

## Harmony Healing Naturopathic Clinic

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# PEDIATRIC HEALTH HISTORY FORM

All questions contained in this questionnaire are strictly confidential  
and will become part of your medical record.

**Name** (Last, First, M.I.): \_\_\_\_\_  M  F **DOB** \_\_\_\_\_

**School Grade:** \_\_\_\_\_ **School Name:** \_\_\_\_\_

**Previous or referring doctor:** \_\_\_\_\_ **Date of last physical exam:** \_\_\_\_\_

**Please list your current health concerns in order of importance:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Mom's Pregnancy**

- Uncomplicated
- Early Labor
- Bleeding
- Diabetes
- Thyroid Problems
- Pre-eclampsia
- Medications During Pregnancy (besides prenatal vitamins):
- None
- Other – Please name: \_\_\_\_\_

**Post Natal Complications**

- None
- Jaundice
- Respiratory
- Cardiac
- Infections
- Gastrointestinal
- Hospitalized. How long and why? \_\_\_\_\_

**Birth History:**

Weight (Lbs): \_\_\_\_\_ Weeks: \_\_\_\_\_  Full Term  Preterm

Vaginal  C-Section  Reason for C- Section \_\_\_\_\_

**Development History:** Rolled Over at (age) \_\_\_\_\_ Walked at \_\_\_\_\_ Sat at \_\_\_\_\_ Talked at \_\_\_\_\_

Nursed? If yes until what age? \_\_\_\_\_

<b><i>Immunizations</i></b> (check and circle how far in the series)	<input type="checkbox"/> Diphtheria	2mo 4mo 6mo 16-18mo	<input type="checkbox"/> Pneumococcal	2mo 4mo 6mo 12-15mo
	<input type="checkbox"/> Pertussis	4-6 yrs 11yrs		
	<input type="checkbox"/> Tetanus	(tetanus only)		
	<input type="checkbox"/> Hepatitis B	Birth-2mo 1-4mo 6-18mo	<input type="checkbox"/> Chickenpox	12mo
	<input type="checkbox"/> HIB	2mo 4mo 6mo 12-15mo	<input type="checkbox"/> Measles <input type="checkbox"/> Mumps	12-14 mo 4-6 yrs
<input type="checkbox"/> Polio OPV or IPV	2mo 4mo 6-18mo 4-6yrs	<input type="checkbox"/> Rubella		
		Other? _____		

Any reactions to immunizations? Please Describe:

**List any medical problems that other doctors have diagnosed**

**Surgeries**

Year	Reason	Hospital

**Other hospitalizations**

Year	Reason	Hospital

**Have you ever had a blood transfusion?**

Yes  No

**List the prescribed medication / inhalers you are taking (including how much, how long, and how often)**

Name the Drug	Strength	Frequency Taken

**List the over-the-counter medications, including vitamins and herbs**

Name the Drug	Strength	Frequency Taken

**Allergies to medications /other**

Name the Drug / Substance	Reaction You Had

**HEALTH HABITS AND PERSONAL SAFETY**

On a scale of 1-10, how would you rate your energy (10 being the highest)?

Sleep Pattern:  Normal  Difficulty falling asleep  Frequent waking  Nightmares  Night terrors  Other  
Sleep Position: \_\_\_\_\_

During Sleep do you:  Grind Teeth  Perspire  Talk  Snore  Walk

Are you exposed to any hazardous substances? (Yes / No) If yes what?

Academic Performance:  Excellent  Average  Difficult

Do you do any kind of physical activity? (Yes / No), if yes, what kind, how much & how often?

Interaction with other children:  Very well    Average    Poor

What is your current weight? \_\_\_\_\_ Height \_\_\_\_\_

Excessive Fears:  Water    Being alone    Thunder    Dark    Flying    Strangers

Animals: Which ones? \_\_\_\_\_  Other: \_\_\_\_\_

## FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
<b><u>Father</u></b>			<b><u>Siblings</u></b>	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
<b><u>Mother</u></b>				<input type="checkbox"/> M	
				<input type="checkbox"/> F	
<b><u>Grandmother</u></b> <i>Maternal</i>				<input type="checkbox"/> M	
				<input type="checkbox"/> F	
<b><u>Grandfather</u></b> <i>Maternal</i>			<input type="checkbox"/> M		
			<input type="checkbox"/> F		
<b><u>Grandmother</u></b> <i>Paternal</i>			<input type="checkbox"/> M		
			<input type="checkbox"/> F		
<b><u>Grandfather</u></b> <i>Paternal</i>			<input type="checkbox"/> M		
			<input type="checkbox"/> F		

