Pediatric Health Summary

|  |  |  |
| --- | --- | --- |
| Childs Name:  | Date:  | Date of birth |
| Parent Home ph: | May I call you at this number? Is it OK to leave a message? | Age |
|  |
| Parent Work ph: | May I call you at this #? Is it OK to leave a message? |  |
|  |
| Parent Cell ph: | May I call you at this number?Is it OK to leave a message? |  |
|  |
| Parent e-mail: | May I contact you via e-mail? |  |
|  |
| Address |
| City, State, Zip |
|  |
| Marital status of parents-- |
| Who may we thank for referring to our office? |

**Prenatal History**

|  |
| --- |
| Mom’s health during pregnancy-- |
| Injuries to mom during pregnancy-- |
| Medication taken by mom during pregnancy-- |
| Alcohol or drug use during pregnancy? |

**Birth History—**Check any that apply (x)

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Vaginal delivery** |  | c-section |
|  | Full term |  | Premature—how many weeks? |
|  | Instruments used at birth |  | Injuries at birth |
|  | List any complications at birth |
|  | List any illnesses at birth |
|  | List any medications received at birth |

**Post-Natal History—**Check any that apply (x)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Refusal to nurse** |  | Irritability during feeding |  | Frequent vomiting |
|  | Difficulty suckling |  | Crying during feeding |  | Head banging |
|  | Difficulty swallowing |  | Drowsy during feeding |  | Tendency to sleep on one side |
|  | Breast fed |
|  | Other problems: |

**Developmental History**

|  |
| --- |
| Please list any history of developmental delay— |

**Past Medical History**

Put an **“X”** by things your child has had in the past. ***Write in the year*** the condition started.

Put a **“C”** for things your child is currently experiencing.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | AIDS |  | Congestive Heart Failure |  | HIV positive |  | Psychiatric care |
|  | Alcoholism |  | Depression |  | Joint replacement |  | Rheumatic Fever |
|  | Anemia |  | Diabetes |  | Kidney Disease |  | Rheumatoid arthritis |
|  | Anorexia |  | Drug Dependent |  | Liver Disease |  | Scarlet fever |
|  | Anxiety |  | Emphysema |  | Measles |  | Sexually transmitted disease |
|  | Appendicitis |  | Epilepsy |  | Migraines |  | Stroke |
|  | Arthritis |  | Glaucoma |  | Miscarriage |  | Suicide attempt |
|  | Asthma |  | Gonorrhea |  | Mononucleosis |  | Suicide thoughts |
|  | Bleeding Disorders |  | Gout |  | Multiple Sclerosis |  | Thyroid problems |
|  | Blood in urine |  | High blood pressure |  | Mumps |  | Tonsillitis |
|  | Breast Lump |  | Heart murmur |  | Panic Attacks |  | Tuberculosis |
|  | Bronchitis |  | Hepatitis |  | Pacemaker |  | Ulcers |
|  | Bulemia |  | Hernia |  | Pneumonia |  | Unconsciousness |
|  | Cancer |  | Herpes |  | Polio |  | Vaginal Infections |
|  | Cataracts |  | Hiatal Hernia |  |  |  | Other: |
|  | Coma |  | High Cholesterol |  |  |  |  |

**Past Surgeries/Procedures (Include Dental—ex. Root canal, teeth pulled)**

|  |  |
| --- | --- |
| Surgery | Date |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Trauma History—**Check (**X**) any box which apply and explain circumstances and when occurred.

|  |  |
| --- | --- |
|  | Motor vehicle accident—if so, when |
|  | Fall—if so, when, how high and injuries? |
|  | Other trauma/injuries: |

**Social History—**Check (**X**) any box that applies

|  |  |
| --- | --- |
|  | Alcohol— # drinks/day or week  |
|  | Cigarette-- # packs/day or week  |
|  | Recreational drug use |

**Exercise—**Check (**X**) any box that applies

|  |  |
| --- | --- |
|  | What does your child do for exercise?  |
|  | How often does your child exercise? # days/week |
|  | How long does your child exercise? # Minutes/day |

**Medications/Herbals/Supplements—**dose and frequency, when started

|  |  |
| --- | --- |
| Medication/Herbal/Supplements | **Start** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Allergies**—List any medications, foods, environmental allergies and the reaction.

|  |
| --- |
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|  |

**Family History—**If any blood relative has suffered from any of the following, please check (**X**) and ***indicate the relative***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Allergies |  | Cancer---what type |  | Heart disease |
|  | Asthma |  | Diabetes |  | High blood pressure |
|  | Anemia |  | Epilepsy/Seizure |  | Kidney/bladder problems |
|  | Arthritis |  | Glaucoma |  | Mental Illness |
|  | Alcoholism |  | Gout |  | Stroke |
|  | Blood Clotting Problems |  | Headaches/migraines |  | Other: |

**Consultants--**Please list other practitioners you see—other physicians, chiropractors, acupuncturist etc and phone #

|  |
| --- |
|  |
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|  |

**Review of Systems:**

Put an **“X”** by things your child has had in the past. Write in the year condition started.

