



Infant & Child Health History Form

Patient Data:

Date: _____

Your Name: _____ Your Mom: _____

Your Dad: _____

Address: _____

City: _____ State: _____ Zip: _____

Sex: ___M___F Birthdate: _____

Home Phone #: _____ Mom's Cell Phone #: _____

Dad's Cell Phone #: _____ Best # to call: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____ Phone #: _____

Insurance Information:

Name of party responsible for payment _____ Phone #: _____

Do you have health insurance? ___ No ___ Yes Name of Company _____

ID# _____ Insurance Company Phone # _____

Name of the insured _____ DOB of insured _____

*If an auto accident please provide:

Insurance Company Name _____ Contact Person _____

Phone #: _____ Claim #: _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature of Parent or Guardian _____ Date _____

Mainly for Moms:

1. Tell us about your pregnancy:

Did you carry to full term? _____

Describe any complications and when they occurred: _____

2. Tell us about your delivery and birth of this child:

Did you use a midwife? _____ Hospital? _____ Obstetrician? _____

Did you have a C-Section? _____ Were forceps used? _____

Vacuum Extraction? _____ Were you induced? _____

Did you have an Epidural? _____ Was it a difficult birth? _____

What was the baby's **APGAR** Score? _____ at 5 minutes? _____

3. Tell us more:

Did you breastfeed? _____ How long? _____ What formula after? _____

Did you consume alcohol during your pregnancy? _____ How much? _____

Did you smoke? _____ How much? _____ How long? _____

Did you take any medication during your pregnancy? _____

For what? _____ What type? _____

Any exposures to ultrasound? _____ How many? _____

4. As a baby/toddler, (birth to 4 years), did any of the following occur?

- | | |
|---|--|
| <input type="checkbox"/> Fall from a changing table | <input type="checkbox"/> Frequent crying spells |
| <input type="checkbox"/> Tumble down stairs | <input type="checkbox"/> Frequent fevers |
| <input type="checkbox"/> Fall out of crib | <input type="checkbox"/> Frequent bouts of diarrhea |
| <input type="checkbox"/> Involved in car accident | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Fall off playground equipment | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Play in Jolly Jumper | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Did not gain weight |
| <input type="checkbox"/> Reaction to vaccination | <input type="checkbox"/> Vomiting/Spitting up after eating |
| <input type="checkbox"/> Congestion | <input type="checkbox"/> Crying when laying flat |
| <input type="checkbox"/> Fussing in baby carrier/car seat | <input type="checkbox"/> Other _____ |

Please explain the above: _____

5. As a young child, (5-12 years), did any of the following occur?

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Fall from a tree | <input type="checkbox"/> Bed-wetting |
|---|--------------------------------------|

- | | |
|--|--|
| <input type="checkbox"/> Fall off a bicycle | <input type="checkbox"/> Hyperactivity/Autism |
| <input type="checkbox"/> Fall off playground equipment | <input type="checkbox"/> Learning difficulties |
| <input type="checkbox"/> Sports accident | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Car accident | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Stomach pains | <input type="checkbox"/> Leg/knee pains |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Other _____ |

Please explain the above: _____

6. Tell us about any vaccinations your child has had: _____

Any reactions to any of these? _____

Were you told that you had a choice in vaccinating your child? **YES** **NO**
 Would you like information on the other side of this issue? **YES** **NO**

7. As a child or adolescent, has your child experienced any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness in arms/hands | <input type="checkbox"/> Foot/ankle/knee pains |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Arm/wrist pains | <input type="checkbox"/> Tingling in arms/legs |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Neck/back pains |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies | <input type="checkbox"/> Shoulder pains |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Growing Pains |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Weight gain/loss | <input type="checkbox"/> Other _____ |

Please explain any of the above: _____

8. Which of the problems you have checked off is the worst? _____

Is this problem: Constant __, Intermittent __, Occasional __, Cyclic __

9. How long has it persisted? _____

10. When it is at its worst, how does it make your child feel? _____

11. What have you done about it that has NOT worked? _____

12. What makes it worse? _____

13. What effect does this problem have on your child's body functions?

On his/her participation in daily activities? _____

14. Describe any hospital stays: _____

15. Approximately how many times have antibiotics been prescribed and for what conditions? _____

16. List any medications your child is currently taking: _____

17. To summarize, what is your purpose for this appointment? _____

18. Is there anything else you feel we should know? _____

I certify that all information provided has been answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to the health of my child.

Authorization For Care Of Minor

I hereby authorize Dr. Lisa Wood and staff to administer care to my Son/Daughter, as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signature of parent or guardian: _____ Date: _____