



PEDIATRIC HEALTH HISTORY

Child's Name: _____ DOB: _____ Age: _____ Gender: _____

Height: _____ Weight: _____ Blood Type: _____

Mom's Name: _____ Dad's Name: _____

Day Phone: _____ Evening Phone: _____ Email: _____

Address: _____

Referred by: _____

Siblings/Ages: _____

Parents' Occupations: _____

School/Daycare: _____

Do the parents smoke? Yes No In the past? When? _____

Pediatrician: _____ Phone Number: _____

Other Healthcare Practitioners/Specialists _____

Vaginal Birth C-Section Birth Epidural Vacuum Extraction or Forceps Complications _____

Breast Fed Bottle Fed Age solids started: _____ Dairy Products included in diet? Yes No

Food Sensitivities: _____

Vaccinated? Yes No Developmental Delays: _____

Childhood Diseases: _____

Surgeries: _____

Other injuries/broken bones: _____

FAMILY HEALTH HISTORY (Current and Historical)

Mom's Health: _____

Natural Strategies for Vibrant Living

Dad's Health: _____

List all current and historic medications (i.e. antibiotics, Ritalin, aspirin, etc.) _____

Vitamin and Mineral Supplementation (*please bring to intake*): _____

Reason for Visit: _____

Date of onset: _____ Sudden Gradual Previous history of same or similar problems: _____

What makes it better: _____ What makes it worse: _____

Other helpful information: _____

DAILY EATING HABITS (List Typical Food/Beverage and time):

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

CHILDHOOD SYMPTOMS:

Rate each of the following symptoms based upon your child's current health profile. (0=never or almost never; 1=occasionally; 2=frequently)

General Symptoms:

- | | | | |
|-------------------------|---|-----------------------------------|------------------------|
| _____ Fevers | _____ Cold Feet | _____ Day Dreams | _____ Cravings |
| _____ High Blood Sugar | _____ Hives | _____ Dizziness or Shaky | _____ Heavy Sleep |
| _____ Headaches | _____ Chills | _____ Rash | _____ Cold Hands |
| _____ Sleepy During Day | _____ Low Blood Sugar | _____ Fainting | _____ Dry Skin |
| _____ Sensitive Abdomen | _____ Wake Up, Can't Fall Back to Sleep | _____ Bleed/Bruise Easily -Where: | _____ Eczema/Psoriasis |

Digestive Tract/Urinary:

- | | | | |
|---|---|---|--------------------------------------|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Belching (excessive) | <input type="checkbox"/> Passing Gas |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Heavy Appetite | <input type="checkbox"/> Itching of Anus/Genitals | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Bloating |
| <input type="checkbox"/> Refusal to Eat | <input type="checkbox"/> Frequency of Bowel Movements | <input type="checkbox"/> Strong Thirst (hot/cold) | |

Ears/Eyes/Lungs/Nose:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Lung Mucus (color): |
| <input type="checkbox"/> Bronchitis (history of) | <input type="checkbox"/> Drainage from Ears | <input type="checkbox"/> Bags under Eyes | <input type="checkbox"/> Watery/Itchy Eyes |
| <input type="checkbox"/> Sinus Mucus (color): | <input type="checkbox"/> Asthma (age of onset): | <input type="checkbox"/> Reddening of Ears | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> "Allergy Salute" (rubs, itches, wipes nose) | <input type="checkbox"/> Pneumonia (history of) | <input type="checkbox"/> Frequent Pulling on Ears | <input type="checkbox"/> Itchy Ears |
| <input type="checkbox"/> Dark Circles Under Eyes | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Reduced Lung Capacity | <input type="checkbox"/> Earaches |

Allergies: _____

Mind/Emotions: _____
