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PEDIATRIC HISTORY FORM

DEAR PARENT: *Please fill this out as thoroughly as possible before your child's first visit. You may fax, email, or mail it to me, or else bring it to your first visit. In the case of children over age 10, please fill it out with your child. If child is adopted, please indicate, and skip those questions you are unable to answer.*

Child's Name:

Address:

DOB:

Parent phone: **parent email address:**

Parents' Name and ages:

Parents' Occupations:

The child lives with one / both parents other (circle one)

Siblings' names and ages:

Family Health History: Please indicate any serious illnesses the child's relatives or descendants have had. If deceased (D), please indicate age at death.

Mother

Father

MGM

MGF

PGM

PGF

Siblings -- List names and health problems:

Medications and natural supplements: Current medications/supplements child is on, with dosage :

Major past medical treatments and/or surgeries (including orthodontics), with approximate dates:

Pregnancy/Labor/Birth:
How was the mother's **pregnancy** with this child? Please indicate any major shocks, surgeries, stresses, or medications that occurred during the pregnancy .

How were the **labor and delivery?** Indicate length of labor and any complications, medications, or interventions.

APGAR scores (if known):

Did the mother have any major unusual **food cravings during pregnancy** with this child?

Was the **child breast-fed?** If yes, for how long?

Vaccines: Please list all vaccines child has had, with dates, and indicate any adverse reactions.

Indicate any **injuries or accidents** child has had, with dates.

Indicate any **past illnesses** (aside from minor colds), as well as **allergies.**

Other **major life stressors** for child? If yes, when?

PRESENT ILLNESSES and CONCERNS
Please list in order of importance to you/your child. Include any emotional or behavioral problems that may be of concern.:

1.

2.

3.

4.

5.

DIET:
Please list all foods eaten yesterday.

Breakfast:

Lunch:

Dinner:

Snacks:

Thirst: Number of 8-oz. cups/bottles of water consumed, on the average, daily:

Does the child prefer warm tepid cold iced **drinks?** (circle one)

Food cravings? Please list. (for instance, sugary foods; milk; starches or breads; sweet foods; sour foods; cereal; etc.)

Any strong **food aversions**?

Sleep:
Preferred **sleep position:**

Average # hours sleep per night _____ from _____ to _____ o'clock

Sleep is (circle all that apply):

restless quiet has tooth grinding night terrors night fears gets hot/uncovers

wants window open talks in sleep walks in sleep unrefreshing sleep

wakes grouchy comes into parents bed wets the bed sweats in sleep

Does the child **nap?** When? Are naps regular?

Is the child **toilet trained**? If yes, at approximately what age for pee_____poop_____

Name any **major fears** your child has (for instance, dark, being alone, animals, dogs, strangers, spiders, things under the bed, etc.)

What is your child especially **bothered or irritated** by?

Favorite **toys, games, activities**:

Temperament/ general physical tendencies: My child is often (circle all that apply)

hot warm chilly sweaty messy abusive neat cranky placid obstinate defiant bossy

violent moody sad clingy obstinate insecure self-critical afraid , shy, timid

Please add me anything else that might help me know your child better. These responses will supplement our interview and my observations. Thanks!!!