FAMILY HEALTH CLINIC - Naturopathic & Preventive Medicine

PEDIATRIC / ADOLESCENT HISTORY FORM

(CONFIDENTIAL: All information in this form remains confidential and will be released only on your written permission)

TODAY'S DATE OR DATE OF FIRST APPOINTMENT ____ / ____ / _____ (MM / DD / YYYY) BIRTHDATE ____ / ____ / _____ (MM / DD / YYYY) AGE _____

PATIENT'S FULL NAME _____ (FIRST) (MIDDLE) (LAST) PATIENT'S PREFFERED NAME _____

GENDER _____ PREFFERED PRONOUNS _____ PARENT'S NAMES _____

ADDRESS _____ CITY _____ POSTAL CODE _____

PARENT'S PHONE NUMBERS: PHONE #1 (AND NAME) _____ PHONE #2 (AND NAME) _____

PARENT'S EMAIL ADDRESS_____ CARE CARD #_____

FOR APPOINTMENT REMINDERS, HOW WOULD YOU PREFER TO BE CONTACTED? ☐ HOME PHONE ☐ CELL PHONE ☐ TEXT ☐ EMAIL

FAMILY PHYSICIAN _____ CHIROPRACTOR _____ SPECIALIST _____

WHO REFERRED YOU TO THIS OFFICE?_____

PRESENT HEALTH PROBLEMS: PLEASE LIST MOST IMPORTANT HEALTH CONCERNS / PROBLEMS

_____

_____

_____

MEDICATIONS:	Now	Past	Frequency
ASPIRIN	☐	☐	_____
TYLENOL	☐	☐	_____
ANTIBIOTICS	☐	☐	_____
DECONGESTANTS	☐	☐	_____
OTHER:_____	☐	☐	_____

SUPPLEMENTS:	Now	Past	Frequency
VITAMINS	☐	☐	_____
MINERALS	☐	☐	_____
FLUORIDE	☐	☐	_____
HERBS	☐	☐	_____
OTHER:_____	☐	☐	_____

ALLERGIES: (to medications, pollens, animals or food)

_____

_____

_____

CHILDHOOD ILLNESSES:

☐ CHICKEN POX ☐ MEASLES ☐ MUMPS ☐ RUBELLA

☐ SCARLET FEVER ☐ RHEUMATIC FEVER ☐ STREP THROAT ☐ PNEUMONIA

☐ MONONUCLEOSIS ☐ EAR INFECTIONS ☐ TONSILLITIS ☐ OTHER _____

IMMUNIZATIONS: age given; any adverse reactions?

☐ DPT (Diptheria, Pertussis, Tetanus) AGE __; Y OR N __
☐ MMR (Measles, Mumps, Rubella) AGE __; Y OR N __
☐ POLIO AGE __; Y OR N __
☐ HAEMOPHILUS INFLU. type B (Meningitis) AGE __; Y OR N __
☐ HEP-B (Hepatitis B) AGE __; Y OR N __
☐ My child has not been immunized

PATIENT'S MEDICAL HISTORY:

	Now	Past	Never
ACNE	☐	☐	☐
ALLERGIES	☐	☐	☐
ANEMIA	☐	☐	☐
ASTHMA	☐	☐	☐
BED WETTING	☐	☐	☐
BIRTH DEFECTS	☐	☐	☐
COLIC	☐	☐	☐
CONSTIPATION	☐	☐	☐
COUGH/WHEEZE	☐	☐	☐
CRADLE CAP	☐	☐	☐
DEPRESSION	☐	☐	☐
DIARRHEA	☐	☐	☐
DIZZY SPELLS	☐	☐	☐
EARACHES	☐	☐	☐
ECZEMA	☐	☐	☐
EXPOSURE TO:			
CIGARETTE SMOKE	☐	☐	☐

	Now	Past	Never
EPILEPSY/SEIZURES	☐	☐	☐
FATIGUE	☐	☐	☐
FREQUENT INFECTIONS	☐	☐	☐
HEADACHES	☐	☐	☐
HEART MURMUR	☐	☐	☐
HIGH FEVER	☐	☐	☐
HYPERACTIVITY	☐	☐	☐
INSOMNIA	☐	☐	☐
JAUNDICE	☐	☐	☐
LEARNING DISORDER	☐	☐	☐
MOODINESS	☐	☐	☐
STUFFY NOSE	☐	☐	☐
THRUSH	☐	☐	☐
VOMITING SPELLS	☐	☐	☐
OTHER _____	☐	☐	☐

