Date: ____________

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Pediatric Confidential Health Information

Patient's Name:______________________ Birth Date:____________ Age:________
Sex/gender identity

Parent's Names: ______________________________________
Other Caregiver's Name and Relation to Patient: ______________________

How did you hear about us? ______________________________

Tell Me About Your Child

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires.

What concerns bring you to our clinic? ______________________________

Please list your child's strengths: ______________________________

Diagnoses or explanations given to you about your child: ____________________

Being as descriptive as possible, please describe your child to me (attach a sheet if necessary)______

When did you first notice your child's problems?______________________

What did you first notice? ______________________________

Was the onset of your child's problem sudden or gradual?____________________

Was there any event or action that you or others think that might have contributed to your child's symptoms (be as detailed as possible)?______________________

Current Living Situation

Who is the child presently living with (i.e. Natural Mother, Stepfather): ______________________________

____

How many people currently live in the household? ______________________________

Is this child adopted? Yes No If yes, please briefly describe the age of the child when adopted and the circumstances of the adoption: ______________________________

____

Parents

How long have the child's parents been: Married: ______________ Separated: ______________

Divorced: __________ Living together: ___________

If the parents are separated or divorced, please describe custody (physical and legal), visitation rights, and medical decision making authority: ______________________________

____

If married, describe current relationship (i.e. supportive, conflictual, etc.) ____________________

____

Please list any previous marriages: ______________________________

____

Are there currently any significant marital stressors? Yes/ No If yes, please explain briefly:

____

____

Biologic Mother

Name: ______________________________________ Age: ______________

Highest grade completed: _________ Occupation: ______________________________

Do any medical illnesses run in the biologic mother's family (i.e. thyroid, diabetes, seizures, movement problems such as tics or other neurological problems, allergies, etc.?) ______________

____

____

Biologic Father

Name: ______________________________________ Age: ______________

Highest grade completed: _________ Occupation: ______________________________

Do any medical illnesses run in the biologic father's family (i.e. thyroid, diabetes, seizures, movement problems such as tics or other neurological problems, allergies, etc.?) ______________

____

____

Siblings

Name	Age	Blood or Step Sibling	In Home?
			Yes No
			Yes No
			Yes No
			Yes No

Have any of the siblings experienced psychological or emotional problems (suicide or suicide attempts, attention or learning difficulties, legal problems, alcohol or substance abuse, social difficulties, or medical problems?) If so, please state who and the nature of the problem:

Please list (current or past) significant areas of conflict in the home between this child and others. ______

Birth History

Mother's age at time of birth: ______Years Father's age at time of birth: ______Years

Were any drugs (over-the-counter, prescription and/or street) or alcohol used during pregnancy: Yes No If so, list the name of the drug and amount or frequency of alcohol use:

How many ultrasounds during pregnancy: ______

Was the child premature? Yes No Number of weeks late: ___ Number of weeks early: ____

Was the delivery unusual in any way? Yes No. If yes, please explain: ______

Did you have a caesarean? Yes No

Baby's birth weight: ______ Apgar Scores ______

Number of days infant was in the hospital after delivery? ______

Any dietary restrictions during pregnancy: Yes No If Yes, please explain: ______

Infancy Period

Child breastfed: Y N For how long: ______ When put on formula: ______

Did the mother have problems with depression after the birth? Yes No If yes, please briefly describe: ______

Check all that apply (birth to present**)**

Anemia
Asthma
Bad foot odor
Bed--Wetting
Chronic sniffles
Colic
Constipation

Cradle Cap
Defiant
Diarrhea
Eczema or psoriasis
Excessive Tantrums
Fears/Phobias
Finicky eating

Growing pains
Hyperactivity
Jaundice as a baby
Nightmares
Poor teeth
Stomach Aches

Developmental History

Motor development (sitting, crawling, walking):	Average	Early	Late
Speech and language:	Average	Early	Late
Bowel trained:	Average	Early	Late
Bladder trained:	Average	Early	Late
Started to read:	Average	Early	Late

Coordination

Handedness:	Left	Right	Both
Writing skills:	Good	Average	Poor
Athletic abilities:	Good	Average	Poor

Current Behaviors, Moods, Attitudes:

Do you have any concerns about this child's: (*If yes, please describe*)

Self esteem? Yes No ______________________________

Sexual knowledge or awareness? Yes No ______________________________

Gender identity? Yes No ______________________________

Sexual orientation? Yes No ______________________________

Please list the types of discipline you have tried with this child and its effectiveness?

____

____

____

Comprehension and Understanding:

Do you consider this child to understand directions and situations as well as other children his/her age? Yes No If No, please explain: ______________________________

____

____

If this child tells a story about a show, event, etc., do you or others have difficulty understanding him/her? Yes No.

If Yes, is it because he/she (check all that apply):

appears confused	has trouble finding the right words
leaves out important information	loses train of thought
is disorganized	other ________________________ ________________________

Does this child have trouble remembering things that he/she really cares about? Yes No

Does this child have difficulty following routines (bedtime, dressing, etc.)? Yes No

Does this child frequently lose things or have trouble being organized? Yes No

Free Time

Please describe how this child generally spends his/her free time (i.e. plays alone, plays with friends, plays sports, watches TV, plays video games, etc.): ________________________________

____

Please list the approximate number of hours per day that this child watches TV: _____________

Please list the approximate number of hours per day that this child plays video games: ________

School History

Did this child attend daycare or preschool? Yes No

If Yes, please estimate approximately how many hours per week:

Beginning with kindergarten, list school and indicate performance:

Grade	School	Academic Performance			Behavioral Performance		
		Good	Fair	Poor	Good	Fair	Poor
KG							
1st							
2nd							
3rd							
4th							
5th							
6th							
7th							
8th							
9th							
10th							
11th							
12th							

Are there any known learning disabilities? Yes No *If Yes, please list*:

Has this child been in any special programs (speech, reading, occupational therapy, etc.)?
Yes No. *If Yes, please explain and list grades*:

Has this child ever had to repeat a grade? Yes No *If Yes, please explain*:

Does this child enjoy school? Yes No
Is this child involved in extracurricular activities? Yes No If yes, please describe:

Peer Relationships

Does this child seek friendships with peers? Yes No
Is this child sought by peers for friendship? Yes No

Check any of the following which describes this child's interactions with peers:

- plays well in groups
- teased by other kids
- no problems
- cooperative
- supportive
- shares well
- plays primarily with younger
- plays primarily with older
- trouble making friends
- loses friends
- no friends
- few friends
- rejected by other kids
- easily led by others
- aggressive or mean
- frequent arguments
- bossy and controlling
- teasing jealous
- feelings get hurt easily
- involved in alcohol
- substance abuse
- involved in delinquent behavior

Child's Medical History

If this child's medical history includes any of the following, **please note the age** when the incident or illness occurred and any other pertinent information.

Hospitalizations:________________
Operations:________________
Failure to grow:________________
Pneumonia:________________
Asthma:________________
Allergies:________________
Skin problems:________________
Multiple ear infections: ________________
Tubes placed:________________
Seizures________________
Persistent high fevers:________________
Movement problems (tics, repetitive move-- ments, etc.)________________
brain/head injury:________________
Other physical trauma:________________

eye problems:________________
hearing problems:________________
anemia:________________
stomach problems:________________
constipation:________________
poisoning:________________
bronchitis:________________
mumps:________________
mono: ________________
thrush:________________
sinus infection: ________________
frequent colds:________________
strep throat:________________
other:________________

Has this child ever had a neurologic evaluation (exam, MRI, CAT Scan, EEG, etc.)? Yes No
If so, please describe:

Has this child's vision been tested? Yes No Normal? Yes No Date last tested
Has this child's hearing been tested? Yes No Normal? Yes No
Date last tested

Child's Present Nutrition Status____________

Height: Weight:
Describe this child's diet:

Have you tried any dietary modifications with your child, and what were the results?

Any known allergies to food? Yes / No. If yes, what foods and when was it tested?

Child's Present Medical Status

Primary Care Doctor: ______________________

May we contact him/her if needed? Yes No

List any present illness(es) for which this child is being treated:

What was the date of this child's last physical exam? ______________________

Was blood work done? Yes No

List all medications (from drugstore or prescription) child is on now and dosages if known:

1) ______________________ 4) ______________________
2) ______________________ 5) ______________________
3) ______________________ 6) ______________________

List all supplements child is on now and dosages if known:

1) ______________________ 4) ______________________
2) ______________________ 5) ______________________
3) ______________________ 6) ______________________

Any known allergies: drugs, environment, animals, etc: ______________________

How does this child sleep at night? ______________________

Previous Treatments

Has this child ever received any type of psychiatric, psychological, or academic evaluation or treatment? Yes No If so, fill in the following:

Person or Institution	Dates	Address	Telephone

Other

Is there anything else you want us to know or that you think would be helpful or important in your health care? ____

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