

Patient's Medical History

Primary Doctor(s)

Name	City	Phone Number

Therapist(s)

nutritionist/speech/occupational/physical/other

Name of Therapist	Type of Therapy	City	Phone Number

Other therapies your child has received

Dried blood analysis, cranial-sacral, etc...

Name of Provider	Type of therapy	City	Phone Number

Patient's Surgical History

Type of Surgery	Date

Prenatal History

Maternal age at delivery: ____yrs

Illnesses during pregnancy: _____

Medications during pregnancy: _____

Group B Strep: positive/negative

Major stress or trauma during pregnancy: _____

Birth History

Was child full term/premature? (circle) Weeks gestation: _____

C-section/Vaginal (circle), if C-section explain why:

If vaginal delivery, was forceps/vacuum (circle) used?

How long was your labor? _____ hours

How long were you actively pushing? _____ minutes

Medications during labor or delivery:

Epidural? Yes/No (circle)

Complications during delivery:

Complications after delivery:

Medications given to child during hospital stay:

Dietary/Nutritional History

Breast-fed? Yes/No (circle) How Long?

Formula-fed? Yes/No (circle) Name of formula:

Started foods at what age? _____ Any problems:

When was whole milk/soy milk (circle) started?

Food allergies? (list food and allergen response)

Food sensitivities? (list food and sensitivity response)

Food cravings? (list food and symptom of craving)

Please describe your child's diet over a typical 3-day period:

Please describe your child's typical stool pattern: (daily, weekly, large, odor, soft, floats, etc...)

Developmental History

Please list age when the following skills were obtained and any problems associated with that skill:

Babbled:	Concern:
First Words:	Concern:
2 word phrases:	Concern:
Rolled over:	Concern:
Pulled to stand:	Concern:
Walked independently:	Concern:
Sitting Up:	Concern:
Running:	Concern:
Walked up/down steps independently:	Concern:
Moved objects between hands:	Concern:
Smiled:	Concern:
Made eye contact:	Concern:
Showed affection (hug, kiss):	Concern:
Performed act/gesture to obtain attention of others:	Concern:
Picked object up with 2 fingers:	Concern:
Responded to name:	Concern:

Family History

List any allergies, chronic illness or genetic problems with the following

Mother:
Father:
Siblings:
Maternal Grandparents:
Paternal Grandparents:
Other:

Social History

Adopted children in home? Yes/No (circle)

Pets in home? Yes/No (circle) List:

Recent changes in home environment: (move, death, etc...)

Explain:

Recent Travel: Yes/No (circle)

Explain:

How does your child respond to change?

What does your child enjoy to do? (sports, music, etc...)

Describe your child emotionally: (happy, sad, etc...)

Have you noticed events/foods that will trigger your child's mood? Yes/No (circle)

Explain:

Environmental History

Location of home: city/suburban/wooded/farm (circle)

Water: city/well

Type of heat: electric/gas/oil/other

Do you live near? power lines/industrial area/agricultural area

Does your home have a lot of? dust/mold/tile/feather items

Does your child have sensitivity to? perfumes/lotions/soaps/animals/mold, etc...

Explain:

Medical History

Please list any pertinent medical history for your child: (please include ear infections, sinusitis, colds, antibiotic uses, thrush, mono, etc...)

List any tests done previously on your child:

Test

Date done

Immunization History

Is your child immunized?

If so, please list any reactions to vaccines such as crying, fever, irritability, etc...

Immunization

Reaction

Medication/Supplements

List any medications/supplements your child has been on and response:

Medication/Supplement

Past

Current

Response

