

Mother's health during pregnancy:

Bleeding Nausea Physical or emotional trauma
 Illnesses Hypertension Cigarettes, alcohol, drug consumption
 Medications Diabetes Thyroid problems

BIRTH HISTORY

Term: Full Premature Late Weight at birth: _____
Length of labor: _____ Complications: _____

Did your child have any of the following problems shortly after birth?

Rashes Birth injuries Blue baby
 Jaundice Seizures Cerebral palsy
 Colic Fever Birth defects
 Other: _____

Child's sleep patterns (1st year):

Food intolerances:

Breast fed: Y / N How long: _____ Formula: Y / N Type (milk, soy): _____
Age began solids: _____ Which foods: _____
Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS

Hives Burning urine Bloody urine Eczema
 Cries easily Bleeding gums Heart murmur Nervous
 Nose bleeds Vomiting spells Sleep problems Asthma
 Acne Anemia Night sweats High fevers
 Jaundice Sensitive to light Chronic rash Stomach aches
 Diarrhea Hearing loss Easy bruising Sore throats
 Flat feet No appetite Body/breath odor Constipation
 Nightmares Frequent colds Bleeding tendency Unusual fears
 Wheezing Joint pains Excessive fatigue Cough
 Dizzy spells Hair loss Frequent urination Allergies

DIET

Please describe your child's typical daily diet:

Breakfast:

Lunch:

Dinner:

Snacks:

To drink:

Thank you for your time and effort. We look forward to providing you with the best possible care. If there is anything else you would like to add at this time please do so on the back of this page or another sheet of paper.

