Initial History Questionaire

Name _____

Birth Date _____ **Age**_____

CHILD'S BIRTH HISTORY

Birth Weight _____ Term (38+ weeks)? **Yes / No** Early (before 38 weeks)? **Yes / No**

Gestational age (weeks of pregnancy completed) _____

Did the mother have any problems during delivery? If yes, please explain.

_____

Did mother use any of the following during pregnancy? Tobacco/cigarettes/vape? **Yes /No**

Alcohol? **Yes / No** Elicit drugs or prescription drugs? **Yes / No** What? _____ When? _____

Type of Delivery: **Vaginal** **Cesarean** If cesarean, why? _____

Did the baby have any problems during delivery or at birth? **Yes / No** If so, please explain.

_____

Breast or Formula fed? _____

CHILD'S GENERAL HEALTH

YES / NO Do you consider your child to be in good health? Explain?_____

YES / NO Does your child have any chronic medical conditions? Explain?_____

YES / NO Has your child had any serious illnesses? Explain?_____

YES / NO Has your child had any serious injuries or accidents? Explain?_____

YES / NO Has your child had any surgery? Explain?_____

YES / NO Has your child ever been hospitalized? Explain?_____

YES / NO Does your child take any medications? Please inform provider

YES / NO Are you concerned about your child's physical, mental or emotional development?
Explain _____

YES / NO Has there ever been concerns about developmental delays?

YES / NO Are you concerned about your child's attention span?

YES / NO Have there been concerns about your child's behavior at school?

YES / NO Have they failed or repeated a grade in school?

YES / NO Are they doing well academically?

YES / NO Do they have any special educational needs? IEP or 504 plan?

PAST MEDICAL HISTORY

Does your child currently have or had any of the following:

Chickenpox	**YES / NO**	Bladder or kidney infections	**YES / NO**
Frequent ear infections	**YES / NO**	Bed-wetting (after age 5)	**YES / NO**
Problems with hearing or ears	**YES / NO**	Any chronic or recurrent skin problems	**YES / NO**
Seasonal Allergies	**YES / NO**	Frequent Headaches	**YES / NO**
Eye or vision problems	**YES / NO**	Neurologic conditions: Seizures/Convulsions	**YES / NO**
Asthma	**YES / NO**	Diabetes	**YES / NO**
Bronchitis, Bronchiolitis or pneumonia	**YES / NO**	Thyroid or endocrine conditions	**YES / NO**
Heart problems or heart murmur	**YES / NO**	Use of Alcohol or elicit drugs	**YES / NO**
Anemia or bleeding problems	**YES / NO**	Females only:	**YES / NO**
Previous Blood Transfusion	**YES / NO**	Started Menstrual periods?	**YES / NO**
Frequent Abdominal pain	**YES / NO**	Any problems with her periods?	**YES / NO**
Constipation requiring doctor visits	**YES / NO**	Any other problems, not listed:	**YES / NO**

PLEASE FLIP TO PAGE 2 ON THE BACK

HOUSEHOLD

Please list all those living in the child's home. Please include parents and siblings.

Name	Relationship to Child	Birth date	Health Problems

If there are siblings not listed, please list their name, age and where they live. _____

_____

If parents are not living together or if child is not living with parents:

1) What is the child's custody status? _____

_____

2) How often does the child see the parent(s) not in the home?

_____

3) Is there are legal custody agreement? If so please define arrangements.

_____

FAMILY HISTORY

Have any family members had any of the following? Siblings, Parents or Grandparents?

YES / NO	Deafness or loss of hearing	Comments_____
YES / NO	Nasal allergies	Comments_____
YES / NO	Asthma or breathing problems	Comments_____
YES / NO	Tuberculosis	Comments_____
YES / NO	Heart Disease (before age 50)	Comments_____
YES / NO	High blood pressure (before age 50)	Comments_____
YES / NO	High Cholesterol	Comments_____
YES / NO	Anemia or require a blood transfusion	Comments_____
YES / NO	Liver disease	Comments_____
YES / NO	Crohn's or Ulcerative Colitis	Comments_____
YES / NO	Diabetes (before age 50)	Comments_____
YES / NO	Bed-wetting (after age 10)	Comments_____
YES / NO	Epilepsy, seizures or convulsions	Comments_____
YES / NO	Headache/Migraines	Comments_____
YES / NO	Alcohol Abuse	Comments_____
YES / NO	Drug Abuse	Comments_____
YES / NO	Mental Illness Anxiety, Depression, ADHD	Comments_____
YES / NO	Intellectual Disability, Autism	Comments_____
YES / NO	Immune problems, HIV or AIDS	Comments_____
YES / NO	Musculoskeletal disorder	Comments_____
YES / NO	Other family history	Comments_____

Reviewed and entered: _____
Initial & Date

PATIENT REGISTRATION FORM

Please PRINT LEGIBLY and COMPLETE ALL information on this form.

Child's Name _____ **DOB** _____

Please list all children:

Last	First	DOB	Resides with

MOTHER'S INFORMATION: Name: _____

DOB _____ **Last** **First** **Middle**

Address: _____

Occupation: _____ **Cell Phone #:** _____ **Home Phone #:** _____

E-mail address: _____ **What is your preferred method for reminder calls: Please Circle**

Text to Cell **E-mail**

This e-mail address will be used to grant access to the patient portal.

For safety and compliance each parent must use their own individual e-mail address for access.

FATHER'S INFORMATION: Name: _____

DOB _____ **Last** **First** **Middle**

Address: _____

Occupation: _____ **Cell Phone #:** _____ **Home Phone #:** _____

E-mail address: _____ **What is your preferred method for reminder calls: Please Circle**

Text to Cell **E-mail**

This e-mail address will be used to grant access to the patient portal.

For safety and compliance each parent must use their own individual e-mail address for access.

INSURANCE INFORMATION:

Child's Primary Insurance Info: _____ **ID No:** _____

Child's Secondary Insurance Info: _____ **ID No:** _____

If there is a PCP listed on the Insurance card, please make sure it is one of our providers.
We will not be able to provide any services unless we are the PCP on the card.

PLEASE LIST ALL INDIVIDUALS THAT HAVE YOUR CONSENT TO BE INVOLVED WITH YOUR CHILD'S HEALTH CARE & MIGHT ACCOMPANY THEM TO OUR OFFICE FOR APPOINTMENTS.

PLEASE NOTE - if an individual's name does not appear on this list and presents your child to this office for treatment, they will be asked to reschedule the appointment at which time they can provide us with your authorization for treatment.

Names and Legal Relationship to the child:

1. _____ 2. _____

3. _____ 4. _____

In order for compliance with Meaningful Use Mandate the Federal Government requires us to ask the following questions:

Your Primary Language: _____

Ethnicity: (Please circle one) Hispanic or Latino Not Hispanic or Latino Decline to answer

Race: (Please circle one). Asian Black Hawaiian or Pacific Islander White. Decline to answer

Signature of responsible party: _____ **Legal Relationship:** **Date:** _____