Initial History Questionnaire

PATIENT INFORMATION

Child's Name: ____ Date of Birth: ________________________

Home Address: ____

Home Phone: ______________________________ Cell Phone: _______________________________________

Form Completed By: ____ Date Completed: _____________________

HOUSEHOLD – Please list all occupants living in the child's home, their relationship to the child, and their age:

____

____

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BIRTH HISTORY – (Under 5 years)

Birth Weight: __________ lbs. __________ oz. Date of adoption *(if applicable)*: ________________

Was the baby born at: ☐ Early ☐ Term ☐ Late *If early*, how many weeks gestation? ____________

Type of Delivery: ☐ Vaginal ☐ Cesarean If cesarean, why? ____________________________

Were there any problems pertaining to the pregnancy or birth? ☐ Yes ☐ No (*If yes, please explain*)

____

During pregnancy, did the mother (*Check all that apply*): ☐ Smoke ☐ Drink Alcohol ☐ Use drugs or medications

GENERAL – (if applicable)

Do you consider your child to be in good health? ☐ Yes ☐ No (*Please explain*): ____________________________

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No (*Please explain*): ______________

Has your child had serious injuries or accidents? ☐ Yes ☐ No (*Please explain*): ____________________________

Has your child had any surgeries? ☐ Yes ☐ No (*Please explain*): ____

Has your child ever been hospitalized? ☐ Yes ☐ No (*Please explain*): ____________________________________

Is your child allergic to any medicine or drugs? ☐ Yes ☐ No (*Please explain*): ____________________________

Does your child take any medications on a regular basis? ☐ Yes ☐ No (*Please explain*): ______________________

DEVELOPMENT – (if applicable)

Name of school (or daycare): ____ Grade: _____________

How is his/her behavior in school? ____

Has he or she repeated a grade in school? ☐ Yes ☐ No If yes, what grade(s)? ______________________

How is he or she doing in academic subjects? ____

Is he or she in special or resource classes? ☐ Yes ☐ No

Are you concerned about your child's physical development? ☐ Yes ☐ No (*please explain)*

____

Are you concerned about your child's mental or emotional development? ☐ Yes ☐ No (*please explain)*

____

Are you concerned about your child's attention span? ☐ Yes ☐ No (*please explain)*

____

FAMILY HISTORY – Have any family members had the following:

Deafness	☐Yes	☐ No	Diabetes (before age 50)	☐Yes	☐ No
Allergies (food or environmental)	☐Yes	☐ No	Epilepsy or Convulsions	☐Yes	☐ No
Asthma	☐Yes	☐ No	Alcohol/Drug Abuse	☐Yes	☐ No
Tuberculosis	☐Yes	☐ No	Mental Illness/Depression	☐Yes	☐ No
Heart Disease or Sudden Death	☐Yes	☐ No	Mental Retardation	☐Yes	☐ No
High Blood Pressure (before age 50)	☐Yes	☐ No	Immune Problems, HIV/AIDS	☐Yes	☐ No
High Cholesterol	☐Yes	☐ No	Cancer	☐Yes	☐ No
Anemia/Bleeding Disorder	☐Yes	☐ No	Gastrointestinal Problems	☐Yes	☐ No
Liver/Kidney Disease	☐Yes	☐ No	Blood Disorders	☐Yes	☐ No

PAST MEDICAL HISTORY – Does your child have *or* has your child ever had:

Allergies (food, drug, or environmental)	☐ Yes	☐ No	Hypertension	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Muscle, Joint, or Bone Problems	☐ Yes	☐ No
Bedwetting	☐ Yes	☐ No	Seizures/Epilepsy	☐ Yes	☐ No
Bladder or Kidney Problems	☐ Yes	☐ No	Serious Injuries or Illnesses	☐ Yes	☐ No
Blood Disorders	☐ Yes	☐ No	Sickle Cell	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Skin Problems	☐ Yes	☐ No
Constipation	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Congenital Anomalies	☐ Yes	☐ No	Immune Problems, HIV/AIDS	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Vision or Eye Problems	☐ Yes	☐ No
Developmental or Behavior Disorders	☐ Yes	☐ No			

If Yes, please explain: ____

ADDITIONAL HISTORY

Does your child smoke cigarettes or use tobacco?	☐ Yes	☐ No
Are firearms present in the home that the child resides?	☐ Yes	☐ No
Are there working smoke/carbon monoxide detectors in the home?	☐ Yes	☐ No
Are there pets in the home?	☐ Yes	☐ No