PATIENT INFORMATION

Full Name: _____
Date of Birth: //_____
Gender: _____
Parent/Guardian Name(s): _____
Relationship to Child: _____
Primary Contact Number: _____
Email: _____
Address: _____
Emergency Contact (Name & Phone): _____

FUN FACTS ABOUT YOUR CHILD

What is your child's favorite color? _____
What is your child's favorite food? _____
What makes your child laugh the most? _____
Does your child have a favorite book or character? _____
What is your child's favorite activity or game? _____
What is something special or unique about your child? _____

HEALTH HISTORY

Primary Concern(s) for Visit: _____
When did this issue begin? _____
What is your goal for bringing your child here?
_____
Has your child been diagnosed with any medical conditions? __ Yes __ No
If yes, please list: _____
Current Medications/Supplements: _____
Allergies (food, environmental, medication):
_____
Past Surgeries/Hospitalizations: _____
Has your child had frequent ear infections? __ Yes __ No
Has your child taken antibiotics previously? __ Yes __ No (If yes, how often and for what conditions?): _____

BIRTH & DEVELOPMENTAL HISTORY

Pregnancy & Birth Complications: __ Yes __ No (If yes, explain): _____
Delivery Method: __ Vaginal __ C-Section
Full Term: __ Yes __ No (If no, weeks gestation at birth: _____)
Any feeding difficulties as an infant? __ Yes __ No
Breastfed? __ Yes __ No If yes, how long? _____
Formula-fed? __ Yes __ No If yes, type used: _____

Did your child experience any of the following as an infant?
__ Colic
__ Reflux
__ Trouble latching
__ Tongue tie
__ Snoring
__ Mouth breathing
__ Teeth grinding
__ Bed wetting
__ Eczema
__ Frequent ear infections

Milestones (walking, talking, etc.) met on time? __ Yes __ No (If no, explain):
_____
Any speech delays or difficulties? __ Yes __ No (If yes, explain): _____

DIET & NUTRITION

Does your child have any known food intolerances or sensitivities? __ Yes __ No (If yes, explain): _____
Describe your child's typical daily diet:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Fluids (water, juice, milk, etc.): _____
How often does your child eat processed or fast food? __ Daily __ Weekly __ Rarely __ Never
Does your child take any vitamins or supplements? __ Yes __ No (If yes, list):
_____

SLEEP & ACTIVITY

What time does your child usually go to bed? _____ PM
What time does your child wake up? _____ AM
Does your child have difficulty falling asleep or staying asleep? __ Yes __ No
Does your child snore or have breathing issues during sleep? __ Yes __ No
Does your child grind their teeth at night? __ Yes __ No
How many hours of physical activity does your child get per day? _____
What types of activities do they enjoy? _____

EMOTIONAL & MENTAL WELL-BEING

How would you describe your child's temperament? _____
Has your child experienced any major stressors or traumatic events? __ Yes __ No (If yes, explain): _____
Does your child experience anxiety, mood swings, or excessive worry? __ Yes __ No
Any behavioral concerns at home or school? __ Yes __ No

Does your child have trouble focusing or paying attention? __ Yes __ No
Does your child have close friendships or struggle socially? _____
What are your child's favorite hobbies or interests? _____

FAMILY & PARENTAL INVOLVEMENT

Who primarily cares for your child? __ Both parents __ Mother __ Father __ Grandparent(s) __ Other
How would you describe your child's home environment? __ Calm __ Structured __ Busy __ Chaotic
How much screen time does your child get daily? _____ Hours
Do you have family meals together? __ Yes __ No
How involved are you in your child's healthcare decisions? __ Very involved __ Somewhat involved __ Minimal involvement
Are you hesitant about vaccines or following an alternative schedule? __ Yes __ No (If yes, explain): _____

LIFESTYLE & ENVIRONMENT

Does your child attend daycare or school? __ Yes __ No If yes, how many hours per day? _____
Any concerns regarding school performance? __ Yes __ No
Does your child have exposure to smoking, pets, or environmental toxins? __ Yes __ No (If yes, explain): _____

PARENT/GUARDIAN CONCERNS & GOALS

What are your top health goals for your child?
_____
Are there any specific topics you'd like to discuss with the provider?
_____

CONSENT & SIGNATURE

I acknowledge that the information provided is accurate to the best of my knowledge.
Parent/Guardian Name (Print): _____
Signature: _____
Date: //_____