Lake Travis Integrative Medicine

New Patient History Questionnaire (Pediatric)

Name_____ Current Date_____

Date of Birth _____

Welcome to our office. This questionnaire has been designed so that we can both review your child's medical history and factors in her/his life that affect health. It is long and detailed! You may use an additional sheet of paper if needed. Some questions may not apply, depending on the age of your child; you may skip these. All information collected will be kept strictly confidential. Thank you for your patience.

General Health: ❒ excellent ❒ good ❒ fair ❒ poor

Past Medical Illnesses:

(Please list any illnesses that have required hospitalization and any other significant health problems)

- ❒ problems during pregnancy, birth, or in the newborn period
  Birth weight: _____
- ❒ accidents, broken bones, other serious injury
- ❒ allergies(asthma,eczema,hay fever), food allergies
- ❒ anemia (low blood count) or bleeding problems
- ❒ bladder/kidney problems: frequent infections, control problems (if unusual for child's age)
- ❒ growth problems: poor weight gain, etc.
- ❒ emotional problems: depression, ongoing or past abuse concerns, behavior problems
- ❒ heart problems, murmur, etc.
- ❒ gastrointestinal problems: frequent upset stomach, diarrhea
- ❒ lung problems: pneumonia, asthma, etc
- ❒ neurologic: seizures, developmental or learning disabilities, cerebral palsy, headaches
- ❒ skin problems
- ❒ sleep problems: insomnia, night terrors, etc.
- ❒ tuberculosis (or positive skin test)

OTHER (and dates and details on items checked above):

_____

_____

_____

_____

Are his/her immunizations up to date? ❒ yes ❒ no When was his/her last dental visit?_____

Please bring immunization record to first appointment.

Past Surgeries (include approximate date and type of procedure):

_____

_____

Current medications (include over-the-counter medicines, sleeping pills, aspirin, laxatives, vitamins, etc. and indicate dose and frequency):

_____

_____

_____

_____

Allergies to any Medication: (list medication and reaction): _____

_____

Family History:

Is your child adopted. . . . . ❒ yes ❒ no

Please list medical history for biological relatives:

Relationship	Name	Age	Living/Deceased	Medical Problems
Mother	_____	___	_____	_____
Father	_____	___	_____	_____
Brothers/Sisters	_____	___	_____	_____
	_____	___	_____	_____
	_____	___	_____	_____
	_____	___	_____	_____
	_____	___	_____	_____

School history

Is your child currently in school?. . . . . ❒ yes ❒ no

❒ Home school ❒ Public school ❒ Private school

What grade level? _____

Has she or he had any difficulty in school and, if so, what was the problem? _____

_____

Abuse

Has your child ever experienced physical or sexual abuse?. . . . . ❒ yes ❒ no

Did she or he receive any counseling? . . . . . ❒yes ❒ no

Travel: Has your child ever been in (or is he/she from): ❒ a foreign country?

Spiritual Life:

Is there a particular spiritual practice/belief system that is meaningful to your family? . . . . . ❒ yes ❒ no

Name or Description, if this is comfortable for you: _____

Do you practice this singly and/or with a group? ❒ alone ❒ with a group

Diet: Does your child follow a special diet?(vegetarian, low salt, low fat etc) . ❒ no ❒ yes: _____

How many times a week does your family eat red meat? _____

How many servings of fruit or vegetables does your child eat every day? _____

What do you give your child for snacks? _____

How many sodas (Coke, Pepsi, etc.) does your child drink every day? _____

How many servings of chips, candy does your child eat every day? _____

Has weight ever been a problem for your child?. . . . . ❒ yes ❒ no

Are you concerned about your child undereating or being preoccupied with weight? . . . . . ❒ yes ❒ no

Has weight ever been a problem for the parents or other adults in the home?. . . . . ❒ yes ❒ no

Has your child ever had to limit certain foods because of a bad reaction to those foods?. . . . . ❒ yes ❒ no

Which foods, what reaction, and do they still avoid those foods:_____

_____

Please list what your child ate yesterday, with approximate amounts:

Breakfast	lunch	supper	snacks
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other providers involved in your child's care:

Do you see other health care providers for your child (such as a therapist, other physicians, chiropractors, acupuncturists, herbalists, etc.) on a regular basis? . . . . . ❒ yes ❒ no

Name	Profession
_____	_____

Would you like your medical provider at the clinic to consult with/coordinate your child's care with her/his other provider(s)? . . . . . ❒ yes ❒ no

Current symptoms:

Circle symptoms or problems your child has now or occasionally, and write details below:

Allergies: sinus congestion, skin rashes, asthma

Nervous system problems: fainting, dizziness, blurry/double vision, hearing problems

Stomach problems: indigestion, abdominal pain, diarrhea, constipation, blood in stools

Lung problems: cough, shortness of breath, wheezing, hoarseness

Heart problems: chest pain, palpitations, trouble breathing lying flat, fainting spells

Circulatory problems: leg swelling, leg cramps with exercise or at night

Skin rash, changing mole(s), itching, warts

Growth problems

Joint problems, back pain

Bladder/kidney problems: frequent urinary tract infections, loss of control of urine(accidents)

(inappropriate for age), problems with foreskin or circumcision.

Problems with sexual development: breast development, hair growth, periods starting before expected

Sleep problems: insomnia, daytime sleepiness, snoring,

Behavior problems, learning problems, development problems,

Development: At what age did your child sit?_____

At what age did your child walk? _____

At what age did your child talk? _____

Does your child wear glasses? ❒ yes ❒ no Contact lenses? ❒ yes ❒ no Braces? ❒ yes ❒ no

Please provide details of problems circled above. If there are other issues that you want to discuss with your child's provider, please record them below or on the back.

_____

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