12160 SE Mt. Scott Blvd.
Happy Valley, OR. 97086
503.609-0890

Pediatric Patient Information

Child's Name _____
First MI Last

Address _____
City State Zip

Date of Birth: _____ Gender ☐ Female ☐ Male Age_____

School Grade_____ School Name_____

Mother's Name and Occupation: _____ Mother's E-mail_____

Mother's Phone: _____
Home Work Cell

Father's Name and Occupation: _____ Father's E-mail _____

Father's Phone: _____
Home Work Cell

Parent's are:
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Living Together
- ☐ Deceased - how old was child when parent died _____

Are parent's listed the Biological parents of the child?_____

Siblings (Names and Date of Birth) _____
_____

What's the best way to communicate with you between office visits (e-mail, home, work, cell)_____

Parent/Legal Guardian Address if different than child _____Mother ____Father

Address _____
City State Zip

Please list one person not living with you to contact in case of emergency:

_____
Name Relationship Phone Number

Address: _____
City State Zip

Who may I thank for referring you?_____

How did you hear of my practice?
- ☐ Friends
- ☐ Family
- ☐ Lecture
- ☐ Website
- ☐ Article or Newsletter
- ☐ Other: _____

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Pediatric Medical Questions

Name: _____**Age**_____**Birthdate**_____ **Date**_____

Child's present physical health_____
_____

Child's present emotional health/disposition_____
_____

Please list the top five health concerns of the child:
1._____
2._____
3. _____
4. _____
5. _____

Has the child been seen by any other health care professional for these issues? If yes please explain_____
_____

What lab work (blood, urine, parasite, other) has the child most recently done?_____

Please list any operations/hospitalizations and the year they took place_____
_____

Please list any ER visits _____

Has child taken Antibiotics in the past □ No □ Yes. If yes, why_____

List any physical trauma (broken bones, stitches, accidents) that have taken place and age of child at the time
_____
_____

Please list any emotional trauma, stress or life changes that the child has experienced
_____
_____

Please list all the medications the child is taking, either over the counter or prescription:
_____
_____

Please list any vitamins, herbs, homeopathics, anthroposophical remedies or supplements the child is currently taking:_____
_____

Are there any known medical allergies? (medications, latex, etc..)_____

With whom does the child live, please describe relationship? Please describe child's daily living arrangements:
_____
_____
_____

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Check if your child has had any of the following:

- ☐ Breath-holding spells
- ☐ Chicken pox
- ☐ Colic or esophageal reflux
- ☐ Dehydration
- ☐ Ear Infections ☐ many ☐ rarely ☐ none
- ☐ Encephalitis
- ☐ Head injuries
- ☐ Headaches
- ☐ Meningitis
- ☐ Passing out (syncope)
- ☐ Strep Infections
- ☐ Seizures ☐ with fever ☐ w/o fever

Family Medical History

Check if your child or family members (parents, siblings, grandparents, aunts, uncles) have had any of the following:

- ☐ Asthma/Wheezing
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Bruise easily
- ☐ Sensory Integration Dysfunction
- ☐ Constipation
- ☐ Colic
- ☐ Cancer
- ☐ Heart Disease
- ☐ Alcohol Addiction
- ☐ Mental Illness
- ☐ Seizures
- ☐ Eczema
- ☐ Psoriasis
- ☐ High Blood Pressure
- ☐ Alzheimers
- ☐ High cholesterol
- ☐ Frequent ear infections
- ☐ Heart murmur
- ☐ Frequent antibiotic use
- ☐ Heart attack at < age 50
- ☐ Frequent Steroid use
- ☐ High blood pressure
- ☐ Pneumonia
- ☐ Croup
- ☐ Tuberculosis
- ☐ High blood lead levels
- ☐ Arthritis
- ☐ Hay fever / allergies
- ☐ Thyroid problems
- ☐ Headaches
- ☐ Diabetes
- ☐ Head injuries
- ☐ Kidney / bladder problems
- ☐ Attention Deficit Disorder
- ☐ Sexually transmitted disease
- ☐ Learning problems
- ☐ Problems with bones
- ☐ Hyperactivity
- ☐ Problems with muscles
- ☐ Developmental delay
- ☐ Emotional disorders
- ☐ Autism
- ☐ Depression
- ☐ Hearing problems
- ☐ Bipolar disorder
- ☐ Dental problems
- ☐ Skin problems / eczema
- ☐ Alcohol / substance abuse
- ☐ Problems with digestion
- ☐ Suicide
- ☐ Gastric Reflux disease
- ☐ Other Illnesses:_____
- ☐ Cancer: Type:_____

