Better Health Clinic

Please take the time to fill out this questionnaire carefully. The information you provide will assist me in formulating a complete health profile for your child. All your answers are absolutely confidential. If you have any questions, please ask.

Name: _____ Date: _____
Parent or guardian's name: _____
Address:
_____
City: _____ State: _____ Zip: _____
Home Phone: _____
Work Phone: (parents) _____
Mobile Phone: (parents)_____
E-Mail: _____
Date of Birth: _____ Age: _____
Physician: _____ Phone: _____
Address:
_____
City: _____ State: _____ Zip: _____
Referred By:_____
In Emergency Notify:_____ Phone: _____

Main Compliant (symptoms, diagnosis)

_____
_____
Duration:_____
Getting worse or better or consistent:_____
What brought on the symptoms:_____
_____
_____
Treatments received (medication, shots, supplements, herbs, etc)
_____
_____
History of similar symptoms or illnesses (number of similar episodes and age(s) of occurrence; severity of previous illness, doctor visit, ER visit, hospitalization; complications)_____
_____
Allergies (chemical, environmental, food, drugs, etc)
_____

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Prescribed or over-the-counter Medications (names & dosages)

_____

_____

_____

Vitamins and supplements/ herbs _____

Diet

Child's diet routinely consists of fresh foods or frozen, or packaged foods?_____

Consumes regularly: cold foods; greasy, fried foods, artificially sweetened foods; salty foods:_____

Appetite (poor appetite, picky eater, irregular appetite)_____

Times for Meals_____

Any disturbance after eating (vomiting, dry heaves, gas, abdominal distension, pain

_____

Bowel movement: (regular, constipation, diarrhea)_____

Sleep

Amount of sleep at night _____hrs naps: _____hrs

Position of sleep (curled up, fetal position, lying on abdomen, inability of sleep on the back, sleep w/ arms and legs thrown outward, covers thrown off, sleeping on one side in particular)_____

_____

Excessive dreaming? _____ Snoring? _____

Activities

General amount of activity during the day (always on the go or usually prefers to do very little)_____

Types of activities (video games, sports, reading, etc)_____

Is the child physically aggressive _____

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Prenatal and Perinatal History

Conception:

- father's age_____ mother's age_____
- General physical/emotional health, stress, consumption of alcohol or drugs during conception
  - father:_____
  - mother:_____
- Mother's menstrual history; previous miscarriages or abortions:

_____

Pregnancy

- Mother's physical/emotional health, stress, consumption of alcohol, cigarettes or drug consumption during pregnancy:

_____

_____

_____

Birth circumstances

- type of delivery:_____
- any complications:

_____

_____

_____

Past Medical History

Previous hospitalizations: _____

Previous operations:_____

Any serious accidents/trauma: _____

History of medications

_____

_____

History of immunizations:_____

_____

_____

Comments

_____

_____

_____

_____