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Child Health History Form

Name _____ Date _____
 Age _____ M F Date of Birth (M/D/Y) _____/_____/_____
 Care Card Number _____
 Home Address _____
 City _____ Province _____ Postal Code _____
 Phone (H) _____ Email: _____
 How did you hear of our clinic? If referred, please indicate by whom _____

Parent/ Guardian Information:

Mother's Name _____ Work Phone: _____
 Occupation: _____ Cell # _____
 Father's Name _____ Work Phone: _____
 Occupation: _____ Cell # _____

Names of Healthcare Providers:

Medical Doctor(s) _____
 Pediatrician _____ Other _____

Age at Autism or ADHD Diagnosis? _____ Symptoms became apparent at what age? _____
 Any additional diagnosis given? List: _____

Developmental History

Sat at _____ (months) Crawled at _____ Walked at _____ Talked at _____
 Regression of speech? ___No ___Yes, at what age? _____
 Was child breastfed? ___No ___Yes, if so how long? _____
 Formula used? ___No ___Yes, if so introduced at what age? _____
 Colic/irritability as baby? ___No ___Yes

Health Issues:

Does your child suffer with other health problems: ___ Allergies ___ Asthma ___ Kidney disease
 ___ Lung Disease ___ Diabetes ___ Thyroid Disease ___ Seizures ___ Heart Disease
 ___ Repeated Infections ___ Fatigue/lethargy ___ Other- explain _____

Skin: Eczema Recurrent rashes Warts Cold sores Dry skin/bumps Itching
 Red cheeks +/- or ears Dark circles under eyes White tongue Hives

Behavior

Biting Hitting Head banging Aggression
 Teeth grinding Hyperactivity Sideways glancing Anxiety
 Cries easily Mood swings Irritability Pushes on eyes/squints
 Spinning Hand movements Tantrums Difficulty with transitions
 Obsessive interests Excessive jumping Puts hands in pants Unresponsive to name
 Eye rolling Inappropriate laughing/giggling Mouthing objects

Sensitivity to: Sound Touch Smells Lights Under-sensitivity

Speech: Non-verbal Single words Sentences Conversational language

Cognition: Limited understanding/awareness Follows commands Normal understanding for age

Play skills: Appropriate Repetitive Parallel play Pretend/imaginative play

Interaction with others: Frequent Occasional/Some Rare None

Motor Skills Delayed gross motor (eg. climbing, running) Delayed fine motor (eg. printing)
 Uncoordinated/clumsy Toe- walking

Sleep Normal Difficulty falling asleep Frequent waking
 Wakes crying/screaming Sweats during sleep Early waking

Digestive Health:

Loose stools or diarrhea ___ Yes ___ No Constipation ___ Yes ___ No
Excessive gas or bloating ___ Yes ___ No Bad breath ___ Yes ___ No
Undigested food in stools ___ Yes ___ No Mucous or blood in stools ___ Yes ___ No
Does your child produce formed stools ___ Yes ___ No Stomach aches/pain ___ Yes ___ No
Bowel movements: # per day _____ Pushes/lays on stomach ___ Yes ___ No
Is your child toilet trained ___ Yes ___ No Cloudy urine or sandy stool ___ Yes ___ No
Color of bowel movements _____

Antibiotic History:

How many courses of antibiotics has your child received: ___ 0-5 ___ 5-10 ___ 10-15 ___ 15-20 ___ 20+
Reason for antibiotic use: ___ Ear Infections ___ Bronchitis/Pneumonia ___ Sinus Infection
___ Intestinal Infection ___ Other (please explain) _____
At what age were the first antibiotics given? _____

Immune: How many colds/flu/ infections per year? _____

Difficulty recovering from illness? ___ Yes ___ No
History of Strep infection? ___ Yes ___ No
History of fungal or yeast infections? ___ Yes ___ No
History of high fevers? ___ Yes ___ No
Chronic nasal congestion or discharge? ___ Yes ___ No
Mouth breathing? ___ Yes ___ No
Hayfever? ___ Yes ___ No
Has child had any allergy testing done? ___ No ___ Yes- list type _____
Any anaphylactic allergies? ___ No ___ Yes- list _____
Any parents or siblings with anaphylactic allergies? ___ No ___ Yes- list _____

Home Environment:

Has child ever lived in a home greater than 50 years old? ___ No ___ Yes
Has child lived in an old house undergoing renovations? ___ No ___ Yes
Has your child had any known exposure to lead paint or pipes ___ No ___ Yes
Has there been exposure to molds ___ No ___ Yes, explain _____
Is child exposed to pesticides or live near farms ___ No ___ Yes
Please list pets/animals in child`s environment _____
Is child exposed to cigarette smoke? ___ Yes ___ No
Type of drinking water used _____

Mother's Pregnancy and Labor:

High Blood Pressure Seizures Diabetes Viral Infections (e.g. flu)
 Infections treated by antibiotics-if yes for what condition _____
Rh status (+ or -) Blood Type _____ Rhogam shot given during pregnancy? No Yes
Any vaccinations during pregnancy No Yes, which ones _____
Any vaccinations while breastfeeding No Yes, which ones _____
Was your child delivered _____ vaginal or C-section Forceps or suction used _____
Was birth premature No Yes, at how many weeks _____ Is child a twin No Yes
Any birth trauma? Describe _____
Complications/infections of baby? _____
Was epidural used? Yes No Was Pitocin/Oxytocin given during labor? Yes No
Did Mom have silver fillings present during pregnancy? No Yes. If yes, how many? _____
Did Mom have any dental work done during pregnancy No Yes
Did mom have any silver fillings removed/fixed while breastfeeding child No Yes
Did mom eat fish/seafood during pregnancy? If yes give frequency _____ X per week or month
Does child have amalgam/silver fillings? No Yes Cavities? No Yes

Vaccinations:

Has child received all recommended vaccinations for their age? Yes No
If no, has child received any of the following (check) : DPT HIB Hep B Polio
 MMR Pneumococcal Varicella Meningococcal Flu shot H1N1
Did your child receive any vaccinations when they were sick? No Yes
Did your child have any vaccine reactions: Fever (circle)- Mild or High Rash Seizures
 Excessive fatigue Vomiting Swelling at injection site Behavior change
 Irritability/screaming Loss of eye contact/speech

Medication Usage:

List any drugs child is currently taking & reason for medication: _____

Has child ever had steroid or anti-fungal drugs? No Yes
Hospitalizations No Yes, reason _____
Any significant injuries or trauma? List _____

Supplements:

List all supplements (vitamins, herbs, homeopathy) child is taking, **including brand and dosage:**

Diet:

Has child been on a Gluten/Casein Free Diet? No Yes, if so how long? _____
Was any benefit observed from GF/CF diet? No Yes Not sure
Have any other special diets been tried? Describe _____
Is child a picky eater? Yes No Does your child use a bottle or soother? Yes No
Please describe your child's typical daily diet:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Drinks: _____
Protein/meat foods eaten _____
Cravings/ favorite foods _____
Appetite: Good Average Poor

Height _____ (cm/in) **Weight** _____ (lb/ kg)

Family History: Check if a blood relative had any of the following and indicate relationship to child.

<input type="checkbox"/> Addiction _____	<input type="checkbox"/> Genetic Disorders _____
<input type="checkbox"/> ADD/ADHD _____	<input type="checkbox"/> Heart Disease _____
<input type="checkbox"/> Allergies _____	<input type="checkbox"/> High Blood Pressure _____
<input type="checkbox"/> Anxiety _____	<input type="checkbox"/> Kidney Disease _____
<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Learning disability _____
<input type="checkbox"/> Autoimmune disease _____	<input type="checkbox"/> Bipolar Disorder _____
<input type="checkbox"/> Autism _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Blood disorders _____	<input type="checkbox"/> Migraines _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> OCD _____
<input type="checkbox"/> Celiac disease _____	<input type="checkbox"/> Multiple Sclerosis _____
<input type="checkbox"/> Crohn's/ulcerative colitis _____	<input type="checkbox"/> Schizophrenia _____
<input type="checkbox"/> Depression _____	<input type="checkbox"/> Syphilis _____
<input type="checkbox"/> Epilepsy/Seizures _____	<input type="checkbox"/> Tuberculosis _____

What are your goals in seeking treatment?

1. _____
2. _____
3. _____

Please bring in any current supplements to the office for your first visit, as well as any blood tests or other lab results received in the last 6 months.

Thank you. I look forward to working together to help your child.