Real Health
ADVANCED CARE CLINICS

Pediatric Questionnaire

Child's Name: _____
First Last Middle Initial

Parent(s) Name(s): _____

Address: _____
Street City State Zip

Phone: _____ **Work:** _____ **Cell :** _____

EMAIL: _____ **Fax:** _____

Child's birth date: _____ **Child's Sex (Circle One):** **Male/Female**

Social Security Number (Optional): _____

Primary Care Physician: _____
Name City

_____
State Zip Phone #

Health insurance: ID No.: _____

Referred by: _____

Siblings: _____

Name	Age	Sex	Birth Date
Name	Age	Sex	Birth Date
Name	Age	Sex	Birth Date
Name	Age	Sex	Birth Date
Name	Age	Sex	Birth Date

Parent's occupation(s): _____

Diagnoses or explanation given to you about your child: _____

_____

(Date of diagnoses: _____/_____/_____)

Other problems to be addressed: _____

_____

_____

PERSONAL INFORMATION (Continued)

Describe your child to me, including his/her history. Please be as detailed as possible.

When did you first notice your child's problem?

What did you first notice?

Was the onset of your child's problem sudden or gradual?

Was there an event or illness that you or others think brought on your child's symptoms?

Please make notation of any other event, action, etc. that you think may have some bearing/relationship to your child's condition. Again, be as detailed as possible and do not hesitate to mention anything, no matter how small or insignificant, that you believe is related to your child's problem(s):

CHILD'S MEDICAL HISTORY

PRIMARY DOCTOR(S)

Name	Phone	City

THERAPIST(S)
Speech - Occupational - Physical – Other

Name	Type	Phone	City	Hrs/Wk

Specialists

NUTRITIONIST

DIGESTIVE HEALTH

Does child have periodic loose stools/diarrhea___ Yes ___ No

Offensive Gas ___Yes ___No Undigested Food in stools ___Yes ___No

Is you child potty trained ___Yes ___No Does your child suffer with reflux/heartburn ___Yes ___No

Is your child currently taking an acid-blocking medication such as Tagamet, Pepcid, etc. ___Yes ___ No

Did occurrence of digestive problems occur following a particular vaccine ___Yes ___No ___ Unsure

Does your child produce formed stools ___Yes ___ No

Have they ever produced formed stools ___Yes ___ No

ANTIBIOTIC HISTORY

How many courses of antibiotics has your child received in lifetime (approx):

___ 0 ___ 1-5 ___5-10 ___10-15 ___15-20 ___20+

Main reason for antibiotic use:

___Ear Infections ___Bronchitis ___Pneumonia ___Sinus Infection ___Intestinal Infection ___Other (please explain)_____

Was your child ever treated for a yeast infection following antibiotic use _____

PRE-NATAL HISTORY

Maternal age at delivery: _____ years

Antibiotics during pregnancy: _____

Illnesses during pregnancy: _____

Medication during pregnancy: _____

Other complications during pregnancy: _____ High Blood Pressure ____ Seizures

____ Diabetes _____ Bacterial Infections ____ Viral Infections ____Other

Please explain:_____

Does Mom know her Rh status ___ (+ or -) Blood Type ___

Did Mom receive Rhogam during pregnancy ___Yes ___No

Did Mom receive any vaccinations during pregnancy ___No ___Yes, which ones

_____

Complications during labor and delivery: _____

_____

Mode of delivery: C-section/vaginal? _____

If C-section, explain why: _____

If vaginal delivery, did you have forceps/vacuum? _____

Was there any concern for birth trauma _____

Medication(s) during labor and delivery? _____

_____

Full term/premature? (Circle one) How many weeks? _____

Complications after delivery? _____

Medications given to child during hospital stay? _____

Did Mom receive any vaccinations after pregnancy while breastfeeding ___No

___Yes, which ones_____

MOTHER'S MEDICAL HISTORY

___Low Thyroid ___ Thyroid Cancer ___ Parathyroid problems ___ Night blindness (difficulty seeing at night)
___Autoimmune Disorders (Lupus, Connective Tissue, Rheumatoid Arthritis, Autoimmune Thyroid)
___Mercury Fillings in Mouth ___ Dental work that contains Nickel
Other, please explain_____
Did Mom have any dental work done during pregnancy ___Yes ___No
Did mom have mercury fillings removed while breastfeeding child ___Yes ___No

