

Center for Integral Health

PEDIATRIC HISTORY

Referred by: _____

Today's Date: _____

Name: _____	Sex: M F	Age: _____	Date of Birth: _____
Bill to: _____	Cell Phone: _____		
Address: _____			
Street	City	State	Zip
Home/Cell Phone: () _____	Email: _____		

MAJOR COMPLAINTS IN ORDER OF IMPORTANCE TO YOU:

COMPLAINT	SINCE	CAUSE

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

MEDICATION	SINCE	ADVERSE EFFECTS

List Any Allergies: _____

HAVE YOU TAKEN CORTISONE TYPE DRUGS? YES or NO

ANY PROLONGED COURSES OF ANTIBIOTICS? _____ WHEN? _____

WHY? _____ LIST ANY ADVERSE EFFECTS? _____

WHICH OF THE FOLLOWING CONDITIONS HAVE YOU HAD?

Abscesses	Allergies	Anemia	Arthritis	Asthma
Bleeding	Cancer	Chicken Pox	Cold Sores	Depression
Diabetes	Epilepsy	Gall stones	Goiter	Gonorrhea
Gout	Hay Fever	Heart Disease	Hepatitis	Herpes
Jaundice	Influenza	Kidney Disease	Leukemia	Malaria
Measles	Mono	Mumps	Parasites	Peritonitis
Pleurisy	Pneumonia	Rheumatic Fever	Rubella	Scarlet Fever
Sex Abuse	Skin Disease	Strep Throat	Sinusitis	Stroke
Sunstroke	Syphilis	Tonsillitis	Tuberculosis	Typhoid Fever
Warts	Whooping Cough	Worms	Yellow Fever	

ANY OTHER MAJOR CONDITIONS? _____

Are there any of the preceding conditions after which you have never been totally well again, or which have been more severe than usual? Which ones? _____

WHAT OPERATIONS HAVE YOU HAD?

OPERATION	WHEN	COMPLICATIONS

WHAT MAJOR INJURIES HAVE YOU HAD?

INJURY	WHEN	LONG TERM EFFECTS

PERINATAL & DEVELOPMENTAL HISTORY

Pregnancy problems _____
 Length of pregnancy _____ Pregnancy Number _____ Delivery Type _____
 Labor and Delivery problems _____
 Birth Wt _____ Ht _____ Apgars _____ Jaundice _____
 Other newborn problems _____
 Feeding history _____
 Developmental milestones: walked _____ said words _____
 sentences _____ first teeth _____
 other milestones _____
 Other unusual habits or idiosyncrasies _____

IMMUNIZATIONS

DPT/DT 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
 Polio 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
 Measles 1. _____ 2. _____ Mumps 1. _____ 2. _____
 Rubella 1. _____ 2. _____
 Hib (hemophilus influenza type B) 1. _____ 2. _____ 3. _____ 4. _____
 Hepatitis B 1. _____ 2. _____ 3. _____
 TB tests (date and result) _____
 Other immunizations? And adverse effects? _____

INDICATE BELOW, WHICH OF THE FOLLOWING AILMENTS OR ANY OTHER MAJOR AILMENTS, HAVE AFFECTED YOUR BLOOD RELATIVES

Alcoholism		Allergies		Arthritis		Asthma		Cancer		Depression	
Diabetes		Epilepsy		Gonorrhoea		Gout		Hay Fever		Heart Disease	
Insanity		Paralysis		Pneumonia		Skin Disease		Syphilis		Tuberculosis	
RELATIVE	AGE IF ALIVE	AGE AT DEATH	AILMENTS								
Mother											
Father											
Brothers											
Sisters											
Children											
Maternal Grandmother											
Maternal Grandfather											
Maternal Aunts/Uncles											
Paternal Grandmother											
Paternal Grandfather											
Paternal Aunts/Uncles											

ARE YOU CURRENTLY UNDER THE CARE OF ANOTHER PHYSICIAN(S)?

PHYSICIAN	FOR WHAT CONDITIONS?	TREATMENT?

HAVE YOU BEEN TREATED WITH HOMEOPATHY BEFORE?

PHYSICIAN	FOR WHAT CONDITIONS?	WHEN??

"I, _____ have received a copy of *The Center for Integral Health's Notice or Privacy Practices*. Signature (Parents signature-on peds form) _____ Date _____