Pediatric – New Patient Health Questionnaire

Patient's Name _____Date of Birth:_____Male___Female___

Form completed by: _____

Name/Contact info for primary care provider/pediatrician: _____

_____

Is your child working with any therapists or specialists? If yes, _____

_____

Please check appropriate box(es) (optional):

African American___ Hispanic___ Mediterranean___ Asian___

Native American___ Caucasian___ Northern European___ Other_____

Please list your main concerns about your child that you are hoping to address (include onset of the diagnosis, treatments tried/failed, triggers, what helps these problems, what makes them worse:

_____

_____

_____

_____

What are your goals for treatment?

_____

_____

_____

What therapies have you tried? When and for how long? Why did treatment stop?

1.		
2.		
3.		
4.		
5.		
6.		

Current Symptoms (check all that apply):

__Abdominal pain

__behavioral problems

__diarrhea

__constipation

__nutrition concerns

__sensory issues

__Allergies

__eczema

__frequent infections (eg. Ear)

__sleep issues

__attention issues

__developmental delay

__fatigue/energy issues

__other: _____

Past Medical History (check those that patient has had in the past or currently has):

__colic

__reflux

__eczema

__allergies

__asthma

__ear infections

__recurrent colds

__pneumonia/bronchitis

__thrush in mouth

__persistent diaper rash

__diarrhea

__constipation

__behavioral problems

__silver dental fillings

__other:_____

Medication History (please list medications or supplements that your child has taken IN THE PAST, including over-the-counter, prescription (especially antibiotics and steroids), and supplements)

Medication	Dates taken	For what reason?	Why stopped?	Effects/Side effects?

Surgical History (please list any surgeries or hospital admissions or ER visits that your child has had):

Surgery/Admission/ER Visit	Date	Reason

Medication History (please list all CURRENT medications, supplements, at home remedies, etc that your child takes):

Medication/Supplement	Dose	Frequency	For how long has he/she been taking?	Effects/Side effects?

Allergies/Sensitivities to medications or foods (list allergen and reaction):

Medications: _____

Foods: _____

Other (soaps, pollen, animals, cleaning products, dust, etc): _____

_____

Vaccination History (check all that apply):

__my child is up to date on vaccines

__my child is not up to date on vaccines

__my child was vaccinated on an alternative schedule

__I would like to talk about vaccinations further

Prenatal/Birth History:

Maternal age at delivery:_____	Fertility Treatments? __yes __no
Illnesses during pregnancy:	Medications during pregnancy (including antibiotics, vaccines, supplements, Rhogam, over the counter medications):
Stressors during pregnancy?	Dental fillings before or during pregnancy?
How many ultrasounds during pregnancy?	Other complications during pregnancy?

Deliver was __vaginal __c-section __induced __antibiotics during labor __forceps __vacuum	Gestation: __full term __pre-term (weeks:___)
Birth weight: _____Apgars___/___	Any other complications during pregnancy or delivery?
Post Partum	
Did child receive antibiotics after delivery? __no __yes why?_____)	Did child receive vaccines after delivery? __no __yes (which one(s)_____)
Did child receive any other medications after delivery? __no __yes (which ones?_____ _____)	
Did mother suffer from any postpartum mood problems (depression, anxiety, blues)? __no __yes (describe_____ _____)	

Developmental History:

Has the child's development been on track/normal? _____

Has the child's primary care provider or pediatrician expressed concern? _____

What age did you or they first notice a delay or concern?_____

Sleep History:

What time does your child fall asleep? _____Wake up for the day?_____

Waking over night? __no __yes (explain: _____)

Falls asleep easily? __yes __no (explain: _____)

Stays asleep through the night? __yes __no (explain: _____)

Environmental History:

Water: __city __well __purified (how: _____)

Flooring in home or daycare: ___carpet ___hardwood ___laminate ___other (_____)

Exposed to cigarette smoke? ___no ___yes (how often _____)

Exposed to mold? __no __yes (explain: _____)

Exposed to perfumes, lotions, scented cleaning products, room sprays, etc? __no __yes

Travel history: _____

Other exposures? _____

Bowel/Digestive History:

How often does your child have a bowel movement? _____

Describe your child's stool:

__well-formed	__floats	__mucousy
__hard, in small pieces	__painful	__bloody
__unusually foul-smelling	__incontinent	__watery
__fatty/greasy	__holds stool in	__undigested food particles
__long, thin, snake-like	__other (_____)	

Does your child complain of heartburn or reflux: __no __yes (describe treatments tried, and outcomes): _____

_____)

Does your child have gas or a bloated belly frequently? __no __yes (describe: _____
_____)

Does your child complain of abdominal pain? __no __yes (describe: _____
_____)

Diet History:

Was your child breastfed? __no __yes (for how long? _____)

Was your child formula-fed? __no __yes (begun at what age? _____ For how long? _____)

At what age were solid foods introduced? _____

What were some of his/her first foods _____

Do you consider your child a picky eater? __no __yes (describe: _____)

Does your child follow any special diet? __no __yes (describe: _____)

What does your child drink throughout the day? __water __juice __ pop __milk __other (_____)

Does your child eat refined sugars? __no __yes (what kind, how often _____

_____)

Does your child eat fast food? __no __yes (what kind, how often _____

_____)

Does your child eat foods with artificial flavors, colors, sweeteners, or preservatives? __no __yes (what kind, how often _____

_____)

Social History:

Does your child attend school? __no __yes

Does your child receive any special services at school? __no __yes (describe: _____

_____)

Who lives in the home with your child (include pets)? _____

_____

Any caregivers besides parents? _____

Please describe any stressful events in the child's life (birth of siblings, death of friends or family, divorce, remarriage, moving homes, changing schools, illnesses, etc): _____

_____

Do you feel that your child interacts normally with other children and adults? __yes __no (describe:_

_____)

Is there anything else you feel I should know about your child or your expectations?

_____
_____
_____
_____
_____