Chesapeake Holistic Health

PEDIATRIC HEALTH HISTORY

Child's Name: _____ DOB: _____ Age: _____ Gender: _____

Height: _____ Weight: _____ Blood Type: _____

Mom's Name: _____ Dad's Name: _____

Day Phone: _____ Evening Phone: _____ Email: _____

Address: _____

Referred by: _____

Siblings/Ages: _____

Parents' Occupations: _____

School/Daycare: _____

Do the parents smoke? ☐ Yes ☐ No ☐ In the past? When? _____

Pediatrician: _____ Phone Number: _____

Other Healthcare Practitioners/Specialists _____

☐ Vaginal Birth ☐ C-Section Birth ☐ Epidural ☐ Vacuum Extraction or Forceps ☐ Complications _____

☐ Breast Fed ☐ Bottle Fed Age solids started: _____ Dairy Products included in diet? ☐ Yes ☐ No

Food Sensitivities: _____

Vaccinated? ☐ Yes ☐ No Developmental Delays: _____

Childhood Diseases: _____

Surgeries: _____

Other injuries/broken bones: _____

FAMILY HEALTH HISTORY (Current and Historical)

Mom's Health: _____

_____

_____

Dad's Health: _____

_____

_____

List all current and historic medications (i.e. antibiotics, Ritalin, aspirin, etc.) _____

_____

Vitamin and Mineral Supplementation ***(please bring to intake)***: _____

_____

Reason for Visit: _____

Date of onset:_____ ☐ Sudden ☐ Gradual Previous history of same or similar problems:_____

What makes it better: _____ What makes it worse: _____

Other helpful information: _____

_____

_____

DAILY EATING HABITS (List Typical Food/Beverage and time):

Breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

_____

Snacks: _____

_____

CHILDHOOD SYMPTOMS:

Rate each of the following symptoms based upon your child's current health profile. **(0=never or almost never; 1=occasionally; 2=frequently)**

General Symptoms:

____ Fevers	____ Cold Feet	____ Day Dreams	____ Cravings
____ High Blood Sugar	____ Hives	____ Dizziness or Shaky	____ Heavy Sleep
____ Headaches	____ Chills	____ Rash	____ Cold Hands
____ Sleepy During Day	____ Low Blood Sugar	____ Fainting	____ Dry Skin
____ Sensitive Abdomen	____ Wake Up, Can't Fall Back to Sleep	____ Bleed/Bruise Easily -Where:	____ Eczema/Psoriasis

Digestive Tract/Urinary:

____ Poor Appetite	____ Bedwetting	____ Belching (excessive)	____ Passing Gas
____ Vomiting	____ Heavy Appetite	____ Itching of Anus/Genitals	____ Nausea
____ Constipation	____ Diarrhea	____ Frequent Urination	____ Bloating
____ Refusal to Eat	____ Frequency of Bowel Movements	____ Strong Thirst (hot/cold)	

Ears/Eyes/Lungs/Nose:

____ Cough	____ Ear Infections	____ Sneezing	____ Lung Mucus (color):
____ Bronchitis (history of)	____ Drainage from Ears	____ Bags under Eyes	____ Watery/Itchy Eyes
____ Sinus Mucus (color):	____ Asthma (age of onset):	____ Reddening of Ears	____ Hearing Loss
____ "Allergy Salute" (rubs, itches, wipes nose)	____ Pneumonia (history of)	____ Frequent Pulling on Ears	____ Itchy Ears
____ Darks Circles Under Eyes	____ Wheezing	____ Reduced Lung Capacity	____ Earaches

Allergies: _____

_____

_____

Mind/Emotions: _____

_____

_____