203-438-9915 **OSTEOPATHIC WELLNESS CENTER** www.osteopathicwellness.net

158 DANBURY ROAD ~ RIDGEFIELD, CT 06877

CHILD MEDICAL AND HEALTH HISTORY

A. Identification

Child's Name:___________________________________ Age:________ Birthdate:____/____/______ Sex: M / F
Address:_____________________________________ City:___________________ State:______________ Zip:_______
Phone: (H)_____________ (W)_____________ (C)___________ (F)_____________ Parent's email: ______________
Social Security #______________________ How did you hear of us?____
Mother's Name:________________________________ Father's Name:__________________________________
Parent's Family Status: Married / Divorced / Separated / Never Married (circle one)
Emergency Contact:__________________________________ Phone:____

B. Insurance Information

Primary Insurance:__________________________ Policy #:_____________________ Group ID:___________________
Patient's relationship to insured: Child / Other
Insured's Name (holder of policy):_______________________________ Insured's SS#:__________________________
Secondary Insurance:________________________________ Policy #:__________________ Group ID:_____________
Patient's relationship to insured: Child / Other
I AM THE PARENT OR LEGAL GUARDIAN AND AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS THIS AND RELATED CLAIMS. I REQUEST PAYMENT TO MYSELF OR TO THE PARTY WHO PROVIDED THE CARE.
Signature____________________________________ Date_____________________

C. Chief Complaint

Please list your child's major problems and/or symptoms and the approximate dates they began (if none, please write your reason for seeking this consultation). Please rank in order of severity.

PROBLEM AND/OR SYMPTOM	DATE PROBLEM BEGAN

If you have seen other practitioners for these problems, indicate the results of these evaluations:
____
____

D. Family Medical History

Please indicate if you, the parents have had any of the following problems in the past. Please note years affected and if mother or father has particular problem.

Alcoholism		Depression		Herpes		Lyme Disease		Smoker	
Allergies		Diabetes		HIV		Mental Illness		Thyroid Disease	
Anemia		Digestive Disease		Hypoglycemia		Migraine Headache			
Arthritis		Drug Problems		Hepatitis		Multiple Sclerosis			
Asthma		Eating Disorder		High Blood Pressure		Prostate Disease			
Cancer		Eczema		Irritable Bowel		Rheumatic Fever			
Celiac Disease		Emphysema		Kidney Disease		Seizures			
Crohn's Disease		Heart Disease		Lupus/AutoImmune		Stomach/Intestinal Ulcers			

How many siblings does the child have?______
Please list names, ages and any medical problems.

Name	Age	Medical Problems?

E. Prenatal History (For mother to complete)

Did you smoke during pregnancy? Yes / No   Did you drink during pregnancy? Yes / No
Did you receive immunizations for flu or tetanus? Yes / No   Did you receive rhogam? Yes / No
Did you have gestational diabetes? Yes / No   Did you have pre-eclampsia (high blood pressure)? Yes / No
Did you have any serious illnesses? Yes / No
If so, please explain:____
____

F. Perinatal Period (For mother to complete)

Was your child born prematurely? Yes / No   if so, how many weeks?_________
Did you experience any complications during delivery? Yes / No   If so, please detail and note any medications you may have been given:____
____

Did your child need any special care after delivery? Yes / No   If so, please explain:____________________________
____

G. Early Childhood

Has your child been diagnosed with any chronic medical conditions to date? Yes / No If so, please list and note who diagnosed condition:

DIAGNOSIS	DOCTOR

Was your child breastfed? Yes / No If so, for how long?_________________

Has your child frequently been treated with antibiotics for respiratory or ear/throat infections? Yes / No If so, approximately how many times? ______________ Were there any delays in developmental milestones? Yes / No If so, please explain:____

H. Immunizations: Specify when received if known (or attach copy of immunization schedule):

IMMUNIZATION	DATES RECEIVED	IMMUNIZATION	DATE RECEIVED
Polio (oral / shot)		Hemophilus Influenza (HIB)	
Measles / Mumps / Rubella		Pnemococcus (PCV)	
Diphtheria/Pertussis/Tetanus			
Hepatitis B			
Chicken Pox			

I. Hospitalization / Surgical History: Dates and reasons:

DATE	REASON

J. Current Medications / Supplements

Please write name, dosage and how often taken.

PRESCRIPTION/OVER THE COUNTER MEDICATIONS	SUPPLEMENTS

Please list any medications your child may have an allergy to and the type of reaction:________________________

____

Environment

Are there any pets in the house? Yes / No If yes, please list type(s)____
Is the child's room carpeted? Yes / No Does any family member smoke in the house? Yes / No

Please complete primary care provider or pediatrician information:
Name:_____________________________ Address:___________________________________ Phone:_____________

If you have a specialist, please complete:
Name:_____________________________ Address:____________________________________ Phone:____________
Specialty____

K. Review of Systems

Please check next to the symptoms that you have experienced over the past 6 months.

	General		Skin		Eyes		Ears		Nose
	Fevers		Dryness		Eye Pain		Excessive Wax		Runny Nose
	Night Sweats		Rashes		Redness		Discharge		Nasal Discharge
	Insomnia		Itching		Discharge		Itching		Sneezing
	Frequent Colds/Flu		Nail Fungus		Itching		Ringing / Tinnitus		Frequent Bleeding
	Fatigue		Brittle Nails		Excessive Tearing		Decreased Hearing		Frequent Snoring
					Dryness				
					Blurred Vision				
					Poor Night Vision				
	Mouth		**Throat**		**Endocrine**		**Cardio/Pulmonary**		**Gastrointestinal**
	Oral Sores		Frequent Soreness		Intolerance to Heat		Shortness of Breath		Heartburn
	Funny Taste		Difficulty Swallowing		Intolerance to Cold		Palpitations		Bloating/Gas
	Bad Breath		Painful Swallowing		Shakiness		Cough		Nausea
	Coating on Tongue		Change in Voice		Fatigue		Chest Pain		Vomiting
			Frequent Clearing Throat		Increased Appetite		Leg Cramps when Walking		Hemorrhoids
			Hoarseness		Decreased Appetite		Leg Cramps at Night		Black or Dark Stools
					Weight Gain/Loss		Varicose Veins		Blood in Stools
					Sweat Easily		Lightheadedness		Constipation
					Cold Hands/Feet		Passed Out		Diarrhea
					Hair Loss/Thinning		Leg Swelling		Thin Stools
					Excess Facial Hair				
					Eyebrows Thinning				
	Neurological		**Mental/Emotional**		**Musculoskeletal**		**Genitourinary**		**Men Only**
	Numbness of a Limb		Anxiety		Joint Pain		Difficulty Urinating		Testicular Lumps
	Weakness of a Limb		Depression		Muscle Aches		Cloudy Urine		Penile Discharge
	Tension Headaches		Suicidal Thoughts		Back Pain		Involuntary Loss of Urine		Penile Lesions
	Migraine Headaches		Panic Attacks		Morning Stiffness		Frequent Urination		Impotence
	Room Spinning		Nervousness				Nighttime Urination		Breast Enlargement
	Head Trauma								
	Memory Loss								

L. Diet Survey

Please check all the following statements, being careful to use the appropriate box related to the frequency of your personal habits.

<u>Frequent</u> = at least once per day <u>Often</u> = several times/week <u>Occasional</u> = once/week or less <u>Seldom</u> = once or twice/month or less
<u>Never</u> = almost total avoidance

	Frequently	Often	Occasional	Seldom	Never
Alcoholic Beverages					
Eat at Restaurants					
Eat at Fast Food Restaurants					
Pastries, Cookies, Candies, Ice Cream, Other Sweets					
Add Sugar to Coffee, Tea, Cereals, Other Foods					
Colas or Other Soft Drinks					
Instant Breakfasts, Pop Tarts, Doughnuts, Muffins					
Cold Breakfast Cereals					
Caffeine Drinks (Coffee, Tea, Cola, Chocolate)					
Deep Fried Food					
Margarine of any Type					
Whole Grain Hot Cereals (Oatmeal, Wheatena, etc.)					
Meat (Beef or Veal, Pork or Ham, Lamb, Liver)					
Chicken or Turkey – Regular or Free Range?					
Fresh Fish					
Processed Meat (Bologna, Turkey Roll, Sausage, etc.)					
Fresh Raw Fruit					
Fresh Vegetables, Raw or Cooked					
Salads					
Whole Grains or Whole Grain Breads					
White Bread or White Flour Products					
Beans and Legumes (Lentil, Kidney, Chickpea, etc.)					
Yogurt – Whole or Lowfat, Plain or Flavored (circle)					
Milk – Whole, Lowfat, or Skimmed (circle)					
Cheese					
Eggs – Regular or Free Range (circle)					
Salt					
Herbs, Fresh and Dried, or Spices					
Drink Adequate Water – Tap, Filtered, Bottled (circle)					
Eat Excessively if Bored or Depressed					
Swallow Food Before Chewing Well					
Hurried or Rushed Meals					
Stuff Yourself					
Read and Understand Food Labels					
Sneak or Hide Foods					
Adequate Fiber or Roughage in Diet					
Artificial Sweeteners (Saccharin, Nutrasweet, etc.)					
Shop at Health Food Stores					