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)_____

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? _____

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
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, goes too often, etc.)	Yes	No			

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