PEDIATRIC INFORMATION FORM (13-17 YRS)

Patient Information

Name: _____ Date:_____
Date of birth: _____ Age: _____
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?

Patient History

How would you describe the pregnancy? □ Normal □ Somewhat difficult □ Very difficult
How would you describe infancy? □ Normal □ Somewhat difficult □ Very difficult
How would you describe childhood? □ Normal □ Somewhat difficult □ Very difficult
If you answered anything but normal, why?

_____
How would you describe overall physical development?
□ Above average □ Typical □ Behind schedule
How would you describe overall mental development?
□ Above average □ Typical □ Behind schedule
Any childhood illnesses/diseases?

_____
Any surgeries?

_____
Any accidents?

_____
Has your child been vaccinated? Yes/No
If yes, which ones? _____
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 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
If yes, how often and what purpose?

_____

Is there anything significant in patient's health history the Doctor should know? `

_____

Health & Wellness

What is the reason for your visit today? □Wellness Check-Up □ Other

Other:

_____

If other, how long has this been a concern?

_____

Is it getting worse? □ Yes □ No □ Not sure

Does it affect activity? □ Not at all □ Somewhat □ Always

Has anything been done already to address this concern?

_____

Are any of the following symptoms present?

☐Stomach pains	☐Hyperactivity/Autism	☐Leg/Knee pains
☐Scoliosis	☐Learning difficulties	☐Low energy Asthma
☐Irritability/Moodiness	☐Low self-esteem	☐Allergies Growing
☐Pains	☐Headaches/Migraines	☐Seizures
☐Infections	☐Tonsillitis Diarrhea	☐Constipation
☐Sleeping problems	☐Repeated colds	☐Digestion
☐General fatigue	☐Acne/Skin problems	☐Depression
☐Menstrual cramps	☐Anxiety	☐Excessive hunger

Other: _____

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Do you participate in any athletic extra curricular activities? Yes/No

If yes, which ones? _____

Rate your diet: □Well-balanced □ Average □ High sugar/processed foods

Do you consume artificial sweeteners? Yes/No

Rate your exercise: □ Frequently □ Sometimes □ Never

How many glasses of water do you drink? _____/day

Number of hours you sleep? hours/day

Sleep quality? □ Good □ Fair □ Poor

Rate your general mood: □ Happy □ Melancholy □ Depends on the day

Is there anything else you would like the Doctor to know?

_____

_____

_____