

COMPLETE THIS PAGE FOR CHILDREN 4-8 YEARS OF AGE

CHILD'S CURRENT HEALTH

DURING PREGNANCY DID YOU USE:
 DRUGS/MEDICATIONS TOBACCO/ALCOHOL
 IF YES, PLEASE EXPLAIN:

DESCRIBE YOUR DELIVERY:
 LABOR WAS CHEMICALLY INDUCED LABOR WAS DOCTOR ASSISTED
 C-SECTION DELIVERY FORCEPS/VACUUM EXTRACTION
 DOCTOR PULLED OR TWISTED BABY PREMATURE DELIVERY
 PLEASE EXPLAIN:

DESCRIBE ANY COMPLICATIONS EXPERIENCED DURING DELIVERY:

HAS YOUR CHILD EVER TAKEN ANTIBIOTICS? YES NO
 PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN HOSPITALIZED? YES NO
 PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT? YES NO
 PLEASE EXPLAIN:

HAS YOUR CHILD EVER HAD SURGERY? YES NO
 PLEASE EXPLAIN:

DOES YOUR CHILD HAVE DIFFICULTY INTERACTING WITH OTHERS?
 YES NO
 PLEASE EXPLAIN:

HAVE YOU OR ANYONE ELSE NOTICED THAT YOUR CHILD IS NERVOUS, TWITCHES, SHAKES OR EXHIBITS ROCKING BEHAVIOR?
 YES NO
 PLEASE EXPLAIN:

DOES YOUR CHILD EVER BANG HIS/HER HEAD REPEATEDLY AGAINST A WALL, BED, OR OTHER OBJECT?
 YES NO
 PLEASE EXPLAIN:

HAS YOUR CHILD BEEN INVOLVED IN ANY HIGH IMPACT/CONTACT TYPE SPORTS (I.E.: SOCCER, FOOTBALL, MARTIAL ARTS, GYMNASTICS, ETC.)
 YES NO
 PLEASE LIST:

WHAT CHANGES (IF ANY) IN YOUR CHILD'S HEALTH OR BEHAVIOR WOULD YOU LIKE ACCOMPLISHED?

CHILD'S HEALTH HISTORY

INSTRUCTIONS: Please check each of the diseases or conditions that the child now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being

<input type="checkbox"/> ASTHMA	<input type="checkbox"/> EAR INFECTIONS	<input type="checkbox"/> SORE THROAT
<input type="checkbox"/> BED WETTING	<input type="checkbox"/> HEADACHES	<input type="checkbox"/> UPSET STOMACH
<input type="checkbox"/> BRONCHITIS	<input type="checkbox"/> HYPERACTIVITY	<input type="checkbox"/> URINARY INFECTIONS
<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> LEARNING DISORDERS	
<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> NERVOUSNESS	

NUTRITION

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S DIET?
 YES NO
 PLEASE EXPLAIN:

DOES YOUR CHILD HAVE FOOD ALLERGIES?
 YES NO
 PLEASE EXPLAIN:

DOES YOUR CHILD HAVE PERSISTENT OR INTERMITTENTLY OCCURRING SKIN RASHES?
 YES NO
 PLEASE EXPLAIN:

DOES YOUR CHILD TAKE VITAMIN SUPPLEMENTS?
 YES NO
 PLEASE EXPLAIN:

DOES YOUR CHILD ELIMINATE STOOLS EACH DAY?
 YES NO
 PLEASE EXPLAIN:

WHAT DOES YOUR CHILD USUALLY EAT FOR BREAKFAST?

WHAT DOES YOUR CHILD USUALLY EAT FOR LUNCH?

WHAT DOES YOUR CHILD USUALLY EAT FOR DINNER?

WHAT DOES YOUR CHILD USUALLY EAT FOR SNACKS?

HOW MUCH COW'S MILK DOES YOUR CHILD DRINK EACH DAY?