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.

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 #

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?