WHOLE FAMILY
wellness center
LLC

Child Health History Intake (0-12 years)

Name _____ Age _____ Date _____

Date of Birth _____ Birth Weight _____ Sex _____

Mother's name _____ Father's name _____

Address _____

City _____ State_____ Zip _____

Telephone # (home) _____

How did you hear about this clinic? _____

Health History Questionnaire

What are your child's most important health problems? List as many as you can in order of importance.

1) _____

2) _____

3) _____

4) _____

What has already been done for the above mentioned problems (not applicable for a well-child visit)?

_____

Does your child have a contagious disease at this time? Y N

If yes, what? _____

Birth History

List major patterns of illness present in the child's birth mother, father or their families:

_____

Did mother receive prenatal care? _____ Prenatal vitamins? _____ Medications (type)? _____

Did mother smoke cigarettes? _____ Drink alcohol? _____ Illicit Drugs (type)? _____

Any previous pregnancies not carried to term? Y N How many? _____ When? _____

Any difficulties with the pregnancy (nausea, vomiting, bleeding, etc):

_____

Type of birth (eg. hospital, home, C-section) _____ Carried to term? ____

If no, how premature? _____ Complications of labor or delivery: _____

Previous Illnesses

Describe difficulties during infancy (eg. colic, skin or lung problems): _____

_____

Has your child had (please circle one)?

Rheumatic Fever	Y N	German Measles	Y N
Chicken Pox	Y N	Measles	Y N

How often does your child get (please fill in):

N = Never **O** = Occasionally **F** = Frequently **C** = Constantly

Colds _____ Sore throat _____ Earaches _____ Coughs _____ Diarrhea _____

Constipation _____ Abdominal aches _____ Other _____

Has your child had any of the following? When? Where?

Electroencephalogram? _____

Psychological evaluation? _____

Hearing tests? _____

Speech/Language tests? _____

Hospitalizations/Surgeries/Injuries

What hospitalizations/Surgeries/Injuries has your child had? When?

_____

_____

Immunization History

U = Up to date **P** = partial **N** = Not done

Pre-school:	_____ HBV (hepatitis B)	_____ Hib (hemophilus influenza type B)
	_____ HAV (hepatitis A)	_____ DTaP (diphtheria, tetanus, pertussis)
	_____ IPV (polio)	_____ MMR (measles, mumps, rubella)
	_____ Varicella (chicken pox)	_____ PCV (pneumococcal bacteria)
School age:	_____ Td (tetanus, diphtheria)	_____ MCV4 (meningitis)
Other:	_____ Influenza	_____ (eg. travel vaccines) _____

Reactions to immunizations? _____

Allergies

Is your child hypersensitive or allergic to:

Any medications? _____

Any foods? _____

Any environmental/pets? _____

Breast fed? Y N How long? _____

Formula fed? Y N How long? _____ Type? _____

Age solid food introduced? _____

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

Please list any prescription medications, over the counter medications, vitamins or other supplements your child is taking.

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

Habits

Does you child watch TV? Y N How many hours per day? _____

Does your child read? Y N How many hours per day? _____

Play video games? Y N How many hours per day? _____

Does your child do sports? Y N How many hours per week?_____

Daycare/School/Home School (circle one) Grade level? _____

What are your child's favorite activities? _____

Anyone in your house smoke? Y N

Are there pets at home? Y N What kind? _____

Social History

Whom does the child live with? _____ Are parents divorced/separated (circle one)? Y N

If so, what if any arrangements are made with the other parent (eg. visitation,etc)? _____

List age and gender of siblings; indicate half, step or deceased where applicable.

_____ _____

_____ _____

_____ _____

How would you describe the child's...

Personality? _____

Intelligence? _____

Temper? _____

Sociability? _____

Environmental

What type of dwelling do you live in? _____ How old? _____

Water supply? _____ Type of heat? _____

Any difficulties with school (describe):

_____

Other Health Related

Describe problems in the following areas:

Digestion: _____

Skin: _____

Respiratory: _____

Urinary: _____

How much sleep does he/she get? From _____ pm to _____ am quality? _____

Was this child early or late in rolling over, teething, talking? _____

Anything not covered in this questionnaire that you feel is important for your doctor to know about?

_____

_____

Thank you! We look forward to working with you and your family. Please feel free to ask any questions along the way. We are happy to recommend other resources to promote healthy families and community.