9820 E Burnside St.
Portland, OR 97216

PEIRSON CENTER FOR CHILDREN

(971) 202-7356
www.peirsoncenter.com

# Pediatric Health History Form

Name: _____ Age_____ Date of Birth_____Gender:_____

Parent(s) Name(s):_____

Address: _____

Phone Number: _____ E-mail Address:_____

Occupation: _____

Emergency Contact Name: _____ Phone Number: _____

What are your biggest concerns or symptoms you would like to address? _____

_____

Goals of Treatment: _____

_____

When, where and by who did you last receive medical health care? _____

Do you have a Primary Care Physician? ❑ Y ❑ N If yes, who_____

Diagnosis: ❑ Down syndrome ❑ Autism ❑ ADD/ADHD ❑ Other_____

**Medications** - List all drugs, vitamins, herbs being taken at present.

| Drug/Herb/Supplement | Dosage | Frequency | Duration |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Does your child take acetaminophen (Tylenol, Paracetamol)? ❑ Y ❑ N If so, how often? _____

Allergies to medications or other substances? ❑ Y ❑ N

| Allergy: | Type of reaction: |
|---|---|
| | |
| | |

**Vaccinations:**

❑ On schedule ❑Modified/delayed schedule ❑No vaccinations

**Hospitalizations/Surgeries**

| Type of Illness or operation/procedure | Date | Hospital |
|---|---|---|
| | | |
| | | |
| | | |

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## Health History

**Pregnancy:**

- ❑ History of miscarriage
- ❑ Excessive nausea
- ❑ Hypothyroidism
- ❑ Low iron
- ❑ Excess fatigue
- ❑ Stress
- ❑ Reflux and/or constipation
- ❑ Excess low back pain
- ❑ Plantar fasciitis (foot pain)

# of weeks gestation:_____ # of other children_____

Supplements taken:_____

**Birth:**

- ❑ C-section
- ❑ Vaginal delivery
- ❑ Jaundice
- ❑ Heart defect
- ❑ Respiratory issues
- ❑ NICU
- ❑ Breastfed
- ❑ Formula
- ❑ NG tube

Birth weight: _____

Birth complications: _____

**Growth:**

Current weight: _____ Clothing size: _____

Current height: _____ Shoe size: _____

Any periods of little or no growth? ❑ Y ❑ N If so, when? _____

**Digestion:**

- ❑ Hard stools/pellets
- ❑ Excess straining
- ❑ Excess odor
- ❑ Soft/firm stools
- ❑ Diarrhea
- ❑ Undigested food
- ❑ Bloated belly
- ❑ Tummy aches/cramping
- ❑ Poor appetite
- ❑ Excess passing gas
- ❑ Excess belching
- ❑ Overeats

Bowel movement frequency: _____ Stool color: _____

**Ear Nose Throat:**

- ❑ Ear infections
- ❑ Ear fluid
- ❑ Tonsil removal
- ❑ Adenoid removal
- ❑ Ear tubes/grommets
- ❑ Passed hearing tests
- ❑ Chronic nasal congestion
- ❑ Sinus infections
- ❑ 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 ❑ Croup ❑ Asthma ❑ Other _____

How many hours of exercise does your child get per day? _____

How many hours of TV per day? _____

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**Sleep:**

❑ Restless sleep ❑ Unusual positions ❑ Snores ❑ Difficulty falling asleep
❑ Gasps ❑ Mouth breathes ❑ Extends neck ❑ Night terrors

Date of last sleep study:_____ Results:_____

# of hours of sleep per night:_____ # wakings during the night:_____

# of hours per nap:_____ # of naps:_____

**Energy:**

❑ Excellent ❑ Good off and on ❑ Poor ❑ Hyperactive

**Gross Motor Skills:**

❑ Rolls over ❑ Sits up unassisted ❑ Crawls (4-point) ❑ Pulls to standing ❑ Cruises on furniture
❑ Walks ❑ Runs ❑ Kicks ball ❑ Jumps ❑ Rides Bike

**Teeth**

❑ Delayed eruption/loss ❑ Prognathism (underbite) ❑ Cavities
❑ Crowded ❑ Grinds teeth ❑ Undergone palate expansion

**Skin/Hair/Nails**

❑ Dry skin ❑ Orange skin ❑ Thin hair
❑ Mottled skin ❑ Rashes/eczema ❑ Brittle, peeling finger and/or toenails

**Cognition/Speech**

❑ Verbal ❑ Speech is developing ❑ Good receptive language
❑ Non-verbal ❑ Appropriate play for age ❑ Receptive language emerging

**Diet**

Breakfast_____
Lunch _____
Dinner_____
Snacks_____
Beverages_____
Breastfed? _❑Pumped ❑Yes, How long? ❑Not able to_ _____
Aversions_____

**Therapies used**

❑ Early Intervention ❑ Anat Baniel ❑ NACD ❑ MNRI
❑ IAHP ❑ Feldenkreis ❑ ICAN ❑ Other_____

**Family History**

❑ Thyroid Disease ❑ Heart Disease ❑ Stroke ❑ IBS/Crohns ❑ Arthritis
❑ Mental Illness ❑ Diabetes ❑ Cancer ❑ Autoimmune ❑ Hay Fever

**Tell us about your experience with medical providers so far (please use the back side of this page to write your response).**