PEDIATRIC FORM

All Medical Information is confidential.

I. General Information.

Name of Child: _____Date: _____

Name of Parent(s)/Legal Guardian(s): _____

Occupation(s):_____

Address: _____ City/Zip: _____

Phone: (home) _____ (cell) _____ (work) _____

Email:

_____

Child's Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Sex (m/f): _____ Grade of School: _____

Child's Primary Care Provider/Contact Information:

_____

Emergency contact name & phone number:

_____

Reasons for your visit:

(1)

(2)

(3)

What initiates the symptoms?

_____

What makes them better?

_____

What makes them worse?

_____

II. MEDICAL HISTORY

Please circle the correct answer for your child.

1. YES (Y) indicates the child has the problem regularly;
2. NO (N) indicates the child never had the problem;
3. PAST (P) indicates the child had the problem in the past but not recently.

Ear Infections:

1. Y 2. N 3.P

If has had, how many total per year: _____

Colds:

1. Y 2. N 3. P

If has had, how many total per year: _____

Strep Throat:

1. Y 2. N 3. P

If has had, how many total: _____

How many times has the child taken antibiotics:

_____

Hearing tests normal:

1. Y 2. N 3. Not tested

Speech impediments:

1. Y 2. N 3. Not tested

Vision tests normal:

1. Y 2. N 3. Not tested

Learning impediments:

1. Y 2. N 3. Not tested

Vaccination History.

Please circle all applicable vaccinations:

MMR Age: _____

Chicken Pox Age: _____

Flu Age: _____

Hep.B Age: _____

Polio: Age: _____

CMV: Age: _____

DPT Age: _____

HPV Age: _____

Others:

_____

Please note any adverse reactions to vaccinations:

_____

System Overview.

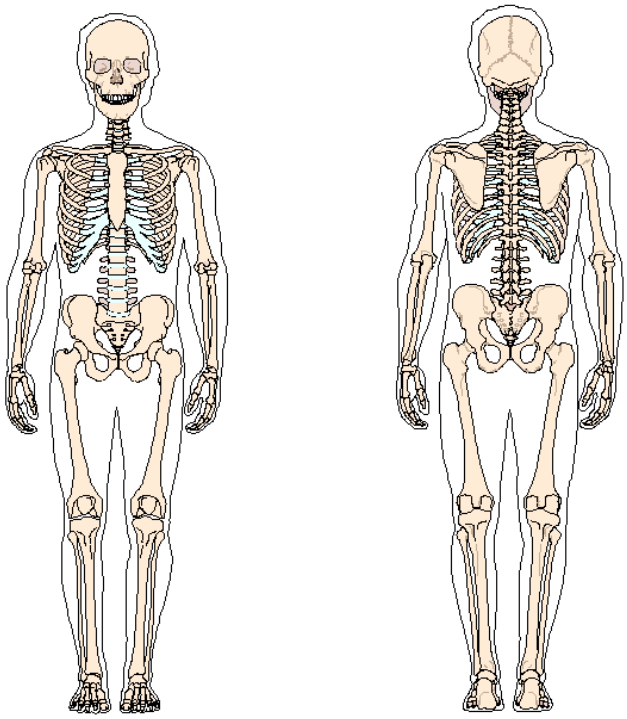
Please circle all that apply:

Jaundice as baby	Diarrhea	Hyperactivity	Nightmares
Cradle cap (crust/seborrheic dermatitis)		Constipation	Eczema/Psoriasis
Finicky eating	Diaper rash	Fears/phobias	Diabetes
Bed wetting	Colic	Stomach aches	Tantrums
Chronic sniffles	Anemia	Epilepsy/Seizures	Allergies
Autism	Depression	Asthma	Growing pains
Early puberty	Very sweaty	Poor teeth	Disobedient

Others:_____

Musculoskeletal Overview

Please indicate any areas of pain in the body on the diagram:



What makes the pain better/worse?

_____

_____

_____

Medication/Supplements.

List all medications (from the drugstore and/or prescription) your child is on now:

MEDICATION	DOSAGE	REASON

List all supplements/vitamins your child is on now:

VITAMINES/SUPPLEMENTS	DOSSAGE	REASON

Allergies.

Is your child allergic or hypersensitive to any:

Drugs?

_____

Foods?

_____

Animals?

_____

Environmental Factors?

_____

Diet.

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Beverages:_____

Is there anything your child does NOT eat?

_____

III. SOCIAL HISTORY of CHILD.

Are both parents living in the home? Yes No

Names and ages of siblings, if any:

_____

Pets:_____

Recent Travel:_____

Recent life changes:_____

Does your child attend school? Yes/what grade? _____ No

Any concerns about school?

_____

Sports/activities:

_____

Any particular household stressors your child has witnessed or gone through:

_____

_____

_____

Anything else you'd like to share?

_____

_____

_____

_____

_____

_____

_____

Parent/Guardian Signature:

_____ Date: _____