

### Pediatric Health History Form

Name: \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender: \_\_\_\_\_

Parent(s) Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Parent(s) Occupation(s): \_\_\_\_\_

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. Use last page if more space is needed.

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
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Health History**

**Pregnancy:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> History of miscarriage | <input type="checkbox"/> Low iron       | <input type="checkbox"/> Reflux and/or constipation    |
| <input type="checkbox"/> Excessive nausea       | <input type="checkbox"/> Excess fatigue | <input type="checkbox"/> Excess low back pain          |
| <input type="checkbox"/> Hypothyroidism         | <input type="checkbox"/> Stress         | <input type="checkbox"/> Plantar fasciitis (foot pain) |

# of weeks gestation: \_\_\_\_\_ # of other children \_\_\_\_\_

Medications/Supplements taken: \_\_\_\_\_

**Birth:**

- |   |   |                                    |
|---|---|------------------------------------|
| <input type="checkbox"/> C-section        | <input type="checkbox"/> Heart defect       | <input type="checkbox"/> Breastfed |
| <input type="checkbox"/> Vaginal delivery | <input type="checkbox"/> Respiratory issues | <input type="checkbox"/> Formula   |
| <input type="checkbox"/> Jaundice         | <input type="checkbox"/> NICU               | <input type="checkbox"/> NG tube   |

Birth weight: \_\_\_\_\_

Birth complications: \_\_\_\_\_

Feeding:  Breastfed, how long? \_\_\_\_\_  Pumped, how long? \_\_\_\_\_

Formula fed, type of formula? (cow's milk, soy, other) \_\_\_\_\_ (list all that apply)

**Growth:**

Current weight: \_\_\_\_\_ Clothing size: \_\_\_\_\_

Current height: \_\_\_\_\_ Shoe size: \_\_\_\_\_

Any periods of little or no growth?  Y  N If so, when? \_\_\_\_\_

**Family History**

- |  |  |                                 |                                      |  |
|--|--|---------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> IBS/Crohn's | <input type="checkbox"/> Arthritis               |
| <input type="checkbox"/> Mental Illness  | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Cancer | <input type="checkbox"/> Autoimmune  | <input type="checkbox"/> Allergies/Eczema/Asthma |

**Digestion:**

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Hard stools/pellets | <input type="checkbox"/> Soft/firm stools | <input type="checkbox"/> Bloating belly       | <input type="checkbox"/> Excess passing gas |
| <input type="checkbox"/> Excess straining    | <input type="checkbox"/> Diarrhea         | <input type="checkbox"/> Tummy aches/cramping | <input type="checkbox"/> Excess belching    |
| <input type="checkbox"/> Excess odor         | <input type="checkbox"/> Undigested food  | <input type="checkbox"/> Poor appetite        | <input type="checkbox"/> Overeats           |

Bowel movement frequency: \_\_\_\_\_ Stool color: \_\_\_\_\_

**Diet**

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

Beverages \_\_\_\_\_

Aversions \_\_\_\_\_

**Ear Nose Throat:**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Ear infections  | <input type="checkbox"/> Ear tubes/grommets       | <input type="checkbox"/> Did not pass hearing tests | <input type="checkbox"/> Frequent mucous in throat |
| <input type="checkbox"/> Ear fluid       | <input type="checkbox"/> Passed hearing tests     | <input type="checkbox"/> Excess ear wax             | <input type="checkbox"/> Chronic cough             |
| <input type="checkbox"/> Tonsil removal  | <input type="checkbox"/> Chronic nasal congestion | <input type="checkbox"/> Enlarged tonsils           | <input type="checkbox"/> Chokes on thin liquids    |
| <input type="checkbox"/> Adenoid removal | <input type="checkbox"/> Sinus infections         | <input type="checkbox"/> Enlarged adenoids          | <input type="checkbox"/> History of strep throat   |

Number of rounds of antibiotics since birth: \_\_\_\_\_

**Respiratory:**

- Pneumonia     Bronchitis     RSV     Croup     Asthma     Other \_\_\_\_\_

How many hours of physical activity does your child get per day? \_\_\_\_\_

How much time outside/in nature does your child get each day? \_\_\_\_\_

How many hours of screen time per day? \_\_\_\_\_

**Sleep:**

- |   |  |                                       |  |
|---|--|---------------------------------------|--|
| <input type="checkbox"/> Restless sleep | <input type="checkbox"/> Unusual positions | <input type="checkbox"/> Snores       | <input type="checkbox"/> Difficulty falling asleep |
| <input type="checkbox"/> Gasps          | <input type="checkbox"/> Mouth breathes    | <input type="checkbox"/> Extends neck | <input type="checkbox"/> 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:**

- |                                     |   |   |  |   |
|-------------------------------------|---|---|--|---|
| <input type="checkbox"/> Rolls over | <input type="checkbox"/> Sits up unassisted | <input type="checkbox"/> Crawls (4-point) | <input type="checkbox"/> Pulls to standing | <input type="checkbox"/> Cruises on furniture |
| <input type="checkbox"/> Walks      | <input type="checkbox"/> Runs               | <input type="checkbox"/> Kicks ball       | <input type="checkbox"/> Jumps             | <input type="checkbox"/> Rides Bike           |

**Teeth**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Delayed eruption/loss | <input type="checkbox"/> Prognathism (underbite) | <input type="checkbox"/> Cavities                   |
| <input type="checkbox"/> Crowded               | <input type="checkbox"/> Grinds teeth            | <input type="checkbox"/> Undergone palate expansion |

**Skin/Hair/Nails**

- |                                       |  |  |
|---------------------------------------|--|--|
| <input type="checkbox"/> Dry skin     | <input type="checkbox"/> Orange skin   | <input type="checkbox"/> Thin hair                               |
| <input type="checkbox"/> Mottled skin | <input type="checkbox"/> Rashes/eczema | <input type="checkbox"/> Brittle, peeling finger and/or toenails |

**Cognition/Speech**

- |                                     |   |  |
|-------------------------------------|---|--|
| <input type="checkbox"/> Verbal     | <input type="checkbox"/> Speech is developing     | <input type="checkbox"/> Good receptive language     |
| <input type="checkbox"/> Non-verbal | <input type="checkbox"/> Appropriate play for age | <input type="checkbox"/> Receptive language emerging |

**Therapies used**

- |   |                                      |                               |                                      |
|---|--------------------------------------|-------------------------------|--------------------------------------|
| <input type="checkbox"/> Early Intervention | <input type="checkbox"/> Anat Baniel | <input type="checkbox"/> NACD | <input type="checkbox"/> MNRI        |
| <input type="checkbox"/> IAHP               | <input type="checkbox"/> Feldenkreis | <input type="checkbox"/> ICAN | <input type="checkbox"/> Other _____ |

9820 E Burnside St.  
Portland, OR 97216



(971) 202-7356  
[www.peirsoncenter.com](http://www.peirsoncenter.com)

---

**Tell us about your experience with medical providers so far.**