CHILDREN'S MEDICAL HISTORY

Patient Name:					
	(Last)		*(First)*		*(MI)*

Date of Birth: _____ Age: _____ Gender: _____

REASON FOR TODAY'S VISIT: _____

Referred by: _____

Parents Email Address: _____

MOTHER'S NAME:_____

Phone Number: (Primary) _____ (Secondary)_____

Address:_____

FATHER'S NAME _____

Phone Number: (Primary) _____ (Secondary)_____

Address: _____

Family History		Age	General Health Condition
Mother:			
Father:			
Sibling:			
Sibling:			
Sibling:			
Sibling:			

Birth and Development

1. Were there any complications during pregnancy? *Explain:*
2. Were there any complications during labor and/or delivery? If yes, explain:
3. Weeks gestation when born:

   Birth weight: condition:

4. At what age did he/she first:

Eat solid food_____	Talk_____
Sit up_____	Talk in sentences _____
Crawl _____	First tooth_____
Stand up _____	Toilet trained_____
Walk _____	

MEDICAL/ NUTRITIONAL HISTORY

Does he/she have a history of: (if yes, please explain)

Colic _____
Excessive fussiness _____
Jaundice_____
Excessive spitting up _____
Vomiting _____
Allergies _____
Food allergies _____
Diarrhea _____
Decreased growth _____
Surgery _____
Trauma/ accidents _____
Major illness _____
Breast feeding _____
Formula feeding _____
Special diet _____

Please list any nutritional supplements, medications and/or medical treatments that your child is currently taking. Please include dosages and any non-traditional medical treatments.

_____
_____

Do you have any other concerns or information about your child's health?

_____
_____

Print Patient Name	DOB
Print Authorized/Legal Representative Name	Date
Authorized/ Legal Representative Signature	Relationship to Patient