Pediatric Health History Form

To ensure your child receives a complete and thorough evaluation, please provide us with the following information.

Child's Name: _____ Date of Birth: _____

Address: _____

Parent/Guardian: _____ Phone Number: _____

Emergency Contact: _____ Phone Number: _____

School: _____ Grade: _____

Please explain why the child is being evaluated:

_____

_____

Has the child been treated for the same condition in the past? If "YES," did it help?

YES NO _____

Has the child received therapy services through any of the following agencies? If "YES," please explain.

Early Intervention/Birth-to-Three YES NO _____

Hospital YES NO _____

School YES NO _____

Other Therapy Agency YES NO _____

Please circle YES or NO for the following questions. For "YES" answers, please explain.

Were there any complications during the pregnancy? YES NO _____

_____

Was the child born more than two weeks early or late? YES NO _____

Were there any complications during the delivery? YES NO _____

_____

Did the child remain in the hospital longer than two days following delivery? YES NO _____

_____

_____

_____

Please list any surgeries and hospitalizations including the approximate date and reason:

Please describe any significant injuries for which the child has been treated (including fractures, dislocations, and sprains) with the approximate date of injury and treatment received:

Has the child ever been diagnosed as having any of the following? For "YES" answers, please explain.

ADD/ADHD	YES	NO	Cancer	YES	NO
Anemia	YES	NO	Cerebral palsy	YES	NO
Anxiety	YES	NO	Constipation	YES	NO
Arthritis	YES	NO	Depression	YES	NO
Asthma/breathing problems	YES	NO	Diabetes	YES	NO
Autism	YES	NO	Epilepsy/seizures	YES	NO
Headaches/migraines	YES	NO	Muscular dystrophy	YES	NO
Hearing impairment	YES	NO	Reflux	YES	NO
Heart problems	YES	NO	Spina bifida	YES	NO
High blood pressure	YES	NO	Stroke/brain bleed	YES	NO
Hypertonia/high tone	YES	NO	Thyroid problems	YES	NO
Hypotonia/low tone	YES	NO	Vision impairment	YES	NO
Kidney disease	YES	NO	Other	YES	NO

Has anyone in the child's immediate family (parents, brothers, sisters) been treated for the following?

Anemia	YES	NO	Epilepsy/seizures	YES	NO
Anxiety	YES	NO	Headaches/migraines	YES	NO
Arthritis	YES	NO	Heart disease	YES	NO
Cancer	YES	NO	High blood pressure	YES	NO
Depression	YES	NO	Kidney disease	YES	NO
Diabetes	YES	NO	Stroke	YES	NO

Please list any prescription medications your child is currently taking including dosage:

_____

_____

_____

Please list any over-the-counter medications, vitamins, or herbal supplements/essential oils your child frequently takes or uses:

_____

_____

_____

Does your child have any allergies? If "YES," please list. YES NO _____

_____

Does your child drink caffeinated beverages? How many per day? YES NO _____

Has your child seen any of the following providers in the last six months? If "YES," please provide name and phone number.

Audiologist	YES	NO	Chiropractor	YES	NO
Cardiologist	YES	NO	Developmental clinic	YES	NO
Immunologist	YES	NO	Pediatrician/medical doctor	YES	NO
Nephrologist	YES	NO	Psychologist/psychiatrist	YES	NO
Neurologist	YES	NO	Pulmonologist	YES	NO
Ophthalmologist	YES	NO	Rheumatologist	YES	NO
Orthopedist	YES	NO	Other	YES	NO

_____

_____

_____

Is your child able to perform the following skills? If so, at what age did they begin?

Sit without support	YES	NO	_____	Roll	YES	NO	_____
Crawl	YES	NO	_____	Stand	YES	NO	_____
Walk	YES	NO	_____	Run	YES	NO	_____
Put words together	YES	NO	_____	Read	YES	NO	_____
Feed him/herself	YES	NO	_____	Color	YES	NO	_____
Get dressed	YES	NO	_____	Cut	YES	NO	_____

Does your child have any special equipment at home (alternative form of communication, adaptive seating, stander, walker, stroller, orthotics/braces, etc.)? Please list.

_____

_____

_____

What is your child having difficulty with at home, in the community, and at school?

_____

_____

_____

Have you recently noticed your child experiencing or reporting any of the following?

Change in mood/behavior	YES	NO	Nausea/vomiting	YES	NO
Decline in grades	YES	NO	Numbness or tingling	YES	NO
Dizziness/lightheadedness	YES	NO	Tremors	YES	NO
Fatigue	YES	NO	Weakness	YES	NO
Fever/chills/sweats	YES	NO	Weight loss/gain	YES	NO

Loss of interest or pleasure in activities YES NO

Other new, unusual, or atypical symptoms YES NO _____

Person completing this form: _____ Date: _____