



## Health History Form

CHILD'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

PARENT'S NAME: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

PHYSICIAN'S NAME: \_\_\_\_\_

PHYSICIAN'S PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

PHYSICIAN'S ADDRESS: \_\_\_\_\_

PRESENT CONCERNS: \_\_\_\_\_

MEDICATIONS: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

### PREGNANCY & BIRTH

Where was your child born? \_\_\_\_\_

Any medical problems during pregnancy and / or delivery? If so, please specify: \_\_\_\_\_

Delivery by: Vaginal birth    Caesarean birth

Birth weight: \_\_\_\_\_

### NUTRITION & FEEDING

Has your child had any feeding/dietary problems?    No    Yes    If yes, please specify:

Child's current diet consists of: \_\_\_\_\_

Please list any food aversions or strong food preferences: \_\_\_\_\_

### SLEEP

How many hrs / night does your child sleep? \_\_\_\_\_

How many naps does your child take a day, and for how long? \_\_\_\_\_

Does your child wake up in the middle of the night?    No    Yes    If so, how many times and for how long? \_\_\_\_\_

What mood is your child in upon waking in the morning? \_\_\_\_\_

**DEVELOPMENT**

At what age did your child:

Sit \_\_\_\_\_ Crawl \_\_\_\_\_ Walk \_\_\_\_\_ Say 3-4 words \_\_\_\_\_ become potty trained \_\_\_\_\_

Do you have any current concerns on your child's development? \_\_\_\_\_

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**PAST MEDICAL HISTORY:**

Please describe any major medical problems, hospitalizations or injuries and their dates.

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**SOCIAL HISTORY:**

Name, Age and Relationship of members living within the home of the child:

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What are your child's preferred play activities? \_\_\_\_\_

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How does your child show frustration? \_\_\_\_\_

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How does your child calm down from being upset? \_\_\_\_\_

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**SCHOOL HISTORY:**

Did/does your child attend: preschool school daycare

Name of school / daycare: \_\_\_\_\_

Any additional information that would assist in the care of your child: \_\_\_\_\_

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