

PEDIATRIC HEALTH HISTORY QUESTIONNAIRE

New Harmony Center for Health & Wellness
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Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your child's condition, but they may play a major role in diagnosis and treatment. Please bring this questionnaire and any recent medical tests to your Initial Evaluation.

All information is strictly confidential.

I. General Patient Information

Today's Date: ___/___/___ Name of Child: _____

Age: _____ Date of Birth: ___/___/___ Place of Birth: _____

Gender: M F Height: _____' _____" Weight: _____ lbs.

Child's Address: _____

City, State, Zip Code: _____

Guardian's Home Phone: _____ Guardian's Cell Phone: _____

Guardian's Email: _____ Yes, it is ok to *occasionally* email me with clinic updates, etc. My information will remain private.

Are you the child's primary care giver (please circle)? Yes No

Name of Parent/Guardian(s): _____

Please indicate your relationship to the child: _____

Guardian's address if different from child's: _____

City, State, Zip, Code: _____

How did you hear about our office? _____

Health Care Providers your child regularly sees (primary care, chiropractors, therapists, bodywork practitioners, etc.)

Please list names, addresses, & phone numbers.

Do any of the above practitioners have a holistic approach to medicine (please check one)? Yes No

If yes, which practitioners: _____

Major Complaint(s), in order of significance:

	Severe	Moderate	Slight	Normal
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How do these conditions impair your child's daily activities? _____

II. Medical History

Please list your child's hospitalizations, surgeries, traumas, or major illnesses:

1. _____ Date of onset: _____
2. _____ Date of onset: _____
3. _____ Date of onset: _____

Please indicate which of the following immunizations your child has received:

<input type="checkbox"/> Polio date: _____	<input type="checkbox"/> Varicella date: _____
<input type="checkbox"/> Hep B date: _____	<input type="checkbox"/> Hib date: _____
<input type="checkbox"/> MMR date: _____	<input type="checkbox"/> Hep A date: _____
<input type="checkbox"/> DTP date: _____	<input type="checkbox"/> Other date: _____

Please describe any complications or reactions to the immunizations: _____

Has your child traveled outside the U.S. If so, where? _____

Please list any allergies or sensitivities your child may have (e.g. to medications, food, scents):

Please list any medications or supplements (e.g. vitamins, herbs) your child is **currently taking**:

1. _____ Date started: _____ Dose: _____
2. _____ Date started: _____ Dose: _____
3. _____ Date started: _____ Dose: _____
4. _____ Date started: _____ Dose: _____

Please list any medications or supplements your child has taken in the past:

1. _____ Dose: _____ Start: _____ Finish: _____
2. _____ Dose: _____ Start: _____ Finish: _____
3. _____ Dose: _____ Start: _____ Finish: _____
4. _____ Dose: _____ Start: _____ Finish: _____

On average, how many times a year is the child on antibiotics? _____

III. Family History

Please indicate whether the following health conditions pertain to anyone in the child’s family:

Condition	Relative	Age of Onset	Details
Heart or blood problems			
Lung problems (e.g. asthma)			
Nervous system problems (e.g. seizures)			
Digestion problems (e.g. Celiac disease)			
Allergies (moderate/severe)			
Skin Problems			
Cancer			
Concerns about weight			
Mental illness (e.g. depression)			
Learning difficulties			
Difficulties with drugs and/or alcohol			
Other			
Other			
Other			

IV. Prenatal History

Health of parents at conception (check one): Poor Good/average Excellent

Mother's age at time of child's birth: _____

Were there any fertility issues? Yes No Please describe: _____

Were there any complications during the pregnancy (e.g. nausea and vomiting, high blood pressure, gestational diabetes)? _____

What medications (including supplements, herbs, recreational drugs or alcohol) did the mother take during her pregnancy?

1. _____ Dose: _____ Reason: _____

2. _____ Dose: _____ Reason: _____

3. _____ Dose: _____ Reason: _____

4. _____ Dose: _____ Reason: _____

Did the mother experience any illness, traumas, or hospitalizations during her pregnancy?

1. _____ Date of onset: _____

2. _____ Date of onset: _____

3. _____ Date of onset: _____

V. Birth/Post Natal History

Your baby's delivery was: Vaginal C-section Induced Early Late

Your baby was delivered at: Home Hospital Other _____

Were there any complications during labor and/or delivery? Please describe: _____

Please indicate your child's weight at birth: _____ Length: _____

Where is this child in the birth order? Only First Middle Last

How many siblings does your child have? _____

Breastfeeding History

How long was your child breastfed? _____

Did any complications occur during this time? _____

At what age were solid foods introduced? _____

Did any complications occur with the introduction of solid foods? _____

Developmental History

At what age did your child experience the following milestones?

Lift his/her head alone _____ Develop his/her first tooth _____

Roll over _____ Walk (with hand held) _____

Crawl _____ Speak his/her first word _____

Please describe any concerns you have about your child's development: _____

VI. Lifestyle

Home Environment

Does anyone in the child's home or place of regular attendance smoke? _____

Is there any alcohol or drug use in the child's home? _____

What (if any) pets reside in the home? _____

Diet

How would you describe your child's diet and appetite (check all that apply):

- Good appetite
- Very picky eater
- Specific preferences and dislikes
- Poor eater
- Eats a variety of foods
- Only eats sweets

Other comments: _____

Please describe a typical day's diet for your child:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Sleep

How many hours does your child sleep each night? _____

Does your child sleep with parent(s)? Yes No _____

Does he/she have difficulty falling asleep? Yes No _____

How many times does he/she wake up in the middle of the night? _____

How often does he/she experience nightmares? _____

How often does he/she experience night urination? _____

Activities

Please give a brief description of your child's daily routine (e.g. attend daycare, public school, sports, etc.):

VII. Emotional Health

Describe your child's behavior and personality: _____

Describe your child's moods (check all that apply): Emotionally stable Moody Irritable

Pronounced mood changes (explain): _____

Temper tantrums (please check one): Yes No Management: _____

Other discipline (reasons, methods): _____

Any known fear's your child has: _____

Your child's stress level (please check one): Low Medium High

Has your child suffered any emotional trauma (e.g. divorce, death, moving homes)?

Emotional climate in child's home: _____

Do you feel that your home is a safe place for your child? _____

VIII. Review of Systems

Please check any that apply to child, add any additions, and provide extra details if necessary:

General: Fever Illness Hospitalizations Injury Frequent colds

Head: Headaches Swelling Rash Hair loss

Eyes: Red Inflammation Tears Lazy eye

Ears: Inflammation Discharge Acuity Infections Hearing loss/sensitivity

Nose: Allergies Breathing difficulties Mucus Bleeding Picking Sinus infection

Mouth: Cavities Swelling gums Cold sores Rash Excessive thirst

Skin: Rash Dryness Eczema Bumpy Skin Cradle cap Moles/birthmarks Scars
 Itching Flushed cheeks Sweating issues

Neck/Throat: Swollen Lymph nodes Stiffness Sore throat

Respiration: Cough Wheezing Asthma Recurrent Infections Pneumonia

Cardiovascular: Paleness Heart Murmur Shortness of breath Palpitations

Gastrointestinal: Stomach aches Diarrhea Constipation Vomiting Gas Belching
 Bloating Loose stools Anal itching

Genitourinary: Painful urination Inflammation Rash

Musculoskeletal: Muscle pain/cramps Stiffness Loss of strength Fractures

Neurological: Seizures Loss of sensation Tremors Anxiety Fatigue
 Coordination problems Blank or staring spells

Please list any other concerns or conditions not already covered on this form: _____