**Do you have any blood relative, aunt, uncle, or grandparent who has had any of the following (check any that apply):**

- |   |  |  |                                       |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Autism           | <input type="checkbox"/> Anemia        | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Syphilis     |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Depression    | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures     |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Tuberculosis  | <input type="checkbox"/> Brain Tumors        | <input type="checkbox"/> Sickle cells |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Schizophrenia       | <input type="checkbox"/> OCD          |
| <input type="checkbox"/> Tics             | <input type="checkbox"/> Gonorrhea     | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Aneurysm     |

**Check conditions YOU have or ever had in the past:**

- |   |   |   |                 |                                 |
|---|---|---|-----------------|---------------------------------|
| <input type="checkbox"/> Aggressiveness | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Passing out      | Sensitivity to: |                                 |
| <input type="checkbox"/> Allergies      | <input type="checkbox"/> Eczema         | <input type="checkbox"/> Pulling own hair |                 | <input type="checkbox"/> Sound  |
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> Encephalitis   | <input type="checkbox"/> Seizures         |                 | <input type="checkbox"/> Tough  |
| <input type="checkbox"/> Bed Wetting    | <input type="checkbox"/> Head Banging   | <input type="checkbox"/> Stuttering       |                 | <input type="checkbox"/> Smells |
| <input type="checkbox"/> Biting         | <input type="checkbox"/> Head injuries  | <input type="checkbox"/> Teeth grinding   |                 | <input type="checkbox"/> Lights |
| <input type="checkbox"/> Bronchitis     | <input type="checkbox"/> Headaches      | <input type="checkbox"/> Whooping cough   |                 |                                 |
| <input type="checkbox"/> Chicken -Pox   | <input type="checkbox"/> Hitting        |   |                 |                                 |
| <input type="checkbox"/> Colic          | <input type="checkbox"/> Meningitis     |   |                 |                                 |

## REVIEW OF SYSTEMS

**CIRCLE symptoms you currently have or had in the last YEAR**

<b>General:</b> Chills, Fever, weight loss, fatigue, cravings, weight gain, changes in appetite, trouble sleeping, cold hands/feet, night sweats, Poor memory, other:	<b>Cardiovascular:</b> Chest pain, high blood pressure, irregular heart beat, low blood pressure, poor circulation, swelling of ankles, varicose veins, difficulty breathing, other:
<b>Skin:</b> Bruise easily, eczema, psoriasis, hives, rash, itching, changes in moles, ulcerations, change in hair/skin texture, other:	<b>Musculoskeletal:</b> muscle weakness, muscle pain, back/neck pain, joint pain or swelling, injuries, numbness, other:
<b>Eye, Ear, Nose, Throat:</b> Bleeding gums, blurred vision, double vision, earache, ear discharge, hay-fever, hoarseness, loss of hearing, nosebleeds, ringing in ears, sinus problems, difficulty swallowing, cold sores, other:	<b>Gastrointestinal:</b> Poor appetite, bloating, constipation, diarrhea, bowel changes, vomiting, gas, hemorrhoids, indigestion, nausea, rectal bleeding, stomach pain, bad breath, belching, black stools, vomiting, vomiting blood, other:
<b>Neurological:</b> headache, dizziness, tremors, fainting, seizures, forgetfulness, nervousness or anxiety, numbness, other:	<b>Endocrine:</b> excessive thirst, excessive hunger, hormonal imbalances, heat/cold intolerance, other:
<b>Genito-urinary:</b> frequent urination, pain on urination, poor bladder control, kidney stones, wake up to urinate, blood in urine, other:	<b>Respiratory:</b> Persistent cough, shortness of breath, wheezing, coughing up blood, production of phlegm, difficulty breathing when lying down, tight chest, asthma, bronchitis, other:

### LIFESTYLE HABITS:

What behaviors or habits do you engage in regularly that support your health?

What behaviors or habits do you engage in regularly that poorly affect your health?

What are some obstacles that are challenging the kind of lifestyle you would like to live?

What are your expectations for today's visit?

Any additional information you would like to add:

*Thank you for your time and effort. We look forward to your visit.*