

Mountain State *Wellness*, PLLC Child History

Please complete this health history questionnaire as thoroughly as possible. The doctor will need this information prior to your child beginning care. The information you provide will help the doctor determine the best care to improve your child's health.

Child's Name: _____ Date of Appointment: _____

Describe the child's **current health complaint** _____

Date of injury/illness? _____

What relieves condition? _____

What worsens condition? _____

Describe the pain? _____

Severity of pain (circle one) None Mild Moderate Severe

Frequency of condition _____

List medical exams/tests performed for condition _____

Birth Process/Pregnancy

Please circle **Yes** or **No** to indicate which terms best describe your child's birth process.

Natural Vaginal Yes No Breech Yes No Forceps Yes No

Vacuum Extraction Yes No Home Birth Yes No Hospital Yes No

Birthing Center Yes No C-section Yes No Underwater Yes No

Epidural Yes No

List and describe any complications during the labor/delivery process _____

List and describe any complications during the pregnancy _____

List ALL vaccines that your child has received _____

List and describe ALL accidents or emergencies _____

List ALL surgeries _____

List ALL prescription or over the counter medications _____

Is your child on any specific diet? _____

Is/was your child breastfed? _____ How long? _____

Please **circle** to indicate if your child has **ever** experienced any of these conditions.

Allergies	Colds/Flu	Headaches	Orthopedic problem
Anemia	Constipation	Heart Trouble	Paralysis
Arm Problems	Convulsions	Hyperactivity	Poor Appetite
Arthritis	Diabetes	Hypertension	Rheumatic Fever
Asthma	Diarrhea	Jaundice	Ruptures/hernias
Backaches	Digestion Problems	Joint Problems	Sinus Trouble
Bed Wetting	Dizziness	Leg Problems	Skin Problems
Behavior Problems	Fainting	Muscle Jerking	Sugar Levels
Broken Bones	Frequent Infections	Neck Problems	Tuberculosis
Chronic Earaches	“Growing Pains”	Neuritis	Walking Problems

Have you ever observed your child pulling his/her hair? _____

Have you ever observed your child banging his/her head on their seat or bed? _____

Have you ever observed your child pulling at his/her ears? _____

Does your child focus on you or objects and track with both eyes? _____

Does your child have red rings on inside of eyes? _____ Watery eyes? _____

Does your child act hungry but will not eat? _____

Does your child have difficulty keeping food or liquid down? _____

Does your child have excessive drooling? _____

Does your child have a chronic cough, bronchitis or pneumonia? _____

Does your child have cold hands and feet? _____

Does your child have sudden mood changes? _____

Does your child cry for no reason? _____

Does your child have outbursts of anger? _____

Does your child have any skin conditions? _____

Does your child sleep well at night? _____

Does your child engage in physical activity? _____

How would describe your child’s current health? (Please circle)

Excellent Very Good Good Fair Poor

How would you rate your child’s overall health today compared to one year ago?

Much Improved Somewhat Improved Same Somewhat worse Much Worse

Legal Guardian Signature/Relationship to child

Date

“Our Vision is Lifetime Family Wellness”