New Patient Child & Adolescent Health History form

Name: _____, Your Mom: _____
Your Dad: _____

Mainly for Moms:

1. Tell us about your pregnancy;

Did you carry to full term? _____

Describe any complications and when they occurred: _____
_____
_____

2. Tell us about your delivery and birth of this child:

Did you use a midwife? _____ Hospital? _____ Obstetrician? _____

Did you have a C-Section? _____ Were forceps used? _____

Vacuum Extraction? _____ Were you induced? _____

Did you have an Epidural? _____ Was it a difficult birth? _____

What was the baby's **APGAR** Score? _____ at 5 minutes? _____

3. Tell us more:

Did you breastfeed? _____ How long? _____ What formula after?_____

Did you consume alcohol during your pregnancy? _____ How much? _____

Did you smoke? _____ How much? _____ How long? _____

Did you take any medication during your pregnancy?

For what? _____ What type? _____

Any exposures to ultrasound?_____, How many?_____

4. As a baby/toddler, (birth to 4 years), did any of the following occur?

___ Fall from a change table
___ Tumble down stairs
___ Fall out of crib
___ Involved in car accident
___ Fall off playground equipment
___ Play in Jolly Jumper
___ Frequent ear infections
___ Tonsilitis
___ Reaction to vaccination
___ Frequent crying spells
___ Frequent fevers
___ Frequent bouts of diarrhea
___ Constipation
___ Sleeping problems
___ Frequent colds
___ Colic
___ Did not gain weight
___ Other_____

Please explain the above: _____
_____
_____

5. As a young child, (5-12 years), did any of the following occur?

___ Fall from a tree
___ Fall of a bicycle
___ Fall of playground equipment
___ Sports accident
___ Car accident
___ Stomach pains
___ Scoliosis
___ Bed wetting
___ Hyperactivity/Autism
___ Learning difficulties
___ Asthma
___ Allergies
___ Leg/knee pains
___ Other_____

Please explain the above: _____
_____
_____

6. Tell us about any vaccinations your child has had: _____
_____
_____

Any reactions to any of these? _____
_____

Were you told that you had a choice in vaccinating your child? ___**YES**, ___**NO**

7. As a child or adolescent, has your child experienced any of the following:

___ Headaches
___ Dizziness
___ Ringing in ears
___ Asthma
___ Hyperactivity
___ Fatigue
___ Numbness in arms/hands
___ Arm/wrist pains
___ Sleeping problems
___ Allergies
___ Stomach problems
___ Weight gain/loss
___ Foot/ankle/knee pains
___ Tingling in arms/legs
___ Neck/back pains
___ Shoulder pains
___ Growing Pains
___ Other: _____

Please explain any of the above: _____
_____
_____

8. **Which of the problems you have checked off is the worst?** _____

_____

Is this problem: Constant __, Intermittent __, Occasional __, Cyclic ____

9. **How long has it persisted?** _____

10. **When it is at its worst, how does it make your child feel?** _____

11. **What have you done about it that has NOT worked?** _____

_____

_____

12. **What makes it worse?** _____

13. **What effect does this problem have of your child's body functions**?

_____

_____

On his/her participation in daily activities? _____

14. **Describe any hospital stays:** _____

_____

15. **Approximately how many times have antibiotics been prescribed and for what conditions?** _____

_____

16. **List any medications your child is currently taking:** _____

_____

17. **To summarize, what is your purpose for this appointment?** _____

_____

_____

18. **Is there anything else you feel we should know?** _____

_____

_____

_____

Signature of parent or guardian: _____

Date: _____

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