Child History Form

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Name_____Date_____

Address_____Phone_____

Age_____Birthdate_____Live with_____

PLEASE FEEL FREE TO ATTACH ADDITIONAL PAGES IF WE HAVE NOT GIVEN YOU ENOUGH SPACE TO WRITE THE INFORMATION REQUESTED. WE DO REVIEW THIS HISTORY TOGETHER SO YOU MAY GIVE INFORMATION THAT IS DIFFICULT TO WRITE.

ALL QUESTIONS SHOULD BE ANSWERED BY YOUR CHILD IF OLD ENOUGH TO CONTRIBUTE WITH COMMENTS BY PARENTS WHERE APPROPRIATE-PLEASE USE A DIFFERENT COLORED PEN OR PENCIL TO DIFFERENTIATE WHO HAS ANSWERED THE QUESTION. THIS FORM IS USED FROM BIRTH THROUGH ADOLESCENCE, SO THERE MAY BE QUESTIONS THAT ARE NOT APPICABLE AT A PARTICULAR AGE. "YOU AND YOUR" REFER TO THE CHILD EXCEPT FOR PREGNANCY AND BIRTH HISTORY.

PREGNANCY AND BIRTH HISTORY

Pregnancy-please list any physical or mental emotional symptoms that you experienced during the pregnancy____

_____

_____

Age of parents at time of pregnancy_____

Any major physical or emotional traumas during pregnancy (ex. Motor vehicle accident, moves, job loss, death of friend or family member)?_____

_____

Describe labor and delivery_____

_____

Medications, herbs, homeopathics, vitamins, minerals used during pregnancy_____

_____used during labor and delivery_____

_____

Used after birth, during first weeks_____

_____

Condition of baby at birth and first two weeks (ex. Breathing, apgar, jaundice, special care nursery, feeding, sleep, behavior)_____

_____

Condition of mom at birth and during first few weeks (ex. Pain, difficulty nursing, post partum depression)_____

_____

Give a brief history of illnesses/injuries for this child from birth to the present condition (give dates if possible)_____

_____

_____

What vaccinations have been received, were there any reactions (what kind, to what vaccine)?_____

_____

What medications, herbs, homeopathics, vitamins, minerals, body work, flower essence etc. have been used?_____

_____

Diet history from birth_____

Bottle/breast fed, for how long?_____

Age introduced first food_____What was order of food?_____

_____any reactions?_____

Please give approximate dates for the following developmental milestones:

Sat by self_____first words_____first steps_____toilet trained (stool)_____

Walked well_____first tooth_____crawled_____toilet trained (urine)_____

PRESENT PICTURE

Please attach a 3 day diet history, include all foods and fluids that you consume for three days

Are you a thirsty person-hot, cold, iced?_____

Food cravings_____

Foods you dislike_____

Food reactions_____

Sleep patterns (ex. Hours of sleep, restless, refreshing, interrupted and by what, sleep position, covering used, windows open or closed, dreams/nightmares)_____

_____

_____

What do you do for exercise? (frequency/type)_____

_____

Allergies (to what and the type or reactions)_____

_____

_____

Surgeries/Hospitalizations (include year)_____

_____

Significant illnesses/Injuries (include year)_____

_____

Significant Emotional issues/experiences (include year)_____

_____

PRESENT PROBLEMS/CONCERNS_____

_____

_____

Describe your present Health and Sense of Well-Being_____

_____

PERSONAL HISTORY

1. How much do you smoke, drink, use any other drugs?_____
2. What medications, vitamins, minerals, herbs, or homeopathics do you use? PLEASE BRING THESE WITH YOU WHEN YOU COME FOR YOUR VISIT_____

_____

Please answer all questions in terms of significant past history and present condition. If you have any of these conditions I will need to know when it started, how does it affect your life and what makes it better or worse.

Any problem with:

3. Vision/Eyes_____
4. Hearing/Ears_____
5. Taste/Mouth/Tongue_____
6. Smell_____
7. Touch_____
8. Walking_____
9. Sitting_____
10. Getting in/out of bed_____
11. Running_____
12. Picking up something_____
13. Joint weakness_____
14. Muscle weekness_____
15. Sinus problems/stuffy nose_____
16. Runny nose/post nasal drip_____
17. Nose bleeds_____
18. Spitting up blood_____
19. Shortness of breath_____
20. Cough, congestion, sneezing_____
21. Dizziness_____
22. Swelling of the hands/feet_____
23. Chest pain_____
24. Pain in the arms/hands_____
25. Pain in legs/feet_____
26. Low back pain_____
27. Neck pain_____
28. Headaches_____
29. Palpitations_____
30. Night sweats/hot flashes_____
31. Loss of apetite/Thirst_____
32. Gain of apetite/Thirst_____
33. Difficulty with chewing/swallowing_____
34. Passing gas/belching/heartburn_____
35. Constipation/diarrhea_____
36. Nausea/Vomitting_____

37. Change in stool_____
38. Change in urine_____
39. Itching/burning/pain/leakage with urination_____
40. Itching/burning/pain vaginally_____
41. Pain with intercourse_____
42. Difficulty achieving an erection/orgasm_____
43. Loss of sex drive/libido_____
44. Discharge/lumps in your breasts_____
45. Dry/oily skin_____
46. Skin rashes/scaling_____
47. Itching_____
48. Heat/cold sensitivity_____
49. Hair loss/loss of sheen/dry_____
50. Nails brittle/peeling_____
51. Swelling/lumps/bumps_____

OTHER HISTORY

Any fears (ex. Height, small spaces, spiders, thunder)_____

_____

How do you handle anger?_____

Do you cry?_____When?_____

Do you like parties?_____Solitary activity?_____

Do you like consolation?_____Performing?_____

Favorite weather_____

Do you prefer indoors/outdoors?_____Mountains/ocean?_____

Have you ever been raped or molested?_____

Have you ever been diagnosed with a sexually transmitted disease and if so what?_____

_____

Have you ever been told you have a fibroid, endometriosis, cysts?_____

What is your usual height and weight and what is it now?_____

What is your blood pressure?_____Any problems with anemia?_____

Any problems with your thyroid or any other glands or hormones?_____

_____

Any recent blood work/tests you have had particularly in the last two years-please bring copies_____

_____

WOMEN'S HEALTH

Last menses_____Number of days between periods_____Mod, light, or heavy_____

Number of days menses lasts_____Color of blood through cycle_____

Number of pregnancies_____Number of births_____Abortions_____Miscarriages_____

Stillbirths_____Problems getting pregnant_____

_____

Experience of labor and delivery_____

Did you nurse or bottle feed/how was this for you?_____

_____

Cramps (what days of cycle, intensity, what makes it better/worse)_____

_____

Moodiness associated with menses(what part of cycle, intensity, anger or tears, what makes it better/worse)_____

_____

_____

Other symptoms associated with menses (what part of cycle, intensity, what makes it better/worse) ex. Headaches, bloating, fluid retention, fatigue, constipation, diarrhea, heaviness in pelvis/legs_____

_____

_____

Changes in your menses since first menses (give age____)-what has changed give length of time since the change and anything that you feel has caused this change_____

_____

_____

Are you aware when you ovulate?_____Symptoms?_____

FAMILY HISTORY

Please list all significant medical history for the following individuals (if deceased list age and cause of death). Also, include your emotional relationship with these persons if significant:

Father_____

_____

Mother_____

_____

Paternal grandmother_____

_____

Paternal grandfather_____

_____

Maternal grandmother_____

_____

Maternal grandfather_____

_____

Sisters_____

_____

Brothers_____

_____

Spouse/Partner_____

_____

Children_____

_____

Other significant people in your life_____

_____

Please describe yourself briefly so I can picture you (such as your temperament, hobbies, interests, how you like to dress, where you like to go, any nicknames, what you do for fun, what you do just for yourself???_____

PLEASE FEEL FREE TO ADD ANY OTHER INFORMATION YOU FEEL MIGHT BE HELPFUL, OR THAT HAVE BEEN MISSED_____