DIETARY/NUTRITIONAL HISTORY

Breast-fed? Yes/No If yes, how long? _____
Bottle-fed? Brand of formula? _____ Begun at what age? _____ For how long? _____
Foods? Begun at what age? _____
First foods?_____
Whole milk? Yes/No If yes, begun at what age? _____

Known allergies to food? (Please list): _____

_____

Suspected sensitivities to foods? (Please list): _____

Food cravings? (Please list): _____

FOODS MY CHILD EATS

(Place **x** in appropriate column)

Food	Daily	3 – 5 times/ week	1 – 3 times/ week	Never or almost never	Used to eat a lot but no longer does
Cookies					
Candy					
Sweet foods					
Caffeine (soda, tea, etc.)					
Chocolate					
Milk: Whole					
2 %					
1 %					
Skim					
Cheese					
Ice Cream					
Salty Foods					
Meat					
Pasta					
Bread: White					
Wheat					
Other					

Check the most appropriate description below of your child's diet:

_____ Mostly baby foods
_____ Mostly carbohydrates (bread, pasta, etc.)
_____ Mostly dairy (milk, cheese, etc.)
_____ Mostly meat
_____ Mostly vegetarian (vegetables, fruits, grains, etc.)

Other. Describe: _____

Please describe your child's stool pattern (Examples: daily, foul, large, mushy, etc.):
_____
_____
_____

Please list the foods and beverages normally consumed by your child for three typical days:

DAY 1
Breakfast: _____
Morning snack(s): _____
Lunch: _____
Afternoon snack(s): _____
Dinner: _____
Other _____

DAY 2
Breakfast: _____
Morning snack(s): _____
Lunch: _____
Afternoon snack(s): _____
Dinner: _____
Other _____

DAY 3
Breakfast: _____
Morning snack(s): _____
Lunch: _____
Afternoon snack(s): _____
Dinner: _____
Other _____

Is child on a Gluten Free Diet ___Yes ___No
Is child on a Casein Free Diet ___Yes ___No
Has child benefited by being on a GF/CF diet?_____
Is child on a Specific Carbohydrate Diet? _____
Is child on a Low Oxalate Diet? _____

DEVELOPMENTAL HISTORY
Please list age when following skills were mastered and any problems associated with these skills:
First words: (Age: _____)
Phrases or sentences: (Age: _____)
Pulling to stand: (Age: _____)
Walking: (Age: _____)
Sitting up: (Age: _____)
Crawling: (Age: _____)
Running: (Age: _____)
Walking up/down steps without help: (Age: _____)
Jumping: (Age: _____)
Learned to pedal: (Age: _____)
Rode 2-wheel bicycle: (Age: _____)

Immunizations

Please indicate date and any reactions for those immunizations that your child has received. If exact date isn't known, please approximate.
"Bowel" refers to any bowel symptom such as diarrhea.
"Swelling" refers to the site of the injection.

Diptheria/Pertussis/Tetanus	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**Other**
DPT 1								
DPT 2								
DPT 3								
DPT 4								
DPT 5								
Adult Diptheris/Tetanus								
Paediatric Diptheris/Tetanus								
H Influenza Type B	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**Other**
Hib 1								
Hib 2								
Hib 3								
Hib 4								
Polio (circle Oral or Injection)	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**Other**
OPV 1 / Injection 1								
OPV 2/ Injection 2								
OPV 3/ Injection 3								
OPV 4/ Injection 4								
OPV 5/ Injection 5								
Measles/Mumps/Rubella	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**Other**
MMR 1								
MMR 2								
Hepatitis B Vaccine	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**Other**
HBV 1								
HBV 2								
HBV 3								
Prevnar (pnemococcal)								
Miscellaneous	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**Other**
Varivax (chicken Pox)								
Tine Test								
Flu Vaccine								

Interviewed by _____