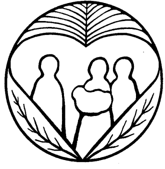

Full Circle Center for Integrative Medicine
4641 Valley East Blvd, #2
Arcata, CA 95521
707-840-4701
Fax 855-420-6321

New Patient History Questionnaire, Child

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. If you have a teenager, they will be given an additional form to fill out themselves. Items pertaining to mental health and/or birth control may be confidential, even from you, according to state law.

General Health: ❒ excellent ❒ good ❒ fair ❒ poor

What do you hope to achieve in your care with us?

❒ New primary care doctor ❒ Consultation about a specific problem

____

If your child is ill, when was the last time your child was well? ______________________________________

Did something trigger your child's change in health? ______________________________________

Please list current and ongoing problems in order of priority:

Describe problem	Mild	Moderate	Severe	Prior treatment/approach	Good	Fair	Poor
Example: Difficulty maintaining attention		*X*		*Elimination diet*		*X*	

If you had a magic wand and could help your child in 3 ways, what would they be?

1. ____
2. ____
3. ____

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

Difficulty getting pregnant or problems during pregnancy: ______________________

❐ Vaginal birth ❐ Cesarean section

Antibiotics in labor: ❐ Yes ❐ No

Birth weight: _________________ Full term? ❐ Yes ❐ No # weeks early_______

Breast fed? ❐ No ❐ Yes - For how long? _____________

Colic? ❐ Yes ❐ No

Number of earaches or other infections in fhe first two years of life: _____________ (first at ___ months)

Number of times he/she had antibiotics in the first two years of life: ____________ (first at ___ months)

❐ 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)
❐ Hospitalizations
❐ **OTHER** ____

Dates and details on items checked above):

____

____

When was his/her last dental visit?____

Past Surgery(include approximate date and type of procedure, why it was done):

____

____

Developmental history: Please indicate the approximate age in months for the following milestones:

Sitting up	___ months	❐ not yet	Dry at night	___ months	❐ not yet
Crawling	___ months	❐ not yet	First words ("dada" etc.)	___ months	❐ not yet
Pulled to stand	___ months	❐ not yet	Spoke clearly	___ months	❐ not yet
Potty trained	___ months	❐ not yet	Lost language	___ months	❐ never
Walked alone	___ months	❐ not yet	Lost eye contact	___ months	❐ never

Immunizations:

Are his/her immunizations up to date? ❐ yes ❐ no If not, please explain: __________________________________

____

Please bring immunization record to first appointment.

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): ____

____

Has your child had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ❒ yes ❒ no
Has your child had prolonged or regular use of Tylenol? ❒ yes ❒ no
Has your child had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.) ❒ yes ❒ no
Frequent antibiotics (>3 times per year?) ❒ yes ❒ no
Use of steroids in the past? ❒ yes ❒ no

Allergies to any Food: (list food and reaction): ____

____

Family History:

Is your child adopted or from a donor insemination? . . . . ❒ yes ❒ no
Please list medical history for biological relatives:

Relationship	Name	Age	Living/Deceased	Medical Problems
Mother	___________	___	________	______________________________
Father	___________	___	________	______________________________
Brothers/Sisters	___________	___	________	______________________________
	___________	___	________	______________________________
	___________	___	________	______________________________

Is there any history in the family of the following illnesses?
(Include mother(M), father(F), sister(S), brother(B), grandmother (GM), grandfather(GF), aunts(A), uncles(U), cousins(C).)

	YES	NO	UNSURE	WHO?
Alcoholism or drug abuse	_____	_____	_____	______________________________
Allergies, severe	_____	_____	_____	______________________________
Attention deficit/learning disorders	_____	_____	_____	______________________________
Bleeding problems	_____	_____	_____	______________________________
Blood clots in legs or chest	_____	_____	_____	______________________________
Depression or mental illness	_____	_____	_____	______________________________
Diabetes	_____	_____	_____	______________________________
Cancer	_____	_____	_____	______________________________ (What organ(s)?)
Heart problems before age 50	_____	_____	_____	______________________________
Kidney disease	_____	_____	_____	______________________________
Liver disease	_____	_____	_____	______________________________
Lung disease	_____	_____	_____	______________________________
Tuberculosis	_____	_____	_____	______________________________
Other (seizures. Etc.):	_____	_____	_____	______________________________

Social History:

Please list everyone who lives in the home with this child and note relationship:

Full Name:	Age:	Relationship:
______________________	______	______________________
______________________	______	______________________
______________________	______	______________________
______________________	______	______________________

Brothers/sisters and parents not living in the home:

Full Name:	Age:	Relationship:
______________________	______	______________________

Who are the main people that care for your child? ______________________________

Pets: Do you have any pets? . . . . ❒ yes ❒ no

Names, species: ______________________________

Living situation:

Are you now or have you recently been homeless?. . . . . ❒ yes ❒ no

If not, do you currently live in an ❒ apartment ❒ house ❒ other

Do you have electricity and running water in your home? . . . . ❒ yes ❒ no

Is food ever in short supply in your home? . . . . ❒ yes ❒ no

Stress/coping:

Does your child get along well with her/his siblings? . . . . ❒ yes ❒ no

Are you currently providing care for a disabled or elderly family member? . . . . ❒ yes ❒ no

Has your child experienced any major life changes that may have impacted his/her health?. . . . . ❒ yes ❒ no

Has your child ever experienced any major losses? . . . . ❒ yes ❒ no

Have you ever sought counseling for your child? . . . . ❒ yes ❒ no

Is your child or family currently in therapy? . . . . ❒ yes ❒ no

Does your child practice stress release methods? ❒ no ❒ yes – If yes, then check all that apply:

❒ Yoga ❒ Meditation ❒ Imagery ❒ Breathing ❒ Prayer ❒ Other: ______________

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

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? ____________________

____

What action was taken? ______________________________

Does your child play well with other children?. . . . . ❒ yes ❒ no

How many hours of television/videos/videogames does your child watch/play every day? ______________

Discipline

What is your method of discipline? ______________________________

Are discipline or behavior problems a problem for you? ______________________________

How do adults in the home deal with conflict? ______________________________

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? (where?)

