Health History Form

PEDIATRIC PATIENT INFORMATION

ALL INFORMATION IS CONFIDENTIAL

Child's (Patient's) Name: ____

Parents'/Legal guardians' names: ____

Name and relation of individual who is filling out this form: ______________________
Date of birth: ______________ Age: _________ Gender (please circle): M or F

Grade Level: __________

Whom does the child live with?
Has any other family member already been a patient at this clinic?______________________

Contacts (in order of preference)
Name and relation to child: ____
Email: ____
Phone: (home) _______________________ (work) Phone: (cell or other) ____________________
Address: ____
May we leave messages relating to your child's visits? Y / N

Name and relation to child: ____
Phone: (home) _______________________ (work) Phone: (cell or other) ____________________
Address: ____
May we leave messages relating to your child's visits? Y / N

Whom does the child live with?

Child's Other Health Care Providers

Provider's name: _______________________________ **Specialty:** ____________________

Address (if available):_____________________________________

Phone: _____________________________________

Provider's name: _______________________________ **Specialty:** ____________________

Address (if available):_____________________________________

Phone: _____________________________________

How did you hear of us? May we thank someone for referring you? ______________________

Has the child had acupuncture or taken herbal medicines before? ______________________

If yes, when & where? ____

For what conditions? ____

What are you seeking treatment for today?_____________________________________

HEALTH HISTORY

What are the patient's most important health concerns? Please list in order of importance:

1.____ Date of Onset: __________

2. ____ Date of Onset: __________

3. ____ Date of Onset: __________

Is the patient currently under physician's care for any of these health concerns? (Please describe)

____

Have you sought any other treatment/s for any of the patient's health concerns? (Please describe):

____

Is there anything that improves or aggravates these conditions?

____

Has the patient had any blood tests, X-rays, CT scans, MRIs, EKGs or other tests related to these health concerns within the past year? Please list and describe the best of your knowledge:

____

____

Date of last physical exam: _____________ Name of physician: ______________________

Physician's address: ______________________________ Physician's phone: ____________

Please list any hospitalization and/or surgeries :

Hospitalization/surgery	Date	Reason

Please list any injuries and/or accidents:

Accident/injury	Date	Relation to health

Patient's height: ____________________ Patient's weight: __________________________

Number of siblings: __________________ Oldest/middle/youngest child: ______________

CONCEPTION/PREGNANCY/BIRTH HISTORY

Did the mother use any of the following during pregnancy?

☐ Tobacco ☐ Alcohol ☐ Recreational drugs:

☐ Prescription medications:

☐ Over-the-counter medications:

☐ Vitamins or supplements:

☐ Other:

Were any of the following interventions used during pregnancy?

☐ Ultrasound ☐ Amniocentesis ☐ Chorionic Villi Sampling ☐ Triple/Quad Screen

☐ Maternal Serum Screening ☐ Other:

How many pregnancies has the mother had before this child?

Conception: natural with medication with IVF with other procedures____________

Term length: ☐ Pre-term (37 weeks or less): _________ weeks

☐ Full-term (38-42 weeks): _________ weeks

☐ Post-term (more than 42 weeks): _________ weeks

Location of birth: ☐ Hospital ☐ Home ☐ Birthing Center ☐ Other:

Type of birth: ☐ Vaginal ☐ C-section

Types of Intervention:

☐ Induced labour ☐ Use of forceps ☐ Epidural/Anesthesia ☐ Vacuum ☐ Episiotomy

☐ Other:

Were there any complications during delivery (e.g., breech delivery)?

Length of labour: _________ Weight of infant at birth:

APGAR score (0 to 10): 1minute ______ 2 minutes ______ 5 minutes: ______

Did the child experience any of the following at or shortly after birth?

☐ Jaundice ☐ Rashes ☐ Seizures ☐ Birth injuries:

☐ Infections:

☐ Difficulties with feeding:

☐ Birth defects:

☐ Other:

DEVELOPMENT

Hearing test:________________________ Speech/language tests_________________

Injuries/surgeries/hospitalizations (please list):____

How was the infant fed?

☐ Breast fed r Formula (milk/soy/other):

☐ Other:

How long was the infant fed this way? ____

Did the infant have any reactions to what they were being fed? ________________________

What foods were introduced before 6 months? (Please list the approximate month that each food was introduced, as well as any reactions that may have occurred).

What foods were introduced between 6 and 12 months? Were there any reactions to these foods?

Did the child ever experience Colic? ❑ Yes ❑ No

If yes, how severe was the colic? ❑ Mild ❑ Moderate ❑ Severe

Please list any food allergies or intolerances that the child has:

Does the child have any dietary restrictions (vegetarian/vegan, religious, etc.)?

Please describe the child's eating habits (e.g., good appetite, picky eater, etc.):

How was the child's health in the first year?

❑ Poor ❑ Fair ❑ Good ❑ Excellent ❑ Unknown

How is the child's health now? ❑ Poor ❑ Fair ❑ Good ❑ Excellent ❑ Unknown

At what age did the child first:

Sit up ____________ Crawl ____________ Walk _____________ Talk _____________

At what age did the child begin teething? _____________ Any difficulties with teething?

Does the child nap during the day? ❑ Yes ❑ No

If yes, what time(s) do they nap?

Does the child have nightmares? ❑ Yes ❑ No

If yes, how often do they have nightmares?

Does the child have any problems associated with sleeping? ❑ Yes ❑ No

If yes, what kind of trouble do they have (e.g., trouble falling asleep, trouble waking up, etc.)?

Does the patient have a bowel movement every day? ____

How many bowel movements each day/week? _____

IMMUNIZATIONS, MEDICATIONS & SYMPTOMS

Type	**Yes**	**No**	**Age(s)**	Date(s)
Hepatitis B				
Rotavirus				
DPT (Diptheria, Pertussis, Tetanus)				
Haemophillius Influenza Type B				
Penumococcal				
Inactivated Poliovirus				
Influenza				
MMR (Measles, Mumps, Rubella)				
Varicella (Chickenpox)				
Hepatitis A				
Meningococcal				
Human Papillomavirus				
Other:				

Please list all prescription and over-the-counter medications the patient is currently taking:

Name	**Dosage**	**Reason for taking**	**Date began taking**

Please list all vitamins, minerals & supplements the patient is currently taking (include energy drinks, etc):

Name	**Dosage**	**Reason for taking**	**Date began taking**

Approximately how many courses of antibiotics has the patient taken since birth? ____________

Please review the following symptoms and mark an X in the appropriate column.
Leave blank if the patient does not experience the symptom.

	Occasional	Frequent		Occasional	Frequent
cough			shortness of breath		
spontaneous sweating			catch colds easily		
nasal congestion/ runny nose			allergies		
post-nasal drip			eczema or psoriasis		
enlarged lymph glands			acne or boils		
sinus congestion or infection			ringworm or fungus		
skin rashes or hives			dry nose, throat or skin		
asthma or wheezing			decreased sense of smell		
bleeding gums			hoarse or sore throat or voice		
low appetite			constipation		
loose stool or diarrhea			hemorrhoids		
acid reflux/heartburn			feelings of claustrophobia		
blood in the stool			excessive appetite		
fatigue after eating			gas or bloating after food		
obsession in activities or relations			nausea or vomiting		
insomnia			palpitations		
tongue or mouth sores			anxiety		
sadness			vivid dreams or nightmares		
mental restlessness			excessive sweating		
chest pain			laughing for no reason		
irritability			hearing impairment		

bitter taste in the mouth			difficulty digesting oily foods		
muscle spasms or twitching			difficulty making decisions		
neck/shoulder tension			ringing in the ears		
low back pain			Foggy headed		
sore, cold or weak knees			frequent urination		
hair loss			cold hands and feet		
urinary incontinence or urgency			body feels heavy		
dizziness/fainting			poor concentration		
floaters in field of vision			sticky taste/feeling in mouth		
hot hands and feet			pain on urination		
afternoon fevers			night sweats		
flushed cheeks			edema or ankle swelling		
headaches			cloudy urine		
heat or cold intolerance			bruise easily		
excessive thirst			muscle weakness		
nose bleeds			numbness/tingling		
ear aches or infections			athlete's foot		

LIFESTYLE

Does the child drink soda? ________ Is it caffeinated? ________ # servings per day/week? _______

How much water does the child drink per day? ____

Please describe the child's typical diet:
Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

meals per day: ________ Does the child eat regular times each day?______________________

snacks per day: _______ How often does the child eat out (or order in)?

____

____

Is the child vegetarian, vegan, kosher? Are there other restrictions to the child's diet?

____

____

Does the child experience any gas, burping, bloating acid reflux or other digestive symptoms after eating any foods?

____

#hours child sleeps per night: ______ Bedtime: ________ Wakes up: ________

Does the child sleep well? __________ Does the child wake feeling rested? _______________

At what time of day is the child's energy typically at its best? ___________ At its worst? ___________

Does the child nap during the day? ❑ Yes ❑ No
If yes, what time(s) do they nap?

Does the child have nightmares? ❑ Yes ❑ No
If yes, how often do they have nightmares?

Does the child have any problems associated with sleeping? ❑ Yes ❑ No
If yes, what kind of trouble do they have (e.g., trouble falling asleep, trouble waking up, etc.)?

SOCIAL PATTERNS

Is the child in: ❑ school ❑ daycare ❑ home care ❑ other:

How would you describe the child's behaviour at school?

How would you describe the child's behaviour at home?

What are the child's interests and favorite activities?

What, if any, recreational activities are the child involved in?

How would you describe the child's temperament/personality?

Is there anything that you would want to change?

Does the child play vigorously or exercise? ❑ Yes ❑ No

How much and how often?

How much television does the child watch? ________ hours a day/week.
How much time does the child play or work with a computer? ________ hours a day/week.

How often does the child read (not for school), or How often does someone read to the child?
☐ Daily ☐ Several times a week ☐ Weekly ☐ Less than weekly

ENVIRONMENT

Are there any pets in the home? ☐ Yes ☐ No
If yes, what type and how many?

Does anyone in the child's household smoke? ☐ Yes ☐ No

How is the child's home heated?

Do you know of any toxins or other hazards that the child is regularly exposed to?
☐ Yes ☐ No
If yes, please describe: How would you describe the emotional climate of the child's home?

Does the child have any known environmental or chemical sensitivities (e.g., perfumes, detergents, odors, soaps, etc.)?

Is there anything that you feel is important that has not been covered?

How much change are you able to make at this time to improve the child's health?
(Please circle) Minimal Some Complete
What do you think should change if anything?

What are the barriers and drivers for any changes you foresee?

FAMILY HISTORY

Father's current age: _____ Please circle: good health poor health deceased (cause & age) _____

Mother's current age: _____ Please circle: good health poor health deceased (cause & age) _____

Please indicate whether the child or any family member has, or has ever had any of the following conditions:

Disorder/Illness	Which family member (include the patient) give important details	Date	Frequency (if applicable)
Alcoholism/addictions			
Allergies/asthma			
Alzheimer's disease			
Anemia			
Arthritis			
Autoimmune disorders			
Bell's Palsy			
Birth defects			
Bleeding disorders			
Blood clots			
Cancer (specify type)			
COPD			
Crohn's disease			
Depression/anxiety			
Diabetes			
Epilepsy			
Fibromalygia			
Gallbladder problems			
Glaucoma			
Heart disease			
Heart murmurs			
Hepatitis			
High cholesterol			
High blood pressure			

HIV/AIDS			
Infectious disease			
Infertility			
Irritable bowel			
Kidney disease			
Kidney stones			
Mental illness			
Osteoporosis			
Pacemaker/defibrillator			
Polycystic Ovary			
Restless Leg			
Shingles			
Stroke			
Thyroid dysfunction			
Tuberculosis			
Ulcers			
Urinary tract infections			
Yeast infections			

Female Health

Is the patient menstruating? ________ Age menses began: _________ Date of last period: ____________

Is the patient sexually active? ______________________________ STDs?________________________________

What birth control does the patient currently use? ____

How long has she used it? ____

What other types of birth control has she used in the past? ____

Do you experience any of the following?

	Occasional	Frequent		Occasional	Frequent
Endometriosis			Fibrocystic breasts		
Ovarian cysts			Breast lumps		
Uterine fibroids			Nipple discharge		
Abnormal pap smear			Vaginal discharge/odor		
Yeast infections			Herpes		
Urinary tract infections			HPV (human papilloma virus)		
Pain/itching of genitalia			Genital lesions/discharge		
PID (pelvic inflammatory disease					

# of days between periods: ______ # of days of bleeding: _____ Bleeding between periods? _____

Are the periods painful? ❑ before period ❑ during period ❑ after period

Is the pain ❑ mild ❑ moderate ❑ severe

Is the pain located in: ❑ low abdomen ❑ low back ❑ thighs ❑ other

Is the quality of the pain ❑ cramping ❑ stabbing ❑ aching ❑ dull ❑ burning ❑ constant ❑comes and goes

Other symptoms related to patient's period:

	Occasional	Frequent		Occasional	Frequent
Discharge			Swollen or painful breasts		
Headaches			Mood swings		

Nausea			Increased appetite		
Constipation			Decreased appetite		
Diarrhea			insomnia		
Cravings					

Is there anything else you would like us to know?

MALE HEALTH

Is the patient sexually active? ___________________________ STDs? ______________________________

Frequency of urination -- daytime: _______________________ night time: _________________________

What birth control does the patient currently use? ____

Color of urine: _________ Is urine clear or murky?: ___________ Is there any odor?: _____________

Intact or Circumcised (Select One)

	occasional	frequent		occasional	frequent
Back pain			Delayed urine stream		
Dribbling urine			Incontinence		
Retention of urine			Hernia		
Testicular pain			Groin pain		
Testicular masses			Leisons or discharge		
Urinary tract infections			Herpes		
Pain/itching of genitalia			HPV (human papilloma virus)		
			Genital lesions/ discharge		

Is there anything else you would like us to know?