Put a **“C”** for things your child is currently experiencing.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **General** |  | **Cardiac/vascular** |  | **GU** |  | **Skin/breast** |
|  | Fever |  | Chest pain  |  | Bladder control |  | Eczema |
|  | Chills |  | Chest pressure |  | Blood in urine |  | Hives |
|  | Night Sweats |  | Fainting |  | Decrease force or urine |  | Itching |
|  | Weight Loss |  | Heart murmur |  | Painful intercourse |  | Rashes |
|  | Fatigue |  | High blood pressure |  | Painful urination |  | Yellow skin/eyes |
|  | Loss of energy |  | Irregular heart beat |  | Pelvic pain |  | Breast lumps |
|  | Loss of sleep |  | Leg pain when walk |  | Sexual dysfunction |  | Nipple discharge |
|  | **Eye** |  | Lightheaded |  | Urinary hesitancy |  | **Endocrine** |
|  | Blurred vision |  | Low blood pressure |  | bedwetting |  | Excessive weight gain |
|  | Double vision |  | Pass out |  | **Neurology** |  | Excessive weight loss |
|  | Crossed-lazy eye(s) |  | Palpitations |  | Cold or numb hands/feet |  | Heat intolerance |
|  | Eye pain |  | Phlebitis |  | Convulsions (seizures) |  | Cold intolerance |
|  | Loss of vision |  | Poor circulation |  | Frequent headaches |  | Hair falling out |
|  | Visual Flashes |  | Shortness of breath |  | Muscle weakness |  | Excessive thirst |
|  | Visual Halos |  |  At rest |  | Numbness/tingling |  | **Heme/lymph** |
|  | Had laser surgeries |  |  With exertion |  | Tremors |  | Easy bruising |
|  | Wear glasses or contacts |  |  Lying flat |  | Unsteady walking |  | Bleeding gums |
|  | **Ear, Nose, Throat** |  | Swollen ankles |  | Vertigo/spinning |  | Lymph nodes |
|  | Decreased hearing |  | Varicose Veins |  | **Psychosocial** |  | **Allergies/Immun** |
|  | Earache |  | **Pulmonary** |  | Anxiety |  | Seasonal allergies |
|  | Ear discharge |  | Cough |  | Depression |  | Other allergies |
|  | Ear fullness |  | Wheezing |  | Nervousness |  | **Diet--# servings/day** |
|  | Ear infections |  | **Gastrointestinal** |  | **Behavior** |  | Water |
|  | Ear ringing-buzzing |  | Abdominal pain |  | Lack of emotional control |  | Coffee |
|  | Hoarseness (prolonged) |  | Black stools |  | Irritable |  | Tea |
|  | Jaw Clicking |  | Bloating |  | Hyperactive |  | Soda |
|  | Jaw locking |  | Blood in stools |  | Easily distracted |  | Meats |
|  | Nosebleeds |  | Constipation |  | Poor attention span |  | Chicken |
|  | Post nasal drip |  | Diarrhea |  | Impulsive |  | Fish |
|  | Sinus problems |  | Heartburn |  |  |  | Breads/cereal |
|  | Sore throat (frequent) |  | Hemorrhoids |  |  |  | Dairy products |
|  | Swallowing difficulty |  | Nausea |  |  |  | Fruits |
|  |  |  | Vomiting |  |  |  | Fruit juice |
|  |  |  |  |  |  |  | Vegetables |

**History of Present Illness**:

Please describe each of your child’s problems in detail. If you have more than one problem, number each problem and answer each question separately for each issue. You may use a second sheet of paper if necessary.

**What** all of your symptoms are—

**When** symptoms began--

What makes it **better** (ex.medication, supplements, physical modalities, rest, exercise, ice/heat, position, foods)

What makes it **worse** (ex. Medication, supplements, physical modalities, rest, exercise, ice/heat, position, foods).

**How often** do you have your symptoms? (ex. Daily, weekly, monthly)

**How long** do your symptoms last when you get them? (ex. Seconds, minutes, hours)

All health care providers seen for this problem, the **diagnosis** they gave you, tests or x-rays done (results if known), and treatment given--

Please answer “yes” or “no” to the following questions:

**Do you have a juicer?**

**Do you have a blender, vitamix or blendtec? (circle one)**

**Do you have a food dehydrator?**

**Do you have a food processor?**

**List what your child typically has for breakfast, lunch, dinner and snacks.** Include times when foods are eaten.

Be specific—if your child has a sandwich, write down type of bread, meat, etc. If your child has cereal, what kind. What kind of milk does your child drink (skim, whole, raw, pasteurized, almond milk etc). What do you put in your child’s salads? What do you put on your child’s veggies (ex. Butter, oil)? If you eat pizza, what is on the pizza?