Spokane Naturopathic Healthcare

Pediatric Health History

Name ______________________________ Date of Birth _____________ Today's date _________

May we contact you at home? ______________ If not, how may we contact you? __________

PRESENT HEALTH CONCERNS

List health concerns in order of their significance.	Prior diagnosis of this problem?
1	
2	
3	
4	
5	

What goals do you have for your visit today? ____

____

____

List current prescription and over the counter medications, with dosages:________________

____

____

____

List vitamins, herbs, & homeopathic remedies that you are currently taking, with dosages:_

____

____

____

List any allergies to medications, environment and food.

SUBSTANCE SEVERITY/SYMPTOMS TREATMENT

____

____

____

Major hospitalizations, surgeries, injuries or broken bones. List procedures, any complications, and dates:

YEAR OPERATION, ILLNESS, INJURY OUTCOME

____

____

PRENATAL HISTORY

Mother's Pregnancy: ______ Normal ______Complications? ________________________

____

Gestation: ____________weeks Birth weight: ____________________________________

Delivery: ___ vaginal ___ C-section Complications? ______________________________

____

DIET HISTORY

Breast Fed? Y N How Long? __________ Formula Fed? Y N How Long? ________

Age Solid Foods Begun ______ What Foods? ______________________________________

Favorite Foods? ____

Sample Daily Diet: (choose a typical day and include food and liquids)

Breakfast

Lunch

Dinner

Snack

CHILDHOOD IMMUNIZATIONS

Up to Date? ___ Yes _____ Missing some ______ Not Vaccinated

Circle those which your child has received:

Hepatitis B HIB Pneumococcal DPT Rotavirus Polio

MMR Chicken Pox Flu Shot HPV Other ____________

DEVELOPMENTAL HISTORY

Is you child easy to care for? Y N Difficult to care for? Y N

Ease of Learning? _____ more quickly than others _____ average ______ more slowly

Age when you child first: could eat with a spoon ________ walked alone________

said 1st word________ toilet trained ________

Any problems with: _____Speech _____Hearing ______Vision

How would you describe you child's personality? ___________________________________

____

Any concerns about your child's development? ______________________________________

____

____

SOCIAL HISTORY

Who lives in the home?

____

Sibling(s): Name Age Health Problems

____

____

____

____

Daycare/Preschool/ School ____________________________ Where ______________________

How many hours each day ______________________ Days per week ____________________

Pets at Home ____

Check any that apply with a "C" for current symptom or a "P" for past symptom:

______Acne
______Allergies
______Anemia
______Asthma
______Bed Wetting
______Birth Defects
______Bleeding Problems
______Colic
______Constipation
______Cough/Wheeze
______Cradle/Cap
______Depression
______Diarrhea
______Dizzy Spells
______Ear Infections
______Eczema
______Epilepsy/Seizures
______Fatigue
______Frequent Infections
______Headaches
______Heart Problems
______High Fever
______Hyperactivity
______Insomnia
______Jaundice
______Learning Disorder
______Moodiness
______Pneumonia/Bronchitis
______Stuffy Nose
______Urinary Tract Infections
______Vomiting Spells
______Other ______________

Family History:
Identify family members who have, or have had any of the following: M, F, PGM, etc

______ Alcoholism/Addiction
______Allergies/Asthma
______Arthritis
______Autoimmune Disease
______Birth Defects
______Cancer
______Colitis/Crohn's
______Diabetes
______Eczema/Dermatitis
______Epilepsy
______Heart Disease
______Hepatitis
______High Blood Pressure
______Hypoglycemia
______Kidney Disease
______Mental Illness
______Migraines
______Obesity
______Osteoporosis
______Stroke
______Thyroid Disorder
______Other