Birth History

Lbs_____ Weeks_____
Health of baby at birth _____APGARS _____

Post Natal Complications
☐ None ☐ Jaundice ☐ Respiratory ☐ Cardiac ☐Infections ☐ Gastrointestinal ☐ Hospitalized -- How long? _____
☐ Cradle cap ☐ Eczema ☐ Colic ☐ Constipation ☐ Tight neck muscles (Torticollis) ☐ Flattening of the skull

Mother's age at delivery _____ Number of Pregnancies_____ Number of Live Births_____

Where is child in birth order (if other siblings)_____

Medications during Pregnancy ☐ None☐ Prenatal Vitamins ☐ Other - Please name_____

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Mother's Pregnancy

□ Uncomplicated □ Early Labor □ Nausea and Vomiting □ Bleeding □ Diabetes □ Thyroid Problems □ Pre-eclampsia
Please describe Mother's Pregnancy (planned, problems, high risk, stressful, emotions, concerns, expectations)

_____

_____

What type of delivery did the mother have? □ vaginal □ C-section □ forceps length of labor_____

Difficulties related to birth:_____

Was the child conceived □ Naturally □ Aid of In Vitro Reproduction Technology.What kind _____

Check all that the mother experienced during pregnancy: □ Cigarette smoking □ Lived with a smoker □ Drank Alcohol □ Recreational drugs □ Prescription Drugs □ Physical abuse □ Emotional abuse

Has child had regression of speech □ yes □ no Difficulty comforting □ yes □ no Difficulty nursing □ yes □ no

Was child breastfed _____ Until what age _____

When was child put on formula_____ What kind _____

When was the child put on solid food_____How did child do initially on solid food_____

Developmental History

How old was child when: Social Smile _____ Tracking _____ Rolled over_____Sat _____
Crawled_____ Walked _____ Talked _____ Toilet trained_____Slept through night_____

Does child bedwet? □ no □ yes (if yes, is there history of any bedwetters in family)_____

Home and Family

How much TV/computer time does the child spend each week?_____average daily hrs _____average weekend hrs

Does the child engage in physical exercise? □ no □ yes, (what kind) _____

Does the child participate in any after school activities_____

Child's special interests or talents_____

What are your child's gifts? (what comes easily to them)_____

What are your child's challenges (things that are difficult)_____

What does your child want to be when he/she is older?_____

Does child have any pets □ no □ yes If yes, what kind_____

Describe child's typical diet (favorite foods, snacks, meals)
Breakfast _____
Lunch _____
Snack _____
Dinner _____

How much water does child drink on daily basis _____
Does child drink soft drinks/soda, if yes, how much _____

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Vaccination History:

Please check if child had the vaccination or not, check some if child had vaccination but did not finish all the shots. List any reactions.

MMR □ Yes □ No □ Some Reaction_____
DTaP □ Yes □ No □ Some Reaction_____
Hep B □ Yes □ No □ Some Reaction_____
Hib □ Yes □ No □ Some Reaction_____
Polio □ Yes □ No □ Some Reaction_____
Chicken Pox □ Yes □ No □ Some Reaction_____
Pneumococcal □ Yes □ No □ Some Reaction_____
Influenze □ Yes □ No □ Some Reaction_____
Hepatitis A □ Yes □ No □ Some Reaction_____
Rotavirus □ Yes □ No □ Some Reaction_____
Meningococcal □ Yes □ No □ Some Reaction_____
HPV □ Yes □ No □ Some Reaction_____
Other _____ □ Some Reaction_____

Please list known allergies to food, drugs, environment or animals_____

Has the child ever lived:

- □ near a Refinery, high voltage power lines, or other highly polluted area
- □ in a house with lead based paint
- □ in a household that had mold in walls
- □ in a house with new paint, cabinets or carpet that seemed to affect child
- □ in a house with smokers

Are pesticides, herbicides or toxic cleaners used in the house where child lives? □ yes □ no

Behavior

Is there a history of □ biting □ hitting □ head banging □ aggressiveness □ odd fascinations □ bed wetting □ stuttering □ teeth grinding at night □ teeth grinding in day □ pulling own hair

How does child interact with other children_____

Child's bedtime _____ Time child awakens_____ Describe how child awakens (dreamy, cheery, crabby, etc.)_____

Sleep Pattern □ normal □ difficulty falling asleep □ frequent waking □ nightmares □ night terrors □other_____

Does your child snore while sleeping? □ no □yes
Does your child have pauses or stop breathing while sleeping? □ no □ yes
Describe any habits of child (thumbsucking, chewing/twisting hair, nail biting, etc)_____

Excessive fears of child or activities that make them anxious: □ water □ being alone □ dark □ night terrors □ thunder □ strangers Please describe_____

Does child have any sensitivity to □ sound □ touch □ smells □ lights □ other (please describe)_____

Abnormal movements □ none □ excessive turning □ hand flapping □ tics

Thank You for taking the time to fill out this form so that I may better know you and your child. I look forward to supporting your family.