Pediatrics

Demographics

Child's name | **Date of birth** | **Gender**

Parent(s)/guardian name | **Phone number**

Address

City | **State** | **Zip**

What is the main reason for today's visit?

Is it getting better or worse with time?

Are there factors that make it better or worse?

Does the child have a history of any serious falls or injuries?

○ Yes ○ No ○ Unsure

If yes, please explain:

Does your child wear a backpack?

☐ Yes, a light backpack ☐ Yes, a heavy backpack ☐ No ☐ other

Does your child participate in sports or exercise activities?

○ Yes ○ No

If yes, please explain:

Does the child participate in hobbies or activities that require prolonged repetitive posture (EX: violin)?

○ Yes ○ No

If yes, please explain:

Where there significant falls or tauma to the mother during pregnancy?

○ Yes ○ No ○ Unknown

If yes, please explain:

.....

Any evidence of birth trauma?

☐ Bruising ☐ Cord around neck ☐ Fast / slow birth ☐ Odd shaped head

☐ Respiratory depression ☐ Stuck in birth canal ☐ Unsure ☐ None

As an infant, was the child breastfed?

☐ Yes ☐ No ☐ Unknown

Was formula Introduced?

○ Yes ○ No ○ Unknown

If yes, at how many months?

.....

Was cow's milk introduced?

○ Yes ○ No ○ Unknown

If yes, at how many months?

.....

Does the child have any food or liquid intolerances or allergies?

○ Yes ○ No ○ Unknown

If yes, please explain:

.....

Dring pregnancy, did the mother smoke?

○ Yes ○ No ○ Unknown

During pregnancy, did the mother drink alcohol?

○ Yes ○ No ○ Unknown

During pregnancy, did the mother use recreational drugs?

○ Yes ○ No ○ Unknown

Did the mother suffer any illnesses during pregnancy?

○ Yes ○ No ○ Unknown

If yes, please explain:

.....

Were nutritional supplements prescribed or taken during pregnancy?

○ Yes ○ No ○ Unknown

If yes, please explain:

.....

Were any invasive procedures performed during pregnancy?

○ Yes ○ No ○ Unknown

If yes, please explain:

.....

Are there pets in the child's home?

○ Yes ○ No ○ Unknown

If yes, please explain:

.....

Are there smokers in the child's home environment?

○ Yes ○ No ○ Unknown

Has the child had any adverse reactions to medications or vaccinations?

○ Yes ○ No ○ Unknown

If yes, please explain:

.....

is there a history of antibiotics given to the child?

○ Yes ○ No ○ Unknown

If yes, please explain:

.....

Have there been difficulties with parent-child bonding?

○ Yes ○ No ○ Unknown

If yes, please explain:

.....

Does the child have behavioral problems?

○ yes ○ No ○ Unknown

If yes, please explain:

.....

Have any of the following behaviors occurred? Please check all that apply.

☐ Attention issues ☐ Bedwetting ☐ Difficulty sleeping

☐ Failure to maintain eye contact ☐ Hearing issues ☐ Nervous ticks ☐ Night terrors

☐ Sleepwalking ☐ Stutter or stammer

On average, how many hours PER WEEK of television does the child watch?

☐ Unsure ☐ 0-5 hours ☐ 6-10 hours ☐ 11-15 hours ☐ 16-20 hours

☐ 21-30 hours ☐ More than 30 hours

How many hours PER WEEK does the child spend watching his/her electronics?

☐ Unsure ☐ 0-5 hours ☐ 6-10 hours ☐ 11-15 hours ☐ 16-20 hours

☐ 21-30 hours ☐ More than 30 hours

Do you feel the child's social and emotional development is normal for their age?

○ Yes ○ No ○ Unknown

Was there any delay in terms of the child's achievement of developmental goals?

☐ None, all developmental goals were met ☐ Delayed response to sound

☐ Delayed ability to follow an object ☐ Delayed ability to hold up head

☐ Delayed ability to vocalize ☐ Delayed ability to sit alone

☐ Delayed normal appearance of teeth ☐ Delayed ability to crawl

☐ Delayed ability to walk

Is there anything else you would like to discuss today?

Consent Form

I certify that I am the patient, or the legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the information above to this office. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement or charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Signature: Date: