Pediatric Patient Profile

Last Name: _____ First Name: _____ MI: ____

Nickname: _____ Date of Birth: _____ Age: _____ Sex: _____

Present Health Concerns
Please list your child's health concerns in order of priority, including date of onset and severity of symptoms.

1. _____
2. _____
3. _____
4. _____
5. _____

What do you believe is causing your child's most important health concerns? _____

_____

What goals do you have for your child's visit today? _____

_____

Healthcare Practitioners: Please list your child's current medical practitioners with their contact information.

	Practitioner's Name	Office Name	City	Phone
Pediatrician				
Specialist				
Specialist				
Therapist				
Pharmacy				

Medications: Please list any prescription drugs, over-the-counter medications and supplements (vitamins, minerals, nutrients, herbs, homeopathic remedies, etc.) you child is currently taking.

Medication/Supplement	Reason	Date began	Dose

Allergies: Please list and describe any severe or life-threatening allergies (medications, stings, foods, etc.):

_____ **(OVER)**

Past Medical History: Please list the date of or age at each event and describe:

Serious Illnesses and Injuries: _____

Surgeries: _____

Hospitalizations: _____

Date of last physical: _____ Date of last blood tests: _____

Childhood Illnesses: Your child's health is: ❍ Good ❍ Fair ❍ Poor

- ❍ Chicken Pox
- ❍ Diphtheria
- ❍ Ear Infections
- ❍ German Measles (Rubella)
- ❍ Measles
- ❍ Mononucleosis (Mono)
- ❍ Mumps
- ❍ Pertussis (whooping cough)
- ❍ Pneumonia
- ❍ Polio
- ❍ Rheumatic Fever
- ❍ Tonsillitis
- ❍ Scarlet Fever
- ❍ Strep Throat (recurrent)
- ❍ Positive TB test
- ❍ Other: _____

Immunizations: Indicate which immunizations have been given to your child and any adverse reactions.

❍ All immunizations up to date ❍ Delayed schedule ❍ Refused immunizations

- ❍ DTP *or* ❍ DTaP _____
- ❍ MMR _____
- ❍ Polio (❍ IPV *or* ❍ OPV) _____
- ❍ Hib _____
- ❍ Pneumococcus (PCV) _____
- ❍ Hep B _____
- ❍ Varicella _____
- ❍ Other _____

Pregnancy History: Birth Mother: # of pregnancies: _____ # of children: _____ Age at delivery: _____

Please check any factors during pregnancy. Health during pregnancy: ❍ Good ❍ Fair ❍ Poor

- ❍ Alcohol Consumption
- ❍ Bleeding
- ❍ High Blood Pressure
- ❍ Stress
- ❍ Nausea
- ❍ Recreational Drugs
- ❍ Smoking
- ❍ Medications: _____
- ❍ Toxemia
- ❍ Trauma/Injury
- ❍ X-Ray

Other health problems or complications during pregnancy: _____

Birth History:

Term: ❍ Early ____ weeks ❍ Full Term ❍ Late ____ weeks Length of labor: _____hours

Place of Birth: ❍ Hospital ❍ Birth Center ❍ Home ❍ Other: _____

Birth Medications (if any): _____

Complications: _____

Newborn: Weight at birth: _____ lbs _____ oz Home from hospital in _____ days

- ❍ Jaundice
- ❍ Cyanosis
- ❍ Infection
- ❍ Fever
- ❍ Seizures
- ❍ Anemia

Other important conditions: _____

Feeding: ❍ Breast Fed_____months ❍ Formula Fed_____ months Type of formula _____

Developmental Milestones: Please indicate your child's age at each milestone:

Sit up _____ months

Crawl _____ months

Walk _____ months

First Tooth _____ months

First Word _____ months

First Sentence _____ months

Toilet Trained _____ months

Additional comments about social, cognitive, or physical development: _____

_____ **(OVER)**

Personal and Family Medical History:
Please check the ☑ box next to each condition that applies to your child or his/her *biological* family members.

Key: P=Paternal; M=Maternal; GF=Grandfather; GM=Grandmother

				Grandparents				Siblings				
	Child	Mom	Dad	PGM	PGF	MGM	MGF					
Current Age or Age at Death												
Alcohol/Drug Abuse												
Allergies or Hay Fever												
Alzheimer's or Dementia												
Anemia												
Anxiety / Panic Attacks												
Arthritis / Joint Disease												
Asthma												
Autoimmune Disease												
Bleeding Disorder												
Cancer (**what type?**)												
Celiac Disease												
Crohns Dis./ Ulcerative Colitis												
COPD / Emphysema												
Depression / Suicide attempt												
Diabetes												
Eczema												
Epilepsy or Seizures												
Glaucoma												
Gall Bladder Disease												
Migraines / Headaches												
Heart Attack												
Heart Disease												
High Blood Pressure												
High Cholesterol												
HIV / AIDS												
Kidney Disease												
Liver Disease / Hepatitis												
Macular Degeneration												
Osteoporosis												
Schizophrenia												
Stroke												
Thyroid disorder												
Other:												
Other:												

Social History

Parents: ❍ Biological ❍ Adoptive ❍ Foster ❍ Step-parent(s)

Parents' Marital status: ❍ Single ❍ Married ❍ Divorced ❍ Re-married ❍ Widowed ❍ Significant Other

Mother's Occupation:_____ Full *or* Part Time Father's Occupation:_____ Full *or* Part Time

Siblings: ❍ *Yes* ❍ *No* Please list their age(s) _____

Household: ❍ Parent(s) ❍ Sibling(s) ❍ Grandparent(s) ❍ Pet(s) _____
❍ Other _____

Pre-School/Daycare/School: _____ Hours per day: ____ Days per week: ____

Personality and Habits:

How does your child react to stressful events? _____

What are your child's primary sources of stress? _____

How much does stress impact your child's life? _____ Hours of play per day? _____

Favorite activities? _____

Does your child:

Exercise regularly? ❍ Yes ❍ No What kind? _____

Sleep soundly and wake rested? ❍ Yes ❍ No If no, why? _____

Sleep: _____ hours per night Naps: _____ hours per day

Play well with others? ❍ Yes ❍ No If no, why? _____

Enjoy time alone? ❍ Yes ❍ No If no, why? _____

Have sensory sensitivities? ❍ Yes ❍ No What kind? _____

Have strong fears or phobias? ❍ Yes ❍ No What kind? _____

Have rituals/repetitive behaviors? ❍ Yes ❍ No What kind? _____

Diet:

Age Solid Foods Begun: _____ months First Foods: _____

Age of Introduction for: Dairy (cow's milk) _____ months Wheat: _____ months

Does your child have any dietary restrictions? _____

Your child's favorite foods? _____

Foods your child refuses? _____

How is your child's appetite? _____ Thirst? _____

Please describe a typical day below:

Breakfast *Time:*_____	Lunch *Time:*_____	Dinner *Time:*_____	Snacks *Times:*_____

Water: _____ oz. per day Other beverages: _____

What else would you like us to know about your child?