Name: _____ DOB: _____

Environmental History

City Water Well Water Bottled Water Daycare Household Pets
Unusual Chemicals or Toxins Tobacco Smoke in Home Recent Travel

Child's Medical History

Immunizations Current? YES NO Records Available YES NO

Please explain any problems of the child in the following areas:

Asthma Ear Infections Cerebral Palsy Chiropractic
Bladder/Kidney Infection Diabetes Seizure(s) Acupuncture
Developmental Delay Learning Disorder Blood Transfusion
Allergies_____ Hearing/Vision Problems_____

Hospitalizations/Operations_____ Injuries_____

Major Illnesses_____ Alternative healthcare_____

School Problems_____ Behavioral Problems _____

Herbal medication or over the counter medications_____

List current medications:_____

Birth History

Maternal Complications Maternal Substance Abuse

If yes, explain_____

Birth Weight:_____ Birth Length:_____ Discharge Weight:_____

Any Problems:_____

Patient is Adopted Where was patient born?_____

Family History (Relationship to patient)

Drug Abuse_____ ___Heart disease before age 50_____

Alcohol Abuse_____ Hearing Problems_____

Tobacco Abuse_____ High blood pressure_____

Domestic Violence_____Stroke_____

Epilepsy/Seizures _____Diabetes_____

Allergies_____ Asthma_____

Birth Defects_____ Cancer_____

Kidney Problems_____ Learning Disorders_____

Mental Illness_____ Any rare or inherited disease_____

Parent / Guardian Signature:_____ **Date:**_____

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