PEDIATRIC FORM

To be used for children 12 years of age or under, and in conjunction with all other forms.

Child's Name:_____Date:_____

Age:_____Date of Birth:_____Sex: F____ M_____

SYMPTOMS: (mark C for current and P for past symptoms)

___Abdominal pain	___Excessive fatigue	____Nightmares
___Acid reflux	___Excessive perspiration	____Night sweats
___Anemia	___Flat feet	____No appetite
___Bad breath	___Frequent headaches	____Nosebleeds
___Bed wetting	___Gas	____Painful urination
___Bleeding gums	___Hearing loss	____Parasites
___Blood in urine	___Heart murmur	____Psoriasis
___Body odour	___High fevers	____Rash
___Bruise easily	___Hives	____Sensitive to light
___Canker sores	___Hyperactivity	____Sleep problems
___Changes in appetite	___Itchy anus	____Stomach aches
___Congestion	___Itchy nose (or picks nose)	____Sore throat
___Constipation	___Itchy vagina	____Teeth grinding
___Cough	___Jaundice	____Talks in sleep
___Cries easily	___Joint pains	____Walks in sleep
___Diarrhea	___Migraines	____Weight gain
___Dizzy spells	___Motion sickness	____Weight loss
___Dry skin	___Nervousness	____Wheezing
___Eczema		____Vomiting spells

For Office Use Only:

MEDICAL HISTORY: (check all that apply)

ADD/ADHD	Dental problems	Neural Tube Defect
Allergies(environmental)	Developmental problems	Pneumonia
Allergies (food)	Ear infections	Rubella
Asthma	Frequent colds	Rheumatic Fever
Autism	Impaired speech	Scarlet Fever
Bronchitis	Measles	Tonsilitis
Chicken Pox	Meningitis	Whooping cough

Croup	Mumps	Other (specify)

Nutritional Supplements (please list). Include herbal and homeopathic as well.

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MEDICATIONS. (check all that apply, and indicate the length of time the child received each medication.

Antacids	Declectin	Methylphenidate (Ritalin)
Antibiotics	Decongestant	Oral Steroids
Antidepressants	Dextroamphetamine (Dexedrine, Dextrostat, Adderall)	Pemoline (Cyclert)
Anti-Histamine	Epilepsy medication	Tylenol
Aspirin	Ibuprofen	Others (please list)
Clonidine	Inhaled Steroids	

Are you aware of any allergies to medications?

IMMUNIZATIONS: (check all that apply)

Diptheria	Influenza	IPV (Polio)
DPT	Measles	PNEU (Pneumoccocal disease)
Hemophilus	MENI (Menigococcal disease)	Small pox
Hepatitis	MMR (Measles, Mumps, Rubella)	Tetanus
Hib (Hemophilus Influenza)	Mumps	VAR (Varicella or chicken pox)

Were there any reactions to immunization(s) If so, at what age?

MOTHER'S HEALTH DURING PREGNANCY: (check all that apply)

Alcohol, Cigarettes, Drug Consumption	Gesational Diabetes	Stress
Anemia	Hypertension	Thyroid problems
Bleeding	Nausea	Uterine infection
Dental problems	Physical or Emotional Trauma	Other (specify):
Diabetes	Pre-eclampsia	

MEDICATIONS WHILE PREGNANT:

MEDICATIONS WHILE NURSING (Mother):

TERM:

Full_____Premature_____Late_____
Weight at birth_____lb

LABOR & DELIVERY:
Was pregnancy induced?_____
Vaginal_____ C-Section_____ Complications during labor?_____
Medications during or after labor?_____

FEEDING:
Breast fed_____ Bottle fed_____
When was formula started?_____
When were solid foods first introduced?_____
What were the first foods introduced?_____
_____

Did your baby have any of the following problems?
_____Jaundice
_____"Blue Baby"
_____Colic
_____Diarrhea
_____Thrush

For Office Use Only:

Health Goals

1. What do you hope to achieve for your child's visit with us?

_____
_____

2. When was the last time the child felt well?_____
_____
3. Did something trigger the child's change in health?_____
_____
4. What makes the child better?_____
_____
5. What makes the child feel worse?_____
_____
6. How does the condition affect the child and the family?_____
_____
7. What do you think is happening and why?_____
_____
8. What do you feel needs to happen for your child to get better? If you have a magic wand what are the three things you would like to change or erase?

_____
_____
_____

History

Present or Current Illness/Symptoms/Diagnosis

Describe the current child's problem/complaint/illness/symptoms here including start or date of onset of symptoms, duration, interventions/medications/remedies, outcome/ result and diagnostic/lab test done.

_____
_____
_____
_____
_____
_____

Past Medical History

Enumerate the past illness/condition or diagnosis that the child has and indicate the year or age it was established in chronological order.

1.
2.
3.
4.
5.

Birth History
Was the mother exposed to chemical or toxins during pregnancy?

Nutrition
How long was the breastfeeding?Bottle feeding?or Mixed feeding given?
