTORY

☐ Breast Fed ☐ Formula Fed How long? _____ If formula, was it soy based? ☐Yes ☐ No
Introduced to cows milk at _____ months Introduced to solids at _____ months
Any food intolerance? ☐Yes ☐ No If yes, what? _____

## CHILDHOOD DISEASES

Mumps ☐Yes ☐ No Age _____ Rubeola ☐Yes ☐ No Age _____ Chicken Pox ☐Yes ☐ No Age _____
Rubella ☐Yes ☐ No Age _____ Whooping Cough ☐Yes ☐ No Age _____ Other _____

## LIFESTYLE INDICATORS

Candy ☐ No ☐ Yes, how often _____
Soda ☐ No ☐ Yes, how often _____
White Flour ☐ No ☐ Yes, how often _____
Meat/Fish ☐ No ☐ Yes, how often _____

Sugar ☐ No ☐ Yes, how often _____
Dairy ☐ No ☐ Yes, how often _____
Soy ☐ No ☐ Yes, how often _____
Juice ☐ No ☐ Yes, how often _____

## CYCLIC FEMALES

Age of onset of first period _____ Is cycle regular? ☐Yes ☐ No Explain _____
Any cramping? ☐ No ☐ Mild ☐ Moderate ☐ Severe Any spotting between periods? ☐Yes ☐ No