Pediatric Health Questionnaire

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Health issues often have many influences. Accurately assessing all the factors and comprehensively managing them is the best way to resolve health challenges. Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to the following questions. Your careful consideration will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help identify underlying causes of concern and will help us to create the most appropriate and thorough individual treatment plan for you. If a particular question does not apply to your child, please feel free to skip it.

Thank you and we look forward to working with you.

Today's date: _____
Given Name : _____
Last First MI
Nickname, if applicable: _____

Approximately how many hours per day does your child spend watching TV, playing video games or using the computer?
None ____ <1 hour ____ 1-2 hours ____ 2-3 hours ____ 3-4 hours ____ 4-5 hours ____ 5+ hours ____

Is your child adopted? Yes ____ No ____
If yes, please describe the circumstances of the adoption. (Birth mother's situation, where adopted from, age at adoption, circumstances living in previous to adoption, etc):

_____

_____

CONCERNS:
My top concern is: _____

Next greatest concern: _____

Concern 3: _____

BIRTH HISTORY:
PRENATAL (before birth):
Age of mother/father at conception: _____ _____
Mother Father
Were there fertility issues prior to pregnancy? Yes ____ No ____
If yes, please describe:

_____
Total number of pregnancies: _____
Health of Mother at conception: Excellent ____ Good ____ Fair ____ Poor ____
Did you receive prenatal medical supervision? Yes ____ No ____
Duration of pregnancy: (in weeks): _____
Mother's diet during and post pregnancy: Excellent ____ Good ____ Fair ____ Poor ____

Please check if any occurred during pregnancy:
Viral illness/rash/fever ____
Yeast infections ____
Dental amalgams placed or removed ____
X-rays ____
Others:

Chemical exposure or father chemical exposure ____
Move to newly built house ____
House painted indoors ____
House exterminated for insects ____

_____

Pregnancy Complications :
Sexually transmitted disease (Chlamydia, Herpes, etc) ____
Group B Strep + ____
Bleeding ____
Diabetes ____
Moderate-severe nausea/Vomiting ____
High Blood Pressure/toxemia ____
Others

Physical or emotional trauma ____
Thyroid Problems ____
Rhogam use ____

Mother's use during pregnancy :
Alcohol ____
Medications ____
Coffee ____
Smoke ____
Recreational Drugs ____
List any medications, supplements and vitamins taken during pregnancy: _____

PERINATAL (at birth):
Weight at birth: _____
Any of the following:
Prolonged rupture of membranes ____
Steroids to mature lungs ____
Medicine to stop labor ____
Others ____

Pitocin ____
Maternal Antibiotics ____
Maternal fever ____

Nature of delivery :
Vaginal ____
C-section ____
Induced ____
General Anesthesia ____
Epidural ____
Others

Home birth ____
Waterbirth ____
Forceps ____
Breech ____
Midwife/doula ____

Baby vigorous and appeared healthy after birth?	Yes ____	No ____
Did the baby breast feed immediately after birth?	Yes ____	No ____
Any complications with mom or baby at birth?	Yes ____	No ____
Neonatal ICU Stay:	Yes ____	No ____

How long in NICU: _____

Any of the following:
IV antibiotics ____
Oxygen (Nasal cannula or CPAP) ____
Intubation (Breathing machine) ____
Apnea/bradycardias ____
Patent Ductus Arteriosus ____
Gavage feeds/feeding tubes ____
Reflux needing medicine or special formulas ____
Others ____
If yes, please describe: _____

PAST MEDICAL HISTORY:
ALLERGY/ IMMUNOLOGY/INFLAMMATION:

Medication Allergies (Known):*	Yes____	No ____
Food or Environmental Allergies (Known):	Yes ____	No ____

Specify the Medication/Supplement/Food and the Reactions caused, if any:

History of Autoimmune disease or Immunodeficiencies? Yes ____ No ____
If yes to above, please explain: _____

EARLY CHILDHOOD ILLNESS/ ANTIBIOTIC USE:
First antibiotic at (specify the age in months): _____
How many times has your child been treated with antibiotics? _____

ILLNESSES/INFECTIONS:
Any significant Infectious diseases? Please describe:

EYE:
Any significant problems involving the eyes? Please describe:

EAR, NOSE & THROAT:
Any significant issues of the ears, nose or throat?

RESPIRATORY SYSTEM:
Has your child had any significant respiratory issues in the past? Please specify:

CARDIOVASCULAR:
Has your child had any significant cardiovascular issues in the past? Please specify:

GASTROINTESTINAL:
Has your child had any significant gastrointestinal issues in the past? Please specify:

GENITAL AND URINARY SYSTEMS:
Has your child had any significant Genito-urinary issues in the past? Please specify:

For young women only:
Age of first menses (Put N/A if not started yet): _____
Date of last menstrual period: _____
Menses: Regular: ____ Irregular: ____
Days between menses and duration of menses: _____

Does your child use contraception (Pills, Patch, ring, condoms, etc)? Yes ____ No ____
Please describe: _____

ORTHOPEDIC:
Has your child had any significant orthopedics issues in the past? Yes ____ No ____
Please specify: _____

METABOLIC/ENDOCRINE:
Has your child had any significant metabolic or endocrine issues in the past? Yes ____ No ____
Please specify: _____

NEUROLOGIC/DEVELOPMENT/MOOD:
Has your child had any significant neurologic, developmental or psychiatric issues in the past?
Yes ____ No ____
Please specify: _____

SKIN:
Has your child had any significant dermatologic issues in the past? Yes ____ No ____
Please specify: _____

HOSPITALIZATIONS/SURGERIES:
HOSPITALIZATIONS: Yes ____ No ____
If yes, specify the Dates and Reasons: _____

_____

SURGERIES: Yes ____ No ____
If yes, specify the Dates and Reasons: _____

_____

PREVIOUS DIAGNOSTIC TESTS PERFORMED
Please list any X-rays, CT Scans, MRI, Ultrasounds, Upper GI series, etc that have been performed on your child and why. (If possible, please obtain and bring a copy of the results to your appointment):

_____

Please list any blood, urine, spinal fluid, stool or other diagnostic tests that have been performed on your child and why (As much as known. If unknown, please obtain and bring a copy of the results to your appointment):

_____

Please list any other diagnostic test that has been performed on your child and why. (Example: EKG, EEG, Sweat Chloride, Endoscopy, Bronchoscopy, etc). What were the results of those tests?

_____

_____

Results: _____

PAST MEDICAL PRACTITIONERS, SPECIALISTS:
Which of the following have you taken your child to previously?
Medical sub specialists ____
Naturopaths ____
Chiropractors ____
Others ____
Please briefly describe what was done with the above practitioners: _____

_____

VACCINATIONS:
How are you vaccinating your child:
We are vaccinating according to the ACIP/AAP recommended guidelines ____
We are vaccinating on an alternative schedule, but plan on fully vaccinating our child ____
We are vaccinating with some vaccines, but not others ____
We are not vaccinating at all ____

MEDICATIONS:
Please list all medications your child is currently taking or has taken in the last year: _____

_____

Prolonged or frequent use of any of the following in the past:
Tylenol/acetaminophen ____
NSAIDS (Aleve, Advil, Motrin, etc) ____
Acid Blocking Drugs (Zantac, Prilosec/Prevacid, etc) ____
Oral antibiotics (Prophylaxis, Acne, etc) ____
Oral Contraceptives ____
Steroids (prednisone, etc) ____
Others: _____

SUPPLEMENTS, HERBS AND HOMEOPATHIC REMEDIES:
Please list all complementary remedies your child is currently taking or has taken in the last 6 months: _____

DEVELOPMENTAL ASSESSMENT:

Does your child have any developmental problems? Yes ____ No ____
If yes, please answer the questions below:
At what age did developmental challenges begin? _____
Is this impression shared among parents and others caring for the child? Yes ____ No ____
What did you first notice? _____

How severe and frequent were the symptoms? _____

FAMILY HISTORY:

What is your child's genetic background?
African ____
Asian ____
South Asian ____
Pacific Islander ____
Middle Eastern ____
Mediterranean ____
Ashkenazi ____
Caucasian/ European ____
Latino/Hispanic ____

Genetic diseases:
Sickle Cell or Thalessemia ____
Cystic fibrosis ____
G6PD, spherocytosis, etc. ____
Inborn errors of metabolism ____
Down Syndrome or other Trisomies ____
Genetic deletion syndromes (Angelman's, etc) ____
Others, please list: _____

Who in the family has, or has had, Cancers or other Neoplasm/growths of:
Skin _____
Blood (Leukemia, lymphoma) _____
Breast/Ovary or Uterine _____
Lung _____
Stomach/colon _____
Liver/pancreas _____
Others: _____
Who in the family has, or has had, Cardiovascular disease:
Hypertension/ high blood pressure _____
Heart attack _____
Strokes _____
Rhythm abnormalities _____
Others: _____

Who in the family has, or has had, Respiratory Diseases:
Asthma _____
Sinusitis _____
Nasal Allergies _____
Recurrent Bronchitis _____
Emphysema _____
Cystic Fibrosis _____
+PPD/ TB Test or TB _____
Others: _____

Who in the family has, or has had, Gastrointestinal Diseases:
Crohn's Disease _____

Ulcerative Colitis _____
Constipation _____
Polyps _____
Irritable Bowel Syndrome _____
Others: _____

Who in the family has, or has had, Hormonal Diseases:
Diabetes (Type 1-- Insulin Dependent) _____
Diabetes (Type 2-- Insulin Resistance) _____
Obesity _____
Thyroid (Hyper/Hypo, or Borderline thyroid problems) _____
Adrenal (Cushings/Addisons or "Adrenal Burnout") _____
Polycystic Ovary Disease _____
Others: _____

Who in the family has, or has had, Autoimmune Diseases:
Lupus (SLE) _____
Dermatomyositis _____
Rheumatoid Arthritis _____
Juvenile Idiopathic Arthritis _____
Sjogrens _____
Scleroderma _____
Others: _____

Who in the family has, or has had, Allergies and Sensitivities:
Eczema _____
Psoriasis _____
Seborrheic Dermatitis _____
Food or environmental allergies _____
Chronic Hives/Urticaria _____
Photosensitivity _____
Others: _____

Who in the family has, or has had, Neurologic Issues:
Headaches or Migraines _____
Alzheimer's or dementia _____
Parkinsons _____
Multiple Sclerosis _____
Tics or Tourettes _____
Restless Legs _____
Seizures/ Epilepsy _____
Others: _____

Who in the family has, or has had, psychiatric/Emotions and Substance Use:
Autism Spectrum Disorder _____
Depression _____
Anxiety _____
ADHD/ADD _____
Schizophrenia _____
Bipolar _____
Substance Use/Abuse _____
Others: _____

Who in the family has, or has had, other medical conditions not otherwise specified: _____

_____

FEEDING & NUTRITIONAL HISTORY:
How long was the baby breastfed?
Never ____ 0-3 months ____ 3-6 months ____ 6-9 months ____ 9-12 months ____ 1 year+ ____

If not, what kind of formula/liquid was given (milk/soy or other)?

How was formula/liquid tolerated?

Frequency of feedings?

When were solid foods introduced?

Which foods were first introduced?

Any reactions?
How would you describe your child's appetite?

What would be the typical foods eaten for each of the following on an average day?
Breakfast:
Lunch:
Dinner:
Snacks:
Liquids:
Have you tried any dietary modifications or special diets for your child in the past? Yes ____ No ____
If so, which ones and what was the result?

Is your child currently on a special diet? Yes ____ No ____
If so, which one? Why? What has been the result?

Does your child avoid any particular foods? Yes ____ No ____
If yes, types and reasons:

Check all factors that apply to your child's current lifestyle and eating habits:
Time constraints ____
Fast eater ____
Significant other or family members have special dietary needs or food preferences ____
Erratic eating patterns ____
Love to eat ____
Dislike healthy food ____
Dislikes eating ____
Eat more than 50% of meals away from home ____
Non-availability to healthy foods ____
Use food as a reward/bribe ____
High intake of soda or juice ____
High intake of dairy/milk ____
Caffeinated beverages ____
Others:

DENTAL:
Do you or your child brush and floss their teeth regularly? Yes ____ No ____
Do you use fluorinated toothpaste or dental rinses? Yes ____ No ____
Does your child have cavities, fillings or had to have teeth pulled due to dental decay? Yes ____ No ____

Approximate date of last dental visit:

ELIMINATION:
Frequency of bowl movement:

Urinary frequency:

Toilet trained: Yes ____ No ____

Concerns: _____

ENVIRONMENT:
Who does the child live with? _____

Mother's name, age and occupation: _____

Father's name, age and occupation: _____

Parents are:
Married ____ Separated ____
Divorced ____ Living together ____
Remarried ____
Others:

_____

Any siblings? Yes ____ No ____
If yes, please list siblings and ages:

_____

Has your child experienced any major life changes that may have impacted his/her health? Yes ____ No ____
Has your child ever witnesses or been the victim of abuse, a victim of crime or experienced a significant trauma? Yes ____ No ____
Have you ever sought counseling for your child? Yes ____ No ____
If yes, please describe briefly:

_____

Where does the child spend his/her most time?

_____

Are there any pets living in the child's house? Yes ____ No ____
If yes, what? _____
Any travel to foreign countries or wilderness camping? Yes ____ No ____
Do you or anyone in the home smoke? Yes ____ No ____
Are you aware of any toxins or other hazards the child may be exposed to (home, extracurricular, school)? Yes ____ No ____
If yes, please specify:

_____

Any exposures to:
Pesticides ____
Herbicides ____
Paints ____
Cleaning chemicals ____
Artificial sweeteners ____
Root canals ____
Car exhaust ____
Power plants ____
Molds ____
Pest extermination ____
Amalgams/fillings ____
Well water ____
Does your child seem especially sensitive to perfumes, gasoline, or other vapors? Yes ____ No ____
If yes, please describe:

_____

EDUCATION:
Does the child attend: Daycare ____ Pre school ____ School ____ Home care ____
Current school and year:

_____

Describe your child's school performance:

_____

Any concerns with child's educational capabilities or habits at school?

_____

Does your child have an IEP or other special education plan? Yes ____ No ____

Does your child receive any additional therapies (Occupational, physical, speech, etc): Yes ____ No ____
If yes, please describe:

SLEEP:
When does your child go to sleep and how many hours does your child sleep?

Does your child sleep through the night?	Yes ____	No ____
Does your child snore?	Yes ____	No ____
Does your child awake refreshed?	Yes ____	No ____
Does your child take naps?	Yes ____	No ____

If yes, how often and how long?

SPIRITUAL/RELIGIOUS ORIENTATION:
Please list your family's spiritual or religious orientation, if any: _____
How active are these beliefs in your life?

SYMPTOM REVIEW:
Please check all current symptoms occurring or present in the past 6 months:

GENERAL:

Weight Loss ____
Weight Gain ____
Dizziness ____
Fatigue ____
Weakness ____
Fever ____
Others:

Daytime Sleepiness ____
Difficulty falling asleep ____
Difficulty staying asleep ____
Fever ____
Injury ____

MOOD, NERVES, NEUROLOGICAL:

Anxiety ____
Hallucinations ____
Mood Disorder ____
Depression/sadness ____
Difficulty with concentrating ____
Difficulty with balance ____
Difficulty with thinking ____
Difficulty with speech ____
Difficulty with memory ____
Fainting ____
Irritability ____
Others:

Light-headedness ____
Eating Disorder ____
Personality changes ____
Lethargy ____
Phobias ____
Seizures ____
Suicidal Thoughts ____
Tingling ____
Tremor/Tic ____
Trembling ____

HEAD & EAR, NOSE, THROAT:

Headache ____
Eye Pain ____
Eye Redness ____
Eye Discharge or Tears ____
Infection ____
Blurred Vision ____
Squinting ____
Dark circles under eyes ____
Tugging on ear(s) ____
Ear Pain ____
Ear Discharge ____

Ringing in Ears ____
Ear Fullness ____
Nose Bleeds ____
Nasal Congestion ____
Nasal Discharge ____
Sinusitis ____
Mouth lesion ____
Teething ____
Drooling ____
Dental/gum problems ____
Decreased or Hearing Loss ____

HEAD & EAR, NOSE, THROAT CONT:
Others:

LYMPH NODES:
Enlarged, Neck ____
Tender, Neck ____
Other Enlarged/Tender ____
Others:

RESPIRATORY:
Difficulty breathing ____
Hoarseness ____
Sore Throat ____
Cough : Dry ____
Cough : Productive ____
Cough : Recent ____
Cough : Ongoing ____
Allergies : In spring ____
Others:

Allergies : In summer ____
Allergies : In fall ____
Allergies : In winter ____
Asthma ____
Snoring ____
Wheezing ____
Chest pain ____
Frequent colds

CARDIOVASCULAR:
Cyanosis ____
Palpitations ____
Rheumatic Fever ____
Others:

Heart Murmur ____
Heart Abnormality ____
Chest pain ____

ABDOMEN & DIGESTION:
Abdominal discomfort: Pain ____
Abdominal discomfort: Bloating ____
Nausea ____
Burping ____
Vomiting ____
Indigestion ____
Gas/Flatulence ____
Diarrhea ____
Constipation ____
Undigested Food in Stool ____
Mucus in Stool ____
Others:

Heartburn, Gastric Reflux ____
Strong Stool Odor ____
Blood in Stool ____
Anorexia ____
Fissures ____
Food Intolerance : Lactose ____
Food Intolerance : All Dairy ____
Food Intolerance : Wheat ____
Foot Intolerance: Gluten (Wheat, Rye) ____

MALE:
Discharge from Penis ____
Testicular Mass ____
Genital Pain ____
Others:

Hernia ____
Undescended testes ____
Sexually Transmitted Infection

FEMALE:
Vaginal abnormality ____
Hernia ____
Vaginal discharge ____
Vaginal irritation ____
Sexually Transmitted Infection ____
Others:

Clotting or heavy bleeding ____
Severe cramping ____
PMS ____
Breast Pain/tenderness ____
Excessive hair growth on body ____

URINARY:

Leaking/Incontinence ____
Infection ____
Hesitancy ____
Discomfort on urination ____
Urine foul odor ____
Others:

Urine contains blood ____
Urine pain and burning ____
Bedwetting ____
Change in frequency ____

MUSCULOSKELETAL:

Pain, Location: ____
Night Pain ____
Muscle Pain ____
Muscle Spasm ____
Muscle Stiffness ____
Muscle Twitches Around Eyes ____
Muscle Twitches Around Legs ____
Muscle Weakness ____
Others:

Limited Range of Motion ____
Swelling ____
Joint Pain ____
Joint Redness ____
Joint Stiffness (Recent) ____
Joint Stiffness (Ongoing) ____
Gait (Walking) abnormality ____
TMJ Problems

SKIN:

Itching of skin ____
Dryness of skin ____
Acne ____
Eczema ____
Psoriasis ____
Skin Darkening ____
Rash or Redness ____
Acquired Lesions ____
Changes in Moles ____
Others:

Hair Loss ____
Vitiligo ____
Easy Bruising ____
Mole/birthmark ____
Fungal Infection ____
Warts ____
Skin color changes ____
Hair or nail problems ____

STRENGTHS:

Accepts new clothes ____
Answers parent ____
Bold, free of fear ____
Cuddly ____
Draws accurate pictures ____
Follows instructions ____
Happy ____
Likes to be held ____
Likes to be swaddled ____
Okay if parents leave ____
Perfect musical pitch ____
Physically coordinated ____
Pleasant/easy to care for ____
Others:

Pronounces words well ____
Responsible ____
Sensitive to people's feelings ____
Sensitive/affectionate ____
Skill: arithmetic computing ____
Skill: doing fine work ____
Skill: playing/small object ____
Skill: throw/catch ball ____
Strong desire to do things ____
Swimming ____
Unusual memory ____
Wants to be liked

SENSORY:

Fearful of harmless objects ____
Fearful of unusual events ____
Unaware of danger ____
Unaware of people's feelings ____
Unaware of self as person ____
Very sensitive to pain ____
Bothered by certain sounds ____
Ear pain ____

Ear ringing ____
Acute hearing ____
Hearing loss ____
Likes certain sounds ____
Sensitive to loud noise ____
Sounds seems painful ____
Covered ears with sounds ____
Excessive ear wax ____

SENSORY CONT:

Likes head burrowed ____
Likes head pressed hard ____
Likes head rubbed ____
Likes head under blanket ____
Likes to be held upside down ____
Likes to be swung in the air ____
Intensely aware of odors ____
Acute sense of smell ____
Examines by smell ____
Finger tip squeezing ____
Dislikes wearing shoes ____
Insensitive to pain ____
Blinking ____
Bothered by bright lights ____
Distorted vision ____
Examines by sight ____
Fails to blink at bright light ____
Likes fans ____
Others:

Likes flickering lights ____
Looks out of corner of eye ____
Poor vision ____
Puts eye to bright light or sun ____
Strabismus (cross eyed) ____
Adopts complicated rituals ____
Collects particular things ____
Corrects imperfections ____
Draws only certain things ____
Fixated on one topic ____
Lines objects precisely ____
Lines things in neat rows ____
Repeats old phrases, sentences ____
Repetitive plays/objects ____
Tidy ____
Upset if things change ____
Upset if things aren't right

BEHAVIOR:

Aloof, indifferent, remote ____
Behavior purposeless ____
Bites or chews fingers ____
Constant movement ____
Curious/gets into things destructive ____
Does opposite/asked ____
Extremely cautious ____
Falls gets hurt running climbing ____
Head banging ____
Holds hands in strange poses ____
Hyperactive ____
Imitates others ____
Lost in thought, unreachable ____
Melts down ____
Poor focus, attention ____
Poor sharing ____
Spends time with pointless tasks ____
Licking ____
Tantrums ____
Likes spinning objects ____
Likes to flick finger in eye ____
Likes to spin things ____
Rhythmic rocking ____
Sits long time staring ____
Slapping books ____
Others:

Toe walking ____
Uninterested in live pet ____
Unusual play ____
Uses adult hand for activity ____
Watches television long time ____
Doesn't do for self ____
Hides skill/knowledge ____
No purpose to play ____
Rejects help ____
Teases others ____
Tries to control others ____
Unable to predict actions ____
Won't attempt/can't do ____
Eye contact poor ____
Finger flicking ____
Flaps hands ____
Jumps when pleased ____
Stares at own hands ____
Tooth taping ____
Whirls self like a top ____
Wiggle finger front of face ____
Insists on what wanted ____
Lack initiative ____
Runs away ____

COMMUNICATION:

Answers by repeating question ____
Asks using "you" not "I" ____
Babbling ____
Does not ask questions ____
Expressive language poor ____
No answers simple questions ____

Point to objects/can't name ____
Receptive language poor ____
Says "no" ____
Says "yes" ____
Says "I" ____
Scripting ____

COMMUNICATION CONT:

Talks to self ____
Uses one word for another ____
Always frightened ____
Anxiety ____
Others:

Inconsolable crying ____
Negative ____
Phobias ____
Severe mood swings ____

Additional Information, if any: