

PEDIATRIC HEALTH ASSESSMENT/REGISTRATION FORM



NAME: _____

NICKNAME: _____

PARENTS: _____

OTHER GUARDIANS: _____

ADDRESS: _____

PHONE: day _____ eve _____

EMAIL: _____

EMERGENCY CONTACT: _____

DATE OF BIRTH: _____ AGE: _____

SOCIAL SECURITY #: _____

I have read the care agreement given to me with this packet and agree to the policies explained in that agreement. I request medical treatment and care from Family to Family for my child. I agree to pay in full at the time of service. I understand that non-standard therapies may be offered or recommended.

Guardian

Signature _____ (date)

MEDICAL HISTORY

Current Medical History

Describe your main health concern(s)/Reason for Visit

List any current illnesses (include age or date of onset)

List other Health Practitioners/Modalities you work with

Medication Allergies (include reaction)

Medications (list all and bring all on your first visits)

Supplements (list all and bring in bottles to your visit)

Past Medical History

Birth History: ___ vaginal ___ cesarean ___ VBAC

Complications: _____

Birth Story: _____

Birth Weight: _____ Group B Strep +: _____

Is/Was your child breastfed? _____ How long? _____

Antibiotics during labor or early infancy? _____

Previous Illnesses (with approximate date/ age)

Hospitalizations (with approximate date/age)

Operations (with approximate date/ age)

Accidents (include approximate date or age)

Reproductive History

Onset of Menses (age) _____ Sexually Active? _____

Preventive Medicine

Immunizations (PLEASE BRING IN VACCINE RECORD)

Routine Schedule ___ Delayed Schedule ___ Declined ___

Any Recent Tests or Bloodwork? _____

Where was it Performed? _____

FAMILY & SOCIAL HISTORY

List the people in your current household (name, relationship, current age):

Do you have any pets? List.

Parents: Single ___ Married ___ Separated ___ Divorced ___

Family Health History

Please list health problems of the following people:

Mother _____

Father _____

Paternal GF _____

Paternal GM _____

Maternal GF _____

Maternal GM _____

Aunts/ Uncles _____

Siblings _____

History of Loss? _____

Where did you grow up? _____

School History

School Name _____

Current Grade _____

Learning Difficulties _____

Behavior Challenges _____

WELLNESS HISTORY

Diet (Typical day)

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages _____

Exercise/Sports

Type _____

How often _____

Hobbies/Interests

Safety

What % do you use your seatbelt? _____

What % do you wear a bike helmet? _____

Environmental Exposures

Time spent in front of a computer? _____

Time watching TV? _____

Time playing video games? _____

Time on cell phone? _____

Time texting? _____

Other Exposures _____

Belief Systems

Please say something about your family's spiritual beliefs:

REVIEW OF SYSTEMS

(Circle all that currently apply)

General

- Weight Loss or Weight Gain
- Night Sweats
- Intolerant of Heat/Cold
- Excessive Thirst

Skin

- Rashes/ Moles
- Warts/ Lumps/bumps
- Hives/ Itching/ Dry Skin/Eczema
- Fungal infection / Poison Ivy
- Pimples/ Acne
- Easy Bruising

Hair

- Dandruff/Cradle Cap
- Unwanted hair/ Hair Loss

Eyes

- Glasses/Contacts
- Eye Pain/ Blurriness
- Watery, Itchy Eyes

Ears

- Hearing loss
- Chronic Ear Infections
- Swimmers Ear/ Ear Wax

Nose & Sinus

- Frequent Colds/ Nose Bleeds
- Sneezing
- Congestion/Throat Clearing

Mouth & Throat

- Cavities/Fillings
- Recent Extractions/ Gum problems
- Bad breath
- Tooth Pain/ Throat Pain
- Jaw clicking/ Teeth clenching
- Canker Sores
- Hoarseness
- Speech Problems

Neck

- Pain/ Stiffness
- Swollen lymph glands
- Enlarged thyroid gland

Breast

- Pain/ Lumps

Respiratory

- Cough (productive or dry)
- Shortness of breath/ Wheezing
- Recurrent Infections

CardioVascular

- History of Heart Murmur
- Irregular Heart Beat
- Fainting Spells

Digestion

- Poor Appetite/ Excessive Hunger

Food Allergies or Sensitivities

Difficulty swallowing

Nausea/ Vomiting

Reflux

Cramping/ Bloating/Gas

Abdominal Pain

Jaundice

Diarrhea/ Constipation

of stools/day _____

Bloody/ Black Stools

Urinary

Frequency or pain

Bed Wetting

Reproductive

Girls

Last Menstrual Period _____

Days between cycles:

<21 / 22-25 / 26-30 / >31/ irregular

PMS symptoms

Constipation/ Swelling

Moodiness/ depression/ irritability

Sore breast/ sugar cravings

Symptoms with Period

Cramping/Clotting

Heavy or Minimal Flow

Days of flow _____

Vaginal dryness/itching

Vaginal discharge/ irritation

Vaginal pain/Pelvic pain

Boys

Penile discharge/Irritation

Scrotum enlargement/Pain

Sexual

History of sexual trauma

Other sexual concerns _____

Neurologic

Headaches/ Seizures

Loss of consciousness/ Concussion

Dizziness/ Vertigo

Trouble with balance

Loss of sensation/ numbness

MusculoSkeletal

Joint Pain/ Stiffness/ Swelling

Muscle weakness/Pain

Psychological

Nervousness/Anxious

Excess worry/Stress

Depression

Behavior Concerns

Difficulty Concentrating

Thoughts of Suicide

Bullied by Others

Sleep

Where do you sleep? _____

When do you go to sleep? _____

When do you awaken? _____

Difficulty falling asleep/Staying asleep

Difficulty going back to sleep

Recurrent dreams or Nightmares

Daytime sleepiness/ Snoring

Allergies

Environmental _____

Chemical _____

Food _____

Other _____

OTHER

please list any additional symptoms below