INITIAL HEALTH QUESTIONNAIRE

CHILD'S NAME: ______________________________
FORM COMPLETED BY: _________________________
DATE OF COMPLETION: ________________________

PLEASE LIST ALL HOUSEHOLD MEMBERS

NAME	RELATIONSHIP TO CHILD	DATE OF BIRTH

If mother and father are not living together, what is the child's custody status?
____
____

BIRTH HISTORY

FOR CHILDREN UNDER 6 YEARS OF AGE			
Birth Weight:__________	Birth Length: ________		
☐ Premature (less than 36 weeks) Weeks gestation: ________ ☐ Pregnancy Complications ☐ Delivery Complications ☐ C-section Explain: ______________________________ ______________________________		Initial feeding: ☐ Breast ☐ Bottle Type of formula: __________________ ☐ Attends Day Care Name: ________________	
During Pregnancy, did Mother: ☐ Smoke ☐ Drink alcohol ☐ Use drugs or medications Explain: ____			

General

- Do you consider your child to be in good health? ☐ Yes ☐ No
  Explain: ____________________
- Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No
  Explain: ____________________
- Has your child had any serious injuries or accidents? ☐ Yes ☐ No
  Explain: ____________________
- Has your child has any surgery? ☐ Yes ☐ No Explain: ____________________
- Has your child ever been hospitalized? ☐ Yes ☐ No Explain: ____________________
- Has your child ever seen any specialists? ☐ Yes ☐ No
  Explain: ____________________
- Is your child allergic to any medications or drugs? ☐ Yes ☐ No
  Explain: ____________________

Development

- Are you concerned about your child's physical development? ☐ Yes ☐ No
  Explain: ____________________
- Are you concerned about your child's mental or emotional development?
  ☐ Yes ☐ No Explain: ____________________
- Are you concerned about your child's attention span?
  ☐ Yes ☐ No Explain: ____________________
- If your child is in school:
- How is his/her behavior in school? ____________________
- Has he/she failed or repeated a grade in school? ____________________
- How is he/she doing in academic subjects? ____________________
- Is he/she in special or resource classes? ____________________

Family History

	Father	Mother	Father Parents	Mother Parents	Brother Sister		Father	Mother	Father Parents	Mother Parents	Brother Sister
Cancer						Kidney Disease					
Diabetes						Glaucoma					
Heart Disease						Bleeding Disorders					
Stroke						Mental Illness					
High Blood Pressure						Mental Retardation					
Immune Problems						Epilepsy/ Seizures					
Other:						Other:					

Explanation of any positive answers above: ____________________

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Past/Current History

CHECK EACH ITEM	YES	NO	EXPLAIN ANY YES ANSWERS
Child ever had Chicken Pox			
Frequent ear infections?			
Problems with ears or hearing?			
Nasal allergies?			
Chronic or frequent colds?			
Problems with eyes or vision?			
Asthma, bronchitis, bronchiolitis, or pneumonia			
Any heart problem or murmur?			
Palpitation or pounding heart?			
Anemia or bleeding problem?			
Blood transfusion?			
Frequent abdominal pain?			
Constipation requiring doctor visits?			
Bladder or kidney infections?			
Blood in urine?			
Bedwetting (after 5 years old)?			
Sleepwalking?			
Has she started her menstrual cycles (girls)?			
Any problems with her periods (girls)?			
Any chronic or recurrent skin problems (acne, eczema, etc.)?			
Frequent Headaches?			
Head Injury?			
Convulsions or other neurological problems?			
Diabetes?			
Thyroid or endocrine problems?			

Questionnaire reviewed by: ______________________________

Title: ____________________

Date reviewed: ______________