CHILD'S HISTORY

Today's Date:_____

Child's Name: _____ Birth Date: _____

Parent's or Guardian's Name: _____

Address: _____ City/State/Zip:_____

Home Phone: _____ Work Phone: _____

FAMILY HISTORY

1. Names and current ages (or age at death and cause of death) of the following:

Father: _____ Mother: _____

Brothers/Sisters: _____ Grandparents: _____

_____ _____

_____ _____

_____ _____

2. Please indicate which members of the child's family, including the child, have been affected by each of these conditions. Include all known blood relatives.

Alcoholism: _____ Allergies or Asthma: _____

_____ _____

Arthritis: _____ Birth Defects: _____

_____ _____

Depression: _____ Diabetes: _____

_____ _____

Cancer or Tumor: _____ Epilepsy or Seizures: _____

_____ _____

Heart Disease: _____ High Blood Pressure:_____

_____ _____

Nervous Breakdown: _____ Drug Abuse/Dependency: _____

_____ _____

Sexually Transmitted Diseases (specify which): Tuberculosis: _____

_____ _____

CHILD'S PERSONAL HISTORY FORM (under age 12):

PREGNANCY & BIRTH

1. Is the child adopted? _____ yes _____ no If yes, at what age? _____

2. Were there any problems during the mother's pregnancy? _____ yes _____ no
   Please elaborate: _____
   _____
   _____

3. Did the mother use any cigarettes, alcohol, prescription or recreational drugs during pregnancy? _____ yes _____ no If yes, which ones: _____
   _____
   _____

4. What was the baby's birth weight? _____ lbs. _____ ozs.

5. Were there any problems during labor or delivery? _____ yes _____ no
   Please elaborate: _____
   _____
   _____

6. Type of birth? _____ vaginal _____ C-Section

ILLNESSES & HOSPITALIZATION

1. Which childhood illnesses has the child had? _____
   _____
   _____

2. Identify any recurrent, serious and/or unusual illnesses the child has experienced?

Date	Illness or Diagnosis	Treatment

CHILD'S PERSONAL HISTORY (under age 12)

FEEDING & DIGESTION

1. Has the child had any unusual feeding problems? Please elaborate: _____
   _____
   _____

2. Has there been any diarrhea or constipation? _____ yes _____ no

3. Does /did the child ever eat dirt, plaster or other indigestibles? _____ yes _____ no
   If yes, please describe: _____
   _____

4. Was the child breast fed? _____ yes _____ no If yes, for how long? _____

DEVELOPMENT & BEHAVIOR

1. At what age did the child first:
   Sit?_____ Cut teeth?_____ Crawl?_____ Walk?_____ Talk?_____

2. Has the child had any of the following? (check all that apply)

_____ problems with teething	_____ extreme shyness	_____ night terrors
_____ high anxiety	_____ trouble getting to sleep	_____ bed-wetting
_____ irritability	_____ precocious sexuality	_____ temper tantrums
_____ violent episodes	_____ discipline problems	_____ ritualistic behavior

VACCINATION HISTORY

1. Has the child ever had a reaction to a vaccine? _____ yes _____ no
   If yes, please describe: _____
   _____
   _____

2. Please give dates (approximate, if exact not known) the following vaccines were given:

DPT:	DT:	Tetanus:	Polio:
_____	_____	_____	_____
MMR:	Hepatitis B:	TB tine test:	Other:
_____	_____	_____	_____

OTHER CONCERNS

1. Please describe your primary concerns for your children's health and well-being: