The Wholistic Family Wellness Center

Pediatric Patient Profile

Last Name: _____ First Name: _____ MI: ____

Nickname:_____ Date of Birth: _____ Age:_____ Sex: _____

Today's Date:_____

Present Health Concerns
Please list your child's health concerns in order of priority, including date of onset and severity of symptoms.
1._____
2._____
3._____
4._____
5._____

What do you believe is causing your child's most important health concerns?
_____
_____

What goals do you have for your child's visit today?
_____
_____

Please list any alternative medicine providers (chiropractors, naturopaths, herbalists, etc) and specialists involved in your child's care:
_____
_____
_____

Please list all medications, herbs, supplements, and homeopathic remedies used regularly by your child:
_____
_____
_____
_____
_____

Please list and describe any allergies your child has to medications, supplements, or foods:
_____
_____

Past Medical History: Please list the date of or age at each event and describe:
Serious Illnesses and Injuries:_____
Surgeries: _____
Hospitalizations: _____
Date of last physical: _____ Date of last blood tests: _____

Childhood Illnesses: Your child's health is: □Good □Fair □Poor

□ Chicken Pox □ Mono □ Polio □ Recurrent Strep Throat
□ Diphtheria □ Mumps □ Rheumatic Fever □ Positive TB test
□ Ear Infections □ Pertussis □ Tonsillitis
□ German Measles (Rubella) □ Pneumonia □ Scarlet Fever
□ Measles
□ Other: _____

Immunizations: Indicate which immunizations have been given to your child, dates, and any adverse reactions.

□ All immunizations up to date □ Delayed schedule □ Declined immunizations

□ DTaP _____
□ MMR_____
□ Polio (□ IPV *or* □ OPV)_____
□ Hib_____
□ Pneumococcus (PCV)_____
□ Hep B_____
□ Varicella_____
□ Other _____

Pregnancy History: Birth Mother: # of pregnancies: _____ # of children:_____ Age at delivery:_____

Please check any factors during pregnancy. Health during pregnancy: □ Good □ Fair □ Poor

□ Alcohol Consumption □ Nausea □ Toxemia
□ Bleeding □ Recreational Drugs □ Trauma/Injury
□ High Blood Pressure □ Smoking □ X-rays
□ Stress □

Medications_____
Other health problems or complications during pregnancy:_____

Birth History:

□ Full Term □ Early ____ weeks □ Late ____ weeks Length of labor:_____ hours

Place of Birth: □ Hospital □ Birth Center □ Home
□Other:_____
Birth Medications (if any): _____
Complications: _____

Newborn: Weight at birth: _____ lbs _____ oz Home from hospital in _____ days

□ Jaundice □ Infection □ Seizures
□ Cyanosis □ Fever □ Anemia

Other important conditions: _____
Feeding: □ Breast Fed_____months □ Formula Fed_____ months Type of formula _____

Developmental Milestones: Please indicate your child's age at each milestone:

Sit up _____ months Walk _____ months First Word _____ months
Crawl _____ months First Tooth _____ months First Sentence _____ months
Toilet Trained _____ months

Additional comments about social, cognitive, or physical development:_____
_____

Family History:
Have any of the child"s parents, siblings, or grandparents ever had any of the following: (please circle)

Diabetes	Alcoholism/drug abuse	Depression/bipolar
Cancer type_____	Heart attacks/heart disease	High cholesterol
Thyroid problems	High blood pressure	Rheumatoid arthritis/lupus
Stroke	Osteoporosis	Other_____

Social History
Parents: □ Biological □ Adoptive □ Foster □ Step-parent(s)
Name of mom_____ Name of dad_____
Parents' Marital status: □ Single □ Married □ Divorced □ Re-married □ Widowed □ Significant Other
Mother's Occupation:_____ Full *or* Part Time Father's Occupation:_____ Full *or* Part Time
Siblings: □ *Yes* □ *No* Please list their names and age(s)_____
_____
Pre-School/Daycare/School:_____ Hours per day:_____ Days per week:_____
Do you have any academic concerns regarding your child?
_____
_____

Personality and Habits:
How does your child react to stressful events? _____
What are your child's primary sources of stress?_____
How much does stress impact your child's life?_____ Hours of play per day? _____
Favorite activities?_____
Does your child:
Exercise regularly? □ Yes □ No What kind?
_____
Sleep soundly and wake rested? □ Yes □ No If no, why?_____
Sleep: _____ hours per night Naps: _____ hours per day
Play well with others? □ Yes □ No If no, why?_____
Enjoy time alone? □ Yes □ No If no, why?_____
Have sensory sensitivities? □ Yes □ No What kind?
_____
Have strong fears or phobias? □ Yes □ No What kind?
_____
Have rituals/repetitive behaviors? □ Yes □ No What kind?
_____

Diet:
Age Solid Foods Begun: _____ months First Foods: _____
Age of Introduction for: Milk _____ months Type of Milk_____ Wheat: _____ months
Does your child have any dietary restrictions?_____
Your child's favorite foods? _____
Foods your child refuses? _____
How is your child's appetite?_____ Thirst?_____