Community Therapeutix
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PEDIATRIC HEALTH QUESTIONNAIRE (AGES 0-13)

CHILD'S NAME ____

CHILD'S PEDIATRICIAN (OR FAMILY MEDICAL DOCTOR)____

MAIN CONCERN ABOUT CHILD'S HEALTH____

HEALTH OF PARENTS PRIOR TO CONCEPTION

Father: Poor____ Fair____ Good____ Excellent____
Mother: Poor____ Fair____ Good____ Excellent____
If poor or fair explain: ______________________________
____
Health of mother during pregnancy:
Poor____ Fair____ Good____ Excellent____
Explain: ____
____
What supplements did you take during pregnancy?
1.________________________
2.________________________
3.________________________
Did you smoke during pregnancy? Yes____ No____
Did you drink alcohol during pregnancy? Yes____ No____
What medications did you take during pregnancy?
Prescribed:
1.________________________
2.________________________
3.________________________
Over the Counter:
1.________________________
2.________________________
3.________________________
Diet during pregnancy:
Poor____ Fair____ Good____ Excellent____
Explain: ____
____
Mother's emotional state during pregnancy?
Excellent____ Stable____
Stressed____ Very Stressed____

BIRTH OF YOUR CHILD

Were there any complications, mild to severe:
____
____
____

My baby was born via:
Vaginal Delivery____ Planned C-section____
Emergency C-section____
Requiring:
Pitocin to induce_________
Forceps delivery_________
Vacuum Extraction _________
Anesthesia _____________
Fetal Distress? ___________
Meconium Staining? ________

CONDITION OF BABY IMMEDIATELY AFTER BIRTH

Apgar scores:
At 1 minute___/10 At 5 minutes___/10
Baby's color:
pink all over___ blue face___ blue hands and feet____
Baby's crying:
Cried immediately after birth______ Cried strongly_____
Cried weakly______ Did not cry for _____ minutes
Baby's activity:
Arms and legs actively moving_______
Rather floppy baby_________
Intensive Care: Yes____ No____ Days in NICU ______
Medications given at birth: Yes_____ No____
Vaccines administered: ______________________________
____
Birth weight: __________ Birth length: _____________
Baby went home on day #_____________
Was baby nursed after birth? Yes_____ No_____

CHILD'S HISTORY

First liquid, apart from water, introduced after your baby was weaned (or if you did not nurse): _________________
List your child's food cravings:
1._____________________ 2. _____________________
3._____________________ 4. _____________________
5._____________________ 6. _____________________
Health of baby for first six months:
Poor____ Fair____ Good____ Excellent____
Colic?
Never_____ Occasionally____ Often_____ Severe_____

Vaccination	Age	Adverse Reaction?

First illness requiring medical attention:
Illness__________________________ Age_________
Treatment____
Number of times treated with antibiotics: ______________
List all medications your child has taken in the past:

1. Med__________________________ Age_________
   Illness______________________________________
   Adverse Reaction? ____________________________
2. Med__________________________ Age_________
   Illness______________________________________
   Adverse Reaction? ____________________________
3. Med__________________________ Age_________
   Illness______________________________________
   Adverse Reaction? ____________________________

Medications your child is currently taking:
1.______________________ 2. ______________________
3.______________________ 4. ______________________
Supplements your child takes on a regular basis:
1.______________________ 2. ______________________
3.______________________ 4. ______________________
Brief history of present health concern (include age of onset, first symptoms and present symptoms:
____
____
____
____
Comments on your child's temperament:
____
____
____

Your child's physical development was:
____Slower than Average ____Average
____Faster than Average
Your child's mental/emotional development was:
____Slower than Average ____Average
____Faster than Average
Behavior and performance at school: _________________
____
____
Describe in detail your child's sleep patterns/habits:
____
____
____
List any known allergies to drugs, food or other substances (please describe)____
____
____
____

Current emotional climate of child's home:
Excellent____ Stable____
Stressed____ Very Stressful____
Child's natural parents are: ____Married ___Common Law
____Separated ____Divorced ____Remarried

Siblings:

Name	Age	State of Health

Indicate if there have been any of the following diseases in grandparents, parents, or siblings. Indicate the number of relatives who have/had the disease:

____Autism ____ADD/ADHD
____Diabetes ____Arthritis
____Mental Illness ____Goiter
____Tuberculosis ____Heart Disease
____Allergies ____Kidney Disease
____Cancer ____Hypertension
____Alzheimer's Disease ____Rheumatism
____Digestive Issues ____Developmental Delay

General state of parents' health (include any chronic illnesses):
Mother____
____
____
Father____
____
____

Parent/Guardian Signature:

________________________________ **Date:** _________________

Provider Reviewed:

________________________________ **Date:** _________________