HealthQuest Institute
Norman C. Neeb, D.O.

929 Fee Fee Rd, Suite 100
Maryland Heights MO 63043

(314)-984-0033 Office
(314)-485-8726 Fax

Pediatric History Form

Patient's Name:		Date:
Date of Birth: (dd/mm/yr)		Sex: M F
Age:	Height:	Weight:
Address:		City or Town:
Province:		Postal Code:
Email:		
Name of Parents:	Mom:	Dad:
	Mom's work ph:	Dad's work ph:
	Mom's cell ph:	Dad's cell ph:
Phone Number:	(Home)	
Name of Person Completing this Form:		
Relationship to Patient:		
Physician:		
Other Specialists/Practitioners Seen: Date Seen: 1. 2. 3. 4.		
How did you find out about this clinic?		
What is the main reason for coming today?		
How long has your child experienced this?		
Is it getting better or worse over time?		

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List in order of importance other health concerns and length of time:

Concerns:	How long has this lasted?

Has your child ever been hospitalized other than at birth? Yes No

Date: Reason:

Is your child currently taking any medication? Yes No

Please list present and past medications, along with reason:

Medication:	When:	Reason:

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General Conditions:	Past	Present		Past	Present
Cancer			Contagious Disease		
Diabetes			Skin infections		
Epilepsy			Pleuritis (siy)		
Heart problems			Pneumonia		
Kidney problems			Fever		
Bruising easily					
Digestive System:					
Trouble digesting			Nausea		
Constipation/Diarrhea			Colic		
Loss of appetite					
Respiratory System:					
Frequent cough			Frequent mucal		
Asthma			Bronchitis		
Ear/Nose/Throat:					
Frequent sore throat			Sinus problems		
Ear aches/ infections			Frequent colds or flu		
Swollen glands			Tonsillitis		
Other:					
Headache			Sleep problems		
Anxiety			Seizures		
Irritability			Bed wetting		
Eczema					

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Please list any medical conditions your child may have or experienced?

Health Maintenance

Parameter	Dates
DPT/DT/TD	
OPV	
MMR	
HIB	
Influenza	
Hepatitis	
PPD/TINE	
PNEUMOVAX	
EYE exam	
DENTAL exam	
Urinalysis	
Others:	

Did your child have a flu, cold or fever at the time of vaccination?

Yes No

Were there any reactions observed? (such as fevers, sleep disturbances, irritability or diarrhea) Please explain:

Cautions: Allergies, Adverse Drug Reactions, Contra-indications

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Were there any health problems <u>with your child</u> during pregnancy?

Were there any health problems <u>with the child's mother</u> during pregnancy?

Were there any episodes of stress with the child's mother during pregnancy?

Other than prenatal vitamins, were there any other medications, drugs or alcohol taken during pregnancy?

Was the mother confined to bed rest during any point in the pregnancy? Yes No
If so, at what stage of the pregnancy and for how long?

Has the mother experienced any prenatal or postpartum depression or anxiety?
Yes No

If yes, have you received any care or treatment for this?

How much time did your child spend in car seats, strollers, jolly jumpers, baby seats, play pens during the first year of life? Explain.

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Please describe your child's behaviour during the first few months of life.
(Did your child cry a lot, did your child spit up, have colic, did your child have to be woken for feedings?)

Were there any marks on your baby's head after birth?

Did your child practice tummy time?

Did your child roll over from back to front - in both directions?

Did your child learn to sit up on their own or were they propped up to learn to sit?

Is there anything else that you would like us to know about your child?

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Pregnancy was: ☐Full term	☐Premature: _____ weeks	
Ultrasound during pregnancy?	☐Yes, number: ☐	☐No
Medications during pregnancy?		
Medications during delivery?		
Were you induced?		
Why:		
Was your child ever in any of the following positions?		
☐ Breech	☐ Side lying	☐ Face/brow presentation
What type of delivery did you have? ☐ Vaginal ☐ Caesarean		
Were there any complications during delivery?		
How long was your labour?		
Were there any complications following delivery?		
Were forceps used during delivery?		
Was suction used during delivery?		
Child's weight at birth:		
Was your child breastfed?	☐ Yes: _____ months	☐ No
Or formula fed?	☐ Yes, Type:	
Introduced to solid foods at: _____ months		
Cow's milk at: _____ months		

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At what age did your child:

Sit up unassisted: _____
Crawl: _____
Become potty trained: _____
Speak 1 word: _____
Walk independently: _____
Run: _____
Eat with utensils: _____
Speak 2-3 words: _____

Please rate your child's daily functioning in the following areas:

Eating:	☐ Normal	☐ Area of concern
Sleep cycle:	☐ Normal	☐ Area of concern
Elimination:	☐ Normal	☐ Area of concern
Dressing:	☐ Normal	☐ Area of concern
Play skills:	☐ Normal	☐ Area of concern

Please tell us a little bit more about your child's language skills:

Languages spoken: ☐ English ☐ Other:

Receptive Language (ability to understand what is being said):
☐ Normal ☐ Area of concern

Expressive language (ability to speak and be understood):
☐ Normal ☐ Area of concern

Has your child previously been tested in any of the following areas:

Vision:	☐ Yes (Date tested: _____)	☐ No
Hearing:	☐ Yes (Date tested: _____)	☐ No
	☐ **Ear Infections**	☐ Tubes in Ears

Is your child currently receiving the following:

Services	***Frequency***	***Location (eg. School vs private)***
☐ Occupational Therapy		
☐ Physical Therapy		
☐ Speech and Language		
☐ Psychology		
☐ Nutrition		
☐ Vision Therapy		
☐ Psychiatry		

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