❒ another region of the United States?

Has your child done wilderness camping? ❒yes ❒ no Where? ______________________________

Safety: Does your child ride in a car seat?. . . . . ❒yes ❒ no

If not, does she/he ever ride without wearing a seat belt? . . . . ❒yes ❒ no

Have you reviewed "child proofing" in your home within the last year?. . . . . ❒yes ❒ no

Do you have a safety plan for your family in the event of a fire or earthquake?. . . . . ❒yes ❒ no

Does your child know the safety plan, if old enough to understand?. . . . . ❒yes ❒ no

Have you done a "drill" of the safety plan with your family?. . . . . ❒yes ❒ no

Are there any weapons in your house?. . . . . ❒yes ❒ no

If there are weapons in the house, are they kept where the child might find them?. . . . . . . ❒yes ❒ no

Are the weapons stored without ammunition or with safety locks?. . . . . ❒yes ❒ no

Are you afraid of your own temper or that of anyone else in your family? . . . . ❒yes ❒ no
Does your child know about safety with strangers? . . . . ❒ yes ❒ no
Does your child know street safety rules? . . . . ❒ yes ❒ no
Does your child have problems with "bullies"?. . . . . ❒ yes ❒ no

Toxic exposures:

Is your child exposed to secondhand smoke? ❒ no ❒ yes – Where? ❒ at home ❒ elsewhere ______________

Does your child have dental fillings**?** ❒ no ❒ yes – What kind? ________________

Other possible exposures:

Past	Current	**Exposures**	Past	Current	
		Mold in bathroom			Mold in cellar, crawlspace, or basement
		Damp cellar or had water in basement			Heavily wooded or damp surroundings
		Pest extermination – inside			Well water
		Pest extermination – outside			Old or crumbling paint (when was house built?_____)
		Forced hot air heat			New carpet or other remodeling
		Farm close to house (non-organic)			Feather or down bedding
		Power plant or lines close to house			Landfill/dump
		Industrial plant close to house			Gas or propane stove or heating

Diet: Who does the shopping in your family? ______________________________

Who does the cooking in your family? ______________________________

Does your child follow a special diet?(vegetarian, low salt, low fat, gluten-free etc) ❒ no ❒ yes:

____

How many meals does your child eat out per week? ❒ 0-1 ❒ 1-3 ❒ 3-5 ❒ more than 5 meals per week

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 percentage of your family's foods are organic for: fruits and vegetables _____ animal products: _____

What do you give your child for snacks? __________________________________

How many sweetened drinks (Coke, Pepsi, fruit juice, etc.) does your child drink every day? _________________

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

Does your child eat a limited variety of foods (<5 per day) . . . . ❒ yes ❒ no
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

Exercise: Does your child exercise daily? . . . . ❒ yes ❒ no
What kind of exercise/play does he/she enjoy? ______________________________________
Does she/he have safety equipment for bicycles, roller skates, etc.? . . . . ❒ yes ❒ no
Are helmets/wrist pads used every time your child is on a bike/skateboard/etc.? . . . .❒ yes ❒ no

Hobbies, other activities(church groups, sports, musical instruments, etc.):

____

What is the best thing about your child? ____

____

Current symptoms:

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

Constitutional: ❒ chills ❒ fatigue ❒ fever ❒ night sweats ❒ weight gain ❒ weight loss

Eyes: ❒ blurry vision ❒ double vision ❒ dry eyes ❒ headache ❒ changes in vision

Ears, nose, throat: ❒ change in sense of smell ❒ dry mouth ❒ ear pain/pressure ❒ hearing loss ❒ mouth pain ❒ sore throat ❒ ringing in ears ❒ trouble swallowing

Heart and circulation: ❒ chest pain ❒ palpitations ❒ fainting spells ❒ Cold hands/feet ❒ difficulty exercising

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

Stomach problems: ❒ abdominal pain ❒ constipation ❒ diarrhea ❒ difficulty swallowing ❒ blood in stools ❒ loss of control of bowels (if already potty trained) ❒ indigestion/heartburn ❒ pain with bowel movements

Bladder/kidney problems: ❒ frequent urinary tract infections ❒ problems with foreskin or circumcision ❒ loss of control of urine(accidents) (inappropriate for age) ❒ blood in urine

Muscles/bones: ❒ Joint problems ❒ back pain ❒ hypermobility ("double jointed") ❒ muscle weakness or pain

Skin: ❒ rash ❒ changing mole(s) ❒ itching ❒ dry skin ❒ warts

Nervous system problems: ❒ dizziness ❒ trouble walking ❒ seizures ❒ numbness ❒ headache

Hormones: ❒ change in hair growth ❒ blood sugar problems ❒ excessive hunger/thirst ❒ lump in neck ❒ intolerance to hot or cold ❒ Growth problems (not enough or too much) ❒ Body hair, breast development, other changes happening too early or too late

Blood: ❒ anemia ❒ bleeding tendency ❒ swollen or tender lymph nodes

Allergies: ❒ eye discharge ❒ hives ❒ itching ❒ sinus congestion ❒ skin rashes ❒ wheezing

Psychological: ❒ Anxiety ❒ Depression ❒ Behavior problems ❒ learning problems ❒ development problems

Sleep problems: ❒ insomnia ❒ daytime sleepiness ❒ snoring

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 use another piece of paper.