PEDIATRIC HISTORY QUESTIONNAIRE

The Hetrick Center
"Your Multidisciplinary Solution"

Date:_____Referred By:_____

Child's Name:_____ DOB:_____ Age:_____

Weight:_____ Height: _____ Parent/Legal Guardian's Name: _____

Relationship to Child:_____ Tel#:_____ Alt#:_____

Emergency Contact Person: _____ Tel#:_____

List in order of importance, your child's Primary Medical Issues that bring you to The Hetrick Center:

1. _____

2. _____

3. _____

List other Medical Issues your child may be seeing other providers for (Please list in Order of Importance):

1. _____

2. _____

3. _____

Pediatrician: _____

What medications/vitamins and dosages is your child currently taking or has taken in the last six months?

_____

_____

What vaccinations has your child received? Diphtheria, Tetanus, Pertussis Haemophilus Influenzae

Inactivated Poliovirus Hepatitis B BCG Meningitis C Meassels, Mumps, Rubella

Varicella Others _____

Does your child have a history of allergies/sensitivities/adverse reactions to any medications? Yes No

If yes please explain: _____

Does your child have any history of allergies to any other substances (latex, environmental, dyes, food, etc.)?

Yes No Explain: _____

_____

Check any of the following conditions your child has suffered from during the past **six months**:

ADD/ADHD Asthma/Allergies Autism Back Pains Bed Wetting Behavioral Problems
Broken Bones Car Accident Cerebral Palsy Chronic Colds Chronic Earaches Colic

Constipation Convulsions Diarrhea Digestive Disorders Dizziness Ear Infections

Epilepsy Fifth's Disease Growing Pains Headaches Hearing Impaired Heart Murmur
Hyperactivity Hypoactivity Nose Bleeds Orthopedic Problems Poor Appetite

Recurring Fevers Scoliosis Seizures Sickle Cell Disease/Traits Speech Impaired

Temper Tantrums Walking Problems How many times per year does your child become ill? _____

Any other illnesses not listed above_____

Check any **Childhood Diseases** your child has had:

Chicken Pox Age_____ Rubella Age_____ Rubeola Age_____ Mumps Age____

Whooping Cough Age_____ Measles Age_____ Rheumatic Fever Age_____

Other _____ Age(s) _____

During **Pregnancy** did the child's mother experience any of the following?

Abnormal Bleeding Falls Motor Vehicle Accident High Blood Pressure Diabetes

Anemia Morning Sickness Indigestion Seizures Swollen Ankles Stress

Thyroid Problems Heart Problems Eclampsia Back Pain Hospitalized

Any other illness/events? Yes No Explain:_____

During the course of **Labor and Delivery** did any of the following take place?

Vaginal Delivery Planned C-Section Emergency C-Section

Natural Birth Birth was Induced Forceps Delivery Vacuum Extraction

Anesthesia Administered Epidural Administered Fetal Distress Meconium Staining

Head Presentation Face Presentation Breech Presentation

Sleep Habits

Does your child sleep through the night? Yes No If no how many times does your child awaken? _____

How many hours a night does your child sleep? _____ hours

Does your child nap? Yes No If so how long and what time(s)? _____

Nutrition
Was your child breastfed? Yes No How Long? _____
Did you use formula? Yes No How Long? _____ What Type? _____
Introduction of Solids at _____months. Introduction of cow's milk at_____months
Please fill in how many of each your child has per day:
Cups of: 100% Juice ____ Milk ____ Water ____ Soda ____ Juice Drink ____ Other _____
Servings of: Protein _____ Fruits_____ Veggies_____ Sugar Items_____ Breads/Pastas_____ Fats____

Does your child have any siblings? Y N If yes, please list any major medical problems that are part of their history_____

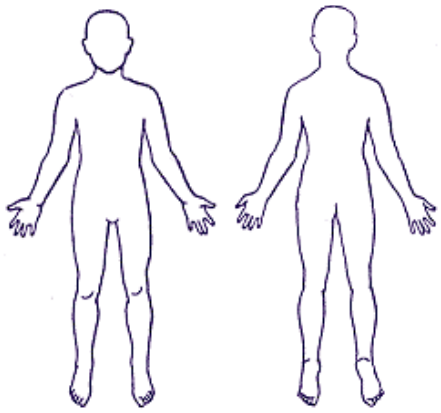
Do the parents have any major medical problems (past or present) that are part of their history? Y N
If yes describe_____

Do the maternal or paternal grandparents have any major medical problems (past or present) that are part of their history? Y N If yes describe _____

1. How long has your child had these symptoms? _____
2. What makes them worse? _____
3. What makes them better? _____
4. Has your child had similar symptoms in the past? _____

To help us better understand the nature & origin of your child's complaints, we ask that you complete this drawing. Use the symbols listed below to detail where they hurt and how it hurts on the figures.

XXXX Pain
////////// Sore
OOOO Scrape
BBBB Bruise



Thank you for completing this form. The information you have provided will assist us in attending to your child's healthcare needs.
I have read and completed all answers to the above questions to the best of my knowledge. I am aware that answering yes to any of the above questions, may require my child to undergo further testing prior to starting any appropriate care. I hereby give my full consent for my child to undergo a rehabilitation exercise program or care designed for her/him if determined to be clinically medically necessary by her/his doctor or therapist. I will notify them of any changes in my child's health status during the duration of the program. It is also my duty to daily inform the doctor, therapist or assistant of any possible complication prior to the initiation of my child's daily rehabilitation or treatment.

Parent/Guardian's signature_____Date_____

Physician signature_____Date_____