Please fill out this form. It will speed up your visit and allow me to serve you better.
All answers are, of course, confidential. Today's Date_____
Child's Name _____ Home Phone #_____
Child's Address
_____
_____
Birthdate _____ Age _____
Parent _____
Occupation _____ Work Phone #
_____
Parent _____
Occupation _____ Work Phone #
_____
Child lives with (List all people in household)
_____
_____
Circle your marital status: Married Separated Single Remarried Divorced Widowed
Brothers or sisters?
Name_____ DOB_____ Sex_____
Name_____ DOB_____ Sex_____
Name_____ DOB_____ Sex_____
Name_____ DOB_____ Sex_____
(Please include siblings related through only one parent and specify which parent?)
Child's school (if applicable)_____

Has your child ever been hospitalized overnight? Yes No Don't Know
Has your child ever had surgery other than stitches for cuts? Yes No Don't Know
For what?
_____
Is your child allergic to any drugs? Yes No Don't Know
Specify drug and what happened
_____
Is your child allergic to anything else? Yes No Don't Know
What?
_____
Has your child ever had
Behavioral or family counseling Yes No Don't Know
Specify type of problem
_____
Special school evaluation or assistance Yes No Don't Know
Pneumonia Yes No Don't Know
Heart problems Yes No Don't Know
Chickenpox Yes No Don't Know
Any major illness Yes No Don't Know
A reaction to any immunization or medicines Yes No Don't Know
Urinary tract infection Yes No Don't Know
Significant injury Yes No Don't Know
Ongoing medical treatment for _____ Yes No Don't Know
Do you have worries about possible problems with your child's
Hearing Yes No Bowel habits Yes No

Pregnancy History (to be filled out by mother). Circle the correct response.
Were you on any medicine or drugs during the pregnancy? Yes No Don't Know
If so, what?
_____
Did you smoke cigarettes during the pregnancy? Yes No Don't Know
If so, how much?
_____
Did you drink alcohol during the pregnancy? Yes No Don't Know
If so, how much?
_____
Was the delivery a breech (bottom first)? Yes No Don't Know
Did you have any type of infection during the pregnancy? Yes No Don't Know
Type _____
How long was the pregnancy? ____ months What was the birth weight? _____
Did you have a C-Section? Yes No Don't Know
Did the baby go home with you from the hospital? Yes No Don't Know
Did the baby have any problems? Yes No Don't Know
Did you breast feed? Yes No Don't Know
If so, how long? _____

Eyes Yes No Development Yes No
Heart Yes No Progress in school Yes No
Frequent cough or stuffy nose Yes No Appetite Yes No
Nose bleeds Yes No Behavior Yes No
Urination (e.g. bedwetting, Yes No
goes too often, etc.)
Other concerns you would like to discuss? Yes No
Specify
_____
_____
Is your child on a special diet? Yes No
If so, what kind?
_____
If your child is old enough to attend school, how many days did he/she miss during last year? _____

Do you think your child is basically healthy? Yes No

During the past 5 months has your child

Had frequent nightmares Yes No Not Applicable

Been difficult to control Yes No Not Applicable

Been fighting a lot Yes No Not Applicable

Had trouble making friends Yes No Not Applicable

Had trouble at school Yes No Not Applicable