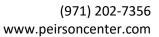




Pediatric Health History Form

Name:	A	ge Date of	Birth	Gender:
Parent(s) Name(s):				
Address:				
Phone Number:				
Parent(s) Occupation(s):				
Emergency Contact Name:		Phone N	umber:	
What are your biggest concerns of	or symptoms you wou	ıld like to address?	?	
Goals of Treatment:				
When, where and by who did you	ı last receive medical	health care?		
Do you have a Primary Care Physi	ician? 🗖 Y 🗖 N	If yes, who		
Diagnosis: Down syndrome	☐ Autism ☐ Al	DD/ADHD 🚨 Otl	her	
Medications - List all drugs, vitam Drug/Herb/Supplement	nins, herbs being take Dosage	•		•
Drug/Herb/Supplement	_	. ,		
	<u> </u>	_		
Does your child take acetaminoph		-	If so, how oft	en?
Allergies to medications or other Allergy:	substances? UYUI Type of reaction			
Vaccinations: ☐ On schedule ☐ M	/odified/delayed sche	edule	□No vaccina	ations
Hospitalizations/Surgeries				
Type of Illness or operation/proce	edure Date		Hospital	





Health History

		Reflux and/or consule Excess low back particle Plantar fasciitis (fo	ain
# of weeks gestation:	# of o	ther children	
Medications/Supplemen	ts taken:		
Vaginal delivery	☐ Heart defect☐ Respiratory issues☐ NICU	☐ Formula	
Birth complications: Feeding:	ow long?	□Pumped, how long? other)	(list all that apply
Growth: Current weight:	Cl	othing size:	
		, o o ci - o .	
Any periods of little or no	o growth? 🔲 Y 🔲 N If s	so, when?	
☐ Mental Illness ☐		e □ IBS/Crohn's □ Arth er □ Autoimmune □ Alle	
		Bloated belly Tummy aches/cramping Poor appetite	
Bowel movement freque	ncy:	Stool color:	
Lunch Dinner Snacks			
Beverages			
			

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		□ Did not pass hearing tests□ Excess ear wax□ Enlarged tonsils□ Enlarged adenoids	☐ Frequent mucous in throat☐ Chronic cough☐ Chokes on thin liquids☐ History of strep throat☐
Number of rounds of	antibiotics since birth:		
Respiratory: • Pneumonia	Bronchitis 🖵 RSV 🖵	Croup □ Asthma □ Ot	her
How much time outsi	hysical activity does your child gode in nature does your child goreen time per day?	get each day?	
	☐ Unusual positions ☐ Sno ☐ Mouth breathes ☐ Ext	ores	
Date of last sleep stud	dy:Re	sults:	
# of hours of sleep pe	r night:# waki	ngs during the night:	
# of hours per nap:	# of na	ps:	
Gross Motor Skills:		point) □ Pulls to standing	Cruises on furnitureRides Bike
Teeth ☐ Delayed eruption, ☐ Crowded	/loss ☐ Prognathism (unde	erbite)	expansion
•	Orange skin	nair e, peeling finger and/or toenail	s
		Good receptive language Receptive language emerging	
Therapies used Early Intervention		I NACD ☐ MNRI	



Tell us about your experience with medical providers so far.