SURGERIES (YEAR & TYPE)

_____

_____

_____

HOSPITALIZATIONS (YEAR & REASON) _____

_____

_____

INJURIES/ACCIDENTS (YEAR & CAUSE) _____

_____

_____

OTHER CONDITIONS _____

_____

WHAT IS YOUR INFANT'S / CHILD'S / ADOLESCENT'S DISPOSITION?_____

_____

PLEASE TURN PAGE

FAMILY HISTORY: INCLUDE BLOOD RELATIVES ONLY

FATHER (age)* _____ ☐ MOTHER (age)* ____ ☐ BROTHERS (ages)* _____ ☐ SISTERS (ages)* _____ ☐

* If deceased, Please list age at death and click check box.

IDENTIFY ALL FAMILY MEMBERS WHO HAVE EVER HAD ANY OF THE FOLLOWING (INDICATE FAMILY MEMBER BY F for FATHER, M for MOTHER, B1, B2, S1, etc.).

___ ALCOHOLISM	___ BLEEDING DISORDER	___ HEART DISEASE	___ OBESITY
___ ALLERGIES	___ CANCER of _____	___ HEARING LOSS	___ STOMACH ULCERS
___ ANEMIA	___ COLITIS	___ HIGH BLOOD PRESSURE	___ STROKE
___ ARTHRITIS	___ DIABETES	___ HYPOGLYCEMIA	___ THYROID DISORDER
___ ASTHMA	___ ECZEMA	___ KIDNEY DISEASE	___ TUBERCULOSIS
___ BIRTH DEFECTS	___ EPILEPSY	___ MENTAL ILLNESS	___ OTHER _____

DOES PATIENT HAVE ANY OF THE ABOVE? _____

IF YES, WHICH ONES

_____

PRENATAL / BIRTH / FEEDING HISTORY:

1. MOTHER'S HEALTH DURING THE PREGNANCY WITH THIS PATIENT

___ AGE	☐ TRAUMA/INJURY	☐ ALCOHOL CONSUMPTION	☐ OTHER _____
☐ BLEEDING	☐ STRESS	☐ DRUGS	☐ TOXEMIA
☐ NAUSEA	☐ HIGH BLOOD PRESSURE	☐ SMOKING	
☐ ILLNESS	☐ X-RAYS	☐ MEDICATIONS _____	

2. TERM ☐ PREMATURE ☐ FULL BIRTH WEIGHT _____

3. WAS PREGNANCY / BIRTH ☐ EASY? ☐ DIFFICULT? ☐ C-SECTION?

4. FEEDING OF INFANT

☐ BREAST FED HOW LONG? _____ COW'S MILK? _____

☐ FORMULA FED HOW LONG? _____ TYPE OF FORMULA _____

AGE SOLID FOODS BEGUN _____ WHAT FOODS? _____

ANY FOOD ALLERGIES OR INTOLERANCES? _____ TO WHAT FOODS? _____

5. SAMPLE DAILY DIET (Choose a typical day and include food and liquids)

BREAKFAST: _____ SNACKS: _____

LUNCH: _____ DINNER: _____

6. PREVIOUS PREGNANCIES BY NATURAL MOTHER AND ANY COMPLICATIONS

_____

SOCIAL HISTORY:

1. PARENTS: ☐ MARRIED ☐ SEPARATED ☐ DIVORCED

PARENT #1's OCCUPATION _____ ☐ FULL TIME ☐ PART TIME

PARENT #2's OCCUPATION _____ ☐ FULL TIME ☐ PART TIME

2. OTHER GUARDIAN: _____ RELATIONSHIP _____

3. OTHERS RESIDING IN HOME _____ RELATIONSHIP _____

4. DAYCARE/PRESCHOOL/SCHOOL: HOW MANY HOURS EACH DAY? _____ # DAYS OF THE WEEK? _____

5. INTERACTION WITH RELATIVES: WHO? _____ HOW OFTEN? _____

DO YOU HAVE ANY OTHER HEALTH CONCERNS YOU WOULD LIKE TO DISCUSS? PLEASE EXPLAIN.

_____

_____

_____

_____

_____