# CHILD HEALTH QUESTIONNAIRE

*(to be filled out by parent)*

Full Name _____ Parent's Name _____

Address _____

City _____ State _____ Zip _____ Emergency Contact _____

Date of birth _____ Gender _____ Relationship _____ Phone _____

Phone (home) _____ (work) _____ (cell) _____ Email _____

Whom may we thank for referring you? _____ Relationship to you _____

I, _____, understand that I am personally responsible for payment at the time when services are rendered.

Signature _____ Date _____

## PRIMARY CONCERN

What is your child's **primary** health problem? _____

_____

Date of original problem: _____ Date of most recent recurrence: _____

Was there an event that created the problem? _____

Has your child had this or similar conditions in the past? _____ Is the problem worsening? _____

What makes it better? _____ Worse? _____

Is the problem interfering with school? _____ Sleep? _____ Activity? _____ Other? _____

What can your child not do now that she/he would like to do? _____

What do you believe is wrong with your child? _____

_____

What are your goals for treatment? _____

# HEALTH HISTORY

List all other **CURRENT** problems **in their order of importance** _____

_____

_____

_____

Please check and describe the following:

Vaginal Birth? No / Yes Duration: _____

C-section? No / Yes If Yes, why?_____

Circle and describe when necessary all that apply:

Forceps / Vacuum / Extraction / Home Birth / Hospital / Birthing Center / Induced / Spontaneous

Full-term / Premature _____ Delivery complications: _____

Did your child suffer with colic, reflux, other? No / Yes

If yes describe_____

List other practitioners seen, treatments, self care activities, and results _____

_____

_____

_____

_____

Does your child have any spinal abnormalities that you are aware of? _____

List **ALL** significant PAST illnesses _____

_____

_____

Please list **ALL** surgeries your child has had, with dates and results _____

_____

Has your child ever been hospitalized other than for surgery? _____

Has your child ever been in an accident (significant fall/trauma) or seriously injured? List dates and describe _____

_____

Describe your child's worst injury ever, and any long lasting effects it has had on his/her health _____

_____

Describe any travel related illnesses _____

How many doses of antibiotics has your child had in his/her lifetime?_____ Reason? _____

Is there a time in your life when your child began feeling significantly less healthy? No / Yes

If yes, describe. _____

How many **times/month** does your child take aspirin?____ Ibuprofen?____ Tylenol?____ Antacids?_____ Laxatives?___

For what purpose are these taken? _____

List all medications your child is currently taking and why. _____

_____

List all medications your child has taken in the past and why _____

_____

## FAMILY HISTORY

Have any of your child's blood relatives (parents, brothers, sisters, aunts, uncles, grandparents, or children), living or deceased, had any of the following problems? **For each YES**, state the age of the person when the problem occurred and their relationship with your child.

| Condition | Yes | No | Age | Relationship |
|---|---|---|---|---|
| Alcoholism/Drug Addiction | | | | |
| Allergies/Asthma | | | | |
| Arthritis | | | | |
| Blood Disorders | | | | |
| Cancer (type ) | | | | |
| Diabetes | | | | |
| Digestive Disorders (type ) | | | | |
| Heart attack before age 55 | | | | |
| Heart attack before after age 55 | | | | |
| High blood pressure | | | | |
| Kidney or Liver disease | | | | |

| Have any of your child's blood relatives (parents, brothers, sisters, aunts, uncles, grandparents, or children), living or deceased, had any of the following problems? **For each YES**, state the age of the person when the problem occurred and their relationship with your child. | | | | |
|---|---|---|---|---|
| Lung disease/tuberculosis | | | | |
| Mental health problems/depression | | | | |
| Seizure Disorder | | | | |
| Stroke | | | | |
| Thyroid Disease | | | | |
| Uterine/Ovarian problems | | | | |

List other problems that run in your family _____

## NUTRITION

Was your child breastfed? No / Yes If Yes, How long? _____

If not - Why? _____ Supplemental Formula _____

What does your child usually eat and drink on a **typical weekday**?

Breakfast _____

Morning snack _____

Lunch _____

Afternoon snack _____

Dinner _____

Evening snack _____

Desserts _____

How many glasses of water per day? _____ Coffee _____ Tea _____ Soda _____ Juice _____

How many meals each week are:

At home _____ Alone _____ In restaurant _____ At fast food place _____ TV Dinners or "convenience" food _____ While at play _____ While watching TV _____ From deli _____ At health food restaurant/take out_____

Does your child enjoy eating cheese? No / Yes Drinking milk? No / Yes If so, how much per day? ___

Does your child like sweets, pastries, cakes, donuts, etc? No / Yes How many servings per day _____

Does your child eat artificial sweeteners in foods/diet soda? No / Yes How many servings per day? ____

Does your child eat sugarcoated cereal or add sugar to cereal? No / Yes How many times per day? ___

What is your child's preferred snack food?_____

Is there one food that your child likes the most, and craves when you they don't have it?_____

How many servings of vegetables per day? _____ Child does not eat any vegetables? No / Yes

List the three healthiest foods your child eats in an average week: _____

List the three unhealthiest foods your child eats in an average week: _____

Are there particular foods that irritate your child in any way? No / Yes If yes, name the foods and describe the problem: _____

Please describe any ways in which you feel your child's diet is **excessive**: _____

_____

Please describe any ways in which you feel your child's diet is **deficient**: _____

_____

List all vitamins and other supplements your child is now taking _____

_____

_____

## HABITS

Describe your child's exercise habits (activity/times per week) _____

Describe your child's current sleeping pattern (bedtime, wake up, napping, difficulty with sleep) _____

Does your child have enough energy for your normal activities? No / Yes

How long does your child watch TV each day? _____

How long does your child play video games/ipad/phones etc? _____

What does your child do for fun/pleasure/relaxation? _____

## PREVENTIVE MEASURES AND SCREENING

When did your child last receive the following (leave blank if it does not apply). Circle the test if your child has had an abnormal result

| | | | |
|---|---|---|---|
| physical | blood test | rectal exam | bone density |
| colonscopy | skin exam | TB skin test | Chest x-ray |
| dental exam | eye exam | hearing test | pap smear |
| mammogram | other tests | | |

Has your child ever had an MRI, X-ray or CT scan? No Yes If so, what for? _____

Is your child up to date on all vaccines? YES / NO

## ALLERGIES AND SENSITIVITIES

Please list any allergies you are aware of (foods/medications/other): _____

Please list any chemical sensitivities you are aware of: (bleach, solvents, perfumes, etc.) _____

Is your child particularly sensitive to the effects of medications? No / Yes

Has your child ever reacted to a medication in an unexpected way? No / Yes

If yes, please describe _____

Has your child had problems with damp or moldy places? N / Y Problems with new building materials? N / Y

## MEDICATIONS

The treatment that the Doctors provide is intended to improve all aspects of your child's health. As your child's care progresses, his/her body may be better able to heal itself in all respects. Because of this, your child's cognitive functions, allergic responses, blood sugar levels, and other important bodily functions may improve. If this occurs, it is possible that the doses of medications your child is now taking will have to be modified, to account for this improvement. It is your responsibility to monitor or have monitored those of your child's functions that relate to medications he or she is currently taking, to ensure that your current dose does not become excessive or deficient in its effect on your child. These and any other changes to your regimen of medications must be made in coordination with and under the instructions of the physician who prescribed them.

## ADDITIONAL INFORMATION

Please arrange to have any other relevant information sent to our office. This might include medical records, lab results, consultation reports, and any other test or study results such as x-rays or CT scans.

This will help the doctors evaluate your condition. Short documents like lab results or MRI reports may be faxed to (919) 759-9177. Longer documents like overall patient records should be copied and sent to the office at 206 East Mulberry Street, Goldsboro NC 27530.

Please list your child's pediatrician and other doctors, so we can send a report to them with the details of your child's case, should it become appropriate to do so. List each doctor's full name and as much of the address information as you know.

| | |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Thank you for completing this questionnaire. The information that you have provided gives the doctors a more complete understanding of your child's health concerns and helps your child receive the highest quality care.

Signature _____ Date _____

Relationship to the patient: _____