Child Information

Patient Information (child):

Today's Date: ____________________

Patient's Name: ____________________

Birthdate: ____________________

Birth location: ____________________

Parent or Legal Guardian Information:

Today's Date: ____________________

Name: ____________________

Address: ____________________

Home Phone: ____________________

Work Phone: ____________________

Cell phone: ____________________

Email: ____________________

Marital Status: ____________________

Patient Information:

Medications currently taking:

____

____

Vitamins or nutritional supplements currently taking:

____

Allergies to medications:

____

Allergies to foods:

____

Allergies to milk or dairy: ____________________

Normal or no childhood diseases? ____________________

Standard vaccinations? Any additional vaccinations?

____

Main Complaints:

Food and Thirst:
Cravings: ____
Aversion: ____

Stomach:
Any bloating, gas or other stomach problems?
____
____

Family Ailments:

Please include information about your mother, father, brothers, sisters, and grandparents. Please list all family members who have had these ailments.

Alcoholism / Drugs: ____
Allergies: ____
Anemia: ____
Arthritis / Gout: ____
Asthma: ____
Bleeding problems: ____
Cancer: ____
Depression: ____
Diabetes: ____
Eczema / Psoriasis / Rashes: __________________________________
Epilepsy: ____
Frequent Infections: ____
Glaucoma: ____
Heart trouble: ____
Hepatitis: ____
High Blood Pressure: ____
Kidney Problems: ____
Mental Illness: ____
Migraines: ____

Polio: ____
Pneumonia: ____
Prostate Problems: ____________________________________
Rheumatic Fever: _____________________________________
Stomach problems: ____________________________________
Stroke: ____
Thyroid problems: ____________________________________
Tuberculosis: ____
Venereal Diseases (herpes, syphilis, gonorrhea, etc.):
____

Timeline:
Please write a brief timeline of your child's life, starting with mother's pregnancy and birth experience, along with timeline of important events, ailments or emotional traumas.

Questions for parents:

Pregnancy

What was your (or birth mom's) predominant emotional state when pregnant with this child?
____
____

During the pregnancy, did you suffer any particular shocks or traumas or losses?
____

Did you take any drugs during your pregnancy?
____

How did your food cravings and aversions change during pregnancy?

____

Were there any complications at birth?

____

Child Development **-** (Answer those that apply)

At what age did your child reach these stages?
Weaning: __________
Talking: ___________
Crawling: _________
Walking: __________
Toilet training: _____
First milk teeth: ____
Permanent teeth: ___

How did your child react to these situations **-(answer those that apply)**

Vaccinations:

____
____

Birth of a younger sibling:

____
____

First day of daycare/school:

____
____

Medical
How many rounds of antibiotics has he/she had and for what?

____

Any skin conditions ever treated with cortisone*?*

____

Did he/she suffer from a childhood disease with severe symptoms (measles, chickenpox, croup, mumps, etc.?

____

Food and Thirst

Cravings: ____
Aversions: ____

Does your child crave sweet, salty, fatty, sour, spicy the most (rank them in order from the most liked to the least liked)?

____

Are they thirsty? How much does they drink in a day?

____

What temperature do they prefer their drinks?

____

Stomach

Any stomach problems?

Sleep

What hour does your child go to bed and how long does it take for them to fall asleep?

Do they tend to wake up at a particular time and why?

Do they do anything in your sleep (speak, laugh, shriek, toss about, grind your teeth, snore etc.)?

Have they ever wet the bed and if so how long was this a problem?

What position does your child sleep in?

Have they had a lot of nightmares*?*

Do you know if they have ever had any recurring dreams*?*

Can you tell me of a dream they have had recently*?*

Puberty/Bowels

Has your child reached puberty? Any problems?

Have they ever had a problem with masturbation?

Do they tend to have constipation or diarrhea?

Frequency of bowel movements?

Perspiration

Does your child perspire a lot? If so, where?

Generalities

What time of day tends to be their best / worst?

Do they tend to be chillier or warmer than others?

What would you say is unusual or distinctive about your child? (Such as behaviors, fears, fantasies, desires, attachments etc.)

Sensitivity

Is your child sensitive to noises, smells, or touch?

Are they unusually sensitive to criticism or reprimands?

How sensitive on a scale of 1-100 is your child to drugs, medications, anesthesia, caffeine, foods?
(1 is not sensitive at all and 100 is so sensitive that they react to almost anything).