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Pediatric New Patient Health Questionnaire

Thank you for taking the time to fill out this new patient health questionnaire. This questionnaire is an important part of your child's initial consultation. Accurate completion of this form will ensure more effective use of your scheduled appointment. These questions will help to identify underlying causes of illness and will assist your doctor in formulating the most appropriate treatment plan. For new patient sick visits, please make sure to complete at least the first 6 pages before the appointment.

Personal Information
Patient's Name:_____ **Date of Birth:**_____ **Male** ◯ **Female** ◯
Form Completed by (include relation to patient):
Name/Address of Primary Care Physician:
Name/Address of Additional Therapists/Specialists Working With Your Child (if any):
Name/Address of Additional Therapists/Specialists Working With Your Child (if any):
Name/Address of Additional Therapists/Specialists Working With Your Child (if any):

Please check appropriate box(es):

☐ African American	☐ Hispanic	☐ Mediterranean	☐ Asian
☐ Native American	☐ Caucasian	☐ Northern European	☐ Other _____

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Diagnosis
Please describe your child's main medical diagnoses or problem(s) that you would like addressed today:
Dates of diagnosis and diagnosing practitioner (please include address and telephone number):
What factors or events, if any, do you believe may have triggered your child's problem/illness?
What are your goals of treatment for your child?
Please describe your child, in as much detail as possible (personality, likes and dislikes, temperament, etc.). Tell me their story (you may use the additional sheet at the end of this document if necessary)…

Current Symptoms or Health Concerns

- ☐ Abdominal Pain
- ☐ Allergies
- ☐ Attention Problems
- ☐ Behavioral Difficulties
- ☐ Constipation
- ☐ Developmental Delay
- ☐ Diarrhea
- ☐ Eczema
- ☐ Energy Problems
- ☐ Environmental Issues
- ☐ Frequent Infections
- ☐ Medications/Therapies
- ☐ Nutrition
- ☐ Obsessions/Compulsions
- ☐ Seizures
- ☐ Sensory Issues
- ☐ Sleep Issues
- ☐ Tics
- ☐ Vaccinations
- ☐ Other Neurologic Issues (please describe):

- ☐ Other (please describe):

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Current Therapies

Please describe your child's current therapies:

- ☐ Acupuncture
- ☐ Auditory training
- ☐ Chiropractic
- ☐ Craniosacral
- ☐ Energy therapy
- ☐ Homeopathy
- ☐ Lovaas- ABA
- ☐ Naturopathy
- ☐ Neural Therapy
- ☐ Occupational Therapy
- ☐ Osteopathy
- ☐ Physical Therapy
- ☐ Sensory Diet
- ☐ Speech Therapy
- ☐ Other (please describe):

Please list all therapies tried and stopped (use additional sheet at the end of this document if necessary):

Therapy tried	Reason Stopped

Past Medical History

Please list any other medical problems that your child has had :

- ☐ Colic
- ☐ Allergies
- ☐ Asthma
- ☐ Eczema
- ☐ Ear Infections
- ☐ Pneumonia/Bronchitis
- ☐ Throat Infections
- ☐ Recurrent colds
- ☐ Reflux
- ☐ Persistent Diaper Rashes
- ☐ Thrush
- ☐ Behavior problems
- ☐ Constipation
- ☐ Diarrhea
- ☐ Dental amalgam fillings
- ☐ Other (please describe):

Please list any medications or supplements that your child has taken in the past, including antibiotics and steroids, and dates of use:

Please list any hospitalizations, emergency room visits, or surgeries. Please give dates, locations, diagnoses, lengths of hospital stays, and surgeries:

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Medication/Supplement History			
Please list all current medications, vitamins, nutritional supplements, herbs, homeopathic remedies, etc. (use additional sheet at the end of this document if necessary):			
Supplement/Medication	**Dose**	**Frequency**	**How long?**

Please list all medications/supplements stopped secondary to not working or negative response. If there was a negative response, please describe. (use additional sheet at the end of this document if necessary):	
Supplement/Medication	**Reason Stopped**

Vaccine History
Please provide a copy of your child's immunization record. Please describe any reactions that your child has had to vaccinations:

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Birth History

Prenatal/Pregnancy History

Maternal age at delivery:

Fertility treatments? ☐ Yes ☐ No **(If yes, please list which ones):**

Illnesses during pregnancy:

Medications during pregnancy (including rhogam, antibiotics, vaccines, herbs, nutritional supplements, others):

Stressors during pregnancy:

Dental amalgams before or during pregnancy? ☐ Yes ☐ No

Other complications during pregnancy:

Birth History

Mode of delivery: ☐ Vaginal delivery ☐ C-section **(If c-section, please explain why):**

If vaginal, was labor induced or augmented with any pitocin or other medications: ☐ Yes ☐ No
(If yes, which medication?):

Forceps or vacuum used? ☐ Yes ☐ No

Gestation: ☐ Premature ☐ Full-term

Birth weight: **Apgar scores (if known):**

Please describe any other complications after delivery:

Postpartum History

Did your child have jaundice? ☐ Yes ☐ No **(If yes, describe what treatments were needed):**

Did you or your child receive antibiotics after delivery? ☐ Yes ☐ No **(If yes, why?):**

Did your child receive any vaccines after delivery? ☐ Yes ☐ No **(If yes, which ones):**

Did you or your child receive any other medications after delivery? ☐ Yes ☐ No **(If yes, why?):**

Did you suffer from postpartum blues/depression? ☐ Yes ☐ No
If yes, please describe any medication or treatments that you required:

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Developmental History
List the age when the following skills were mastered and any problems associated with them:
Has your child's development been normal? ☐ Yes ☐ No If no, please describe the developmental problem(s), and at what age the problem(s) began to appear:
First words (mama, dada, etc.):
Phrases or sentences:
Sitting unsupported:
Crawling:
Pulling to stand:
Walking unsupported:
Climbing:
Running:
Walking up/down stairs unassisted:
Jumping:
Hopping on one foot:
Pedaling a tricycle:
Riding 2-wheel bicycle:
Feeding self with spoon:
Put on clothing:
Potty-trained:

Allergies/Sensitivities				
Please list any medications or supplements that your child has had a reaction to. Describe the reaction:				
Please list any other sensitivities that you child has, or that you suspect your child may have:				
☐ Perfumes/cosmetics	☐ Cleaning products	☐ Soaps	☐ Detergents	☐ Gasoline
☐ Dust	☐ Mold	☐ Pollens/Grasses	☐ Animals (dander)	☐ Chemicals☐
☐ Other (please describe):		☐ Foods, which ones?		

Sleep History
Please describe the pattern and quality of your child's sleep? (i.e., does your child sleep soundly, or toss and turn, have nightmares? Does your child wake up refreshed?)
What time does your child typically fall asleep at night? **What time does your child typically wake up?** **How many hours of sleep does your child get every day?**
Does your child fall asleep easily? ☐ Yes ☐ No If no, please explain:
Does your child stay asleep through the night? ☐ Yes ☐ No If no, please explain:

Environmental History
Water: ☐ City ☐ Well Purification system? ☐ Yes ☐ No If yes, please describe:
Type of Heat: ☐ Electric ☐ Gas ☐ Oil ☐ Other If other, please describe:
Live near: ☐ Power lines ☐ Woods ☐ Industrial Areas ☐ Water
If you live near water, list type: ☐ River ☐ Ocean ☐ Swamp ☐ Other If other, please describe:
Child's bedding: ☐ Down ☐ Synthetic Mattress/pillow cover? ☐ Yes ☐ No
Flooring: ☐ Carpet ☐ Area rug ☐ Wood ☐ Other If other, please describe:
Does your home have a lot of: ☐ Dust ☐ Mold
Is your child exposed to cigarette smoke? ☐ Yes ☐ No
Travel history:
Please list any other exposures your child may have had in the past and present:

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Digestive History

How often does your child have a bowel movement?

What is your child's stool like (check all that apply)?

- ☐ Well-formed
- ☐ Mucousy
- ☐ Loose, falls apart
- ☐ Watery
- ☐ Small, hard pieces
- ☐ Greasy, floats
- ☐ Bloody
- ☐ Thin and long, ribbons
- ☐ Foul-smelling
- ☐ Painful
- ☐ Lots of undigested food particles
- ☐ Other (please describe):

Does your child have heartburn or reflux? ☐ Yes ☐ No **(If yes, please list any treatments):**

Does your child have frequent gas or belly bloating? ☐ Yes ☐ No **(If yes, please describe):**

Does your child have any abdominal pain? ☐ Yes ☐ No **(If yes, please describe):**

Diet History

Was your child breastfed? ☐ Yes ☐ No **If yes, for how long?** _____

Was your child bottle-fed? ☐ Yes ☐ No **Brand of formula?** _____

Begun at what age? _____ **For how long?** _____

At what age were solids introduced? _____ **First foods:**

Do you have any concerns about your child's current diet? ☐ Yes ☐ No
If yes, what concerns?

Please describe your child's current diet:

☐ No restrictions ☐ Gluten Free ☐ Casein Free ☐ Yeast Free
☐ Salicylate Free ☐ Low Phenolics ☐ Organic ☐ High Protein/Low Carb
☐ IgG Reactive Foods Avoidance ☐ Specific Carbohydrate Diet
☐ Other (please describe):

Please describe your child's typical breakfast:

Please describe your child's typical lunch:

Please describe your child's typical dinner:

Please describe your child's typical snacks:

What does your child drink throughout the day?

Does your child eat refined sugar? ☐ Yes ☐ No (If yes, what kind and how often):

Does your child eat fast food? ☐ Yes ☐ No (If yes, what kind and how often):

Does your child eat food with artificial colors/flavorings or preservations? ☐ Yes ☐ No (If yes, how often):

Does your child eat artificial sweeteners? ☐ Yes ☐ No (If yes, what kind and how often):

Does your child drink soda? ☐ Yes ☐ No (If yes, what kind and how often):

Please list all diets tried and stopped (use additional sheet at the end of this document if necessary):	
Diet tried	**Reason Stopped**

School History
School Name:
Address:
Grade:
Teacher:
Phone: **Fax:**
Does your child have an Individualized Education Plan (IEP)? ☐ Yes ☐ No
Does your child receive any special services at school? ☐ Yes ☐ No If yes, please list:
Do you have any concerns regarding your child's school progress (academics, social, teacher, peer relationships)? ☐ Yes ☐ No If yes, please describe:

Social History
Who lives in the home with your child?
Please list any pets in the house:
Please list any caregivers beside parents:
Please describe family relationships:
Please describe any recent stressful events (life changes, losses, births, deaths, divorce, remarriage, moves, illness, financial problems, arguments with family/friend, etc.):
How does your child interact with other children?
How does your child interact with adults?
What makes your child: **Happy?** **Sad?** **Angry?** **Stressed?**

Please send copies of any evaluations, consultations, laboratory tests, vaccinations, and any other information you feel is important for us to review.

Please use this space to describe anything else you would like us to know about your child. List any other history, pertinent thoughts, or question that you would like to address: