PEDIATRIC INFORMATION FORM (BIRTH-12 YRS)

Patient Information

Name: _____ Date: _____
Date of birth: _____ Age:_____ Sex: □ Male □ Female
Parent/Guardian's name(s):_____
Street address: _____
City: _____ State: _____ Zip code: _____
Email address: _____
Home phone: _____ Cell phone: _____
Insurance Provider/ID#: _____

Whom may we thank for referring you?
_____

Prenatal History

Any complications during pregnancy:
_____
Any alcohol? Yes/No Any tobacco? Yes/No Any vaccines/medication? Yes/No
Reason for vaccines/medication:
_____
Illness/infections during pregnancy:
_____
Ultrasounds or other testing:
_____
What things were done to stay healthy during pregnancy?
_____
_____

Birth History

Place of birth: □ Home □ Birthing Center □ Hospital
Provider: □ Midwife □ OB-Gyn □ Other
Type of birth: □ Vaginal □ Cesarean

Were pain medications used? Yes/No Pitocin used? Yes/No
Was labor induced? Yes/No If yes, why?
Birth trauma? □ Doctor assisted □ Twisting/Pulling □ Vacuum Extraction
□ Forceps
APGAR score if known: _____
Did your child have a misshaped skull/head? Yes/No
Did you breast-feed your child? Yes/No How long?_____
Any food allergies: _____
Has your child been vaccinated? Yes/No
Reason: □ Informed decision □ Recommended □ Didn't know I had a choice

Did your child have any negative reaction to the vaccines? Yes/No
If yes, were they reported? Yes/No
Has your child ever had any surgeries? Yes/No
If yes, elaborate: _____

Has your child been on antibiotics? Yes/No
If yes, how often and what purpose?
_____
Is your child currently taking any medication? Yes/No
If yes, how often and what purpose?
_____
Is your child currently taking any vitamins? Yes/No
_____

Baby/Toddler (0-4)
Have any of the following occurred?

☐ Jaundice	☐ Anemia	☐ Frequent Crying Spells
☐ Seizures	☐ Infections	☐ Tonsillitis
☐ Frequent ear infections	☐ Colic	☐ Frequent diarrhea
☐ Constipation	☐ Sleeping Problems	☐ Frequent
☐ Car accident	☐ Repeated Colds	☐ Fall from a changing table
☐ Cyanosis	☐ Fall out of crib	☐ Fall off playground
☐ Tumble down stairs	☐ Fevers	☐ Play in a Johnny Jumper

Other:
_____

Child (5-12)
Have any of the following occurred?

☐ Fall from a tree	☐ Fall off a bicycle	☐ Fall on playground
☐ Sports accident	☐ Car accidents	☐ Stomach pains
☐ Hyperactivity/Autism	☐ Leg/Knee pains	☐ Scoliosis
☐ Learning difficulties	☐ Bed-wetting	☐ Asthma
☐ Allergies	☐ Growing Pains	☐ Headaches/Migraines

Other:
_____

Which of the above bothers your child the most?
_____

When did it begin? _____ Is it getting worse? Yes/No
Does it affect activity? ☐ Not at all ☐ Somewhat ☐ Always
Does your child participate in any athletic extra curricular activities? Yes/No
If yes, which ones? _____
Rate your child's diet: ☐ Well-balanced ☐ Average ☐ High sugar/processed foods
Does your child consume artificial sweeteners? Yes/No
Number of hours your child sleeps? _____hours/day
Sleep quality? ☐ Good ☐ Fair ☐ Poor
Is there anything else the Doctor should know?
_____
_____
_____