



INITIAL PARENT FORM

Child's Name _____ Date _____

Date of Birth _____ Age _____ Grade/School _____

Father's Name _____ Occupation _____

Mother's Name _____ Occupation _____

Where does your child live? _____

Please list all the child's brother and sisters:

Name	Age	Education/Occupation	Health	Where they live
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____

Who referred your child to us? _____

Pediatric MD/Family MD _____

Address _____ City _____ State _____ Phone _____

Date of last visit _____ Date of last physical _____

Dentist _____ Date of last visit _____

Specialist _____ Type _____ Date of last visit _____

Problem _____

Have there been any significant changes in the family such as:

- Marriage Divorce Death Birth
 Job Loss Move to new home Move to new school
 No Significant Changes Other _____

If yes, please explain _____



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What is the primary reason for your child's visit today? _____

How long ago did the child's problems appear? _____

Past Medical History

Were there any difficulties with the pregnancy, labor or delivery of this child?

___Yes ___No If yes, please describe _____

Please describe your child's development at the following ages. Identify if any significant milestones were not met on time (i.e. toilet training, walking, talking, etc).

Birth to 1 year: _____

3 to 6 years: _____

6 to 12 years: _____

13 years and up: _____

Has your child ever been hospitalized? ___Yes ___No If yes:
When? Where? For what?

Has your child ever had surgery? ___Yes ___No If yes:
When? Where? By Whom? For What?



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Has your child ever had any of the following illnesses or problems? (Circle Yes or No):

			When	Describe
Hepatitis	Yes	No	_____	_____
Epilepsy	Yes	No	_____	_____
Rheumatic Fever	Yes	No	_____	_____
TB	Yes	No	_____	_____
Mononucleosis	Yes	No	_____	_____
Diabetes	Yes	No	_____	_____
Asthma	Yes	No	_____	_____
Cancer	Yes	No	_____	_____
Thyroid Disease	Yes	No	_____	_____
Kidney/Urinary	Yes	No	_____	_____
Eye/Vision Problems	Yes	No	_____	_____
Joint Pain	Yes	No	_____	_____
Menstrual Problems	Yes	No	_____	_____
Stomach/Intestine	Yes	No	_____	_____
Migraines	Yes	No	_____	_____
Chest Pain	Yes	No	_____	_____
Weight Loss	Yes	No	_____	_____
Depression	Yes	No	_____	_____
Drug/Alcohol Use	Yes	No	_____	_____
Back/Neck Pain	Yes	No	_____	_____
Fainting	Yes	No	_____	_____
Cold all of the time	Yes	No	_____	_____

Safety/Prevention

Does your child drive?

_____ Yes _____ No

Does your child wear a seat belt?

_____ Always _____ Sometimes _____ Never



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Is your child sexually active? Yes No Not Sure N/A

If yes, do you think he/she practices contraception? Yes No Not Sure

Has your child had any major injuries? Yes No If yes,

When? _____ What? _____ What treatment was needed? _____

Does your child have any history of abuse? Yes No

If yes, please describe _____

Does your child drink alcohol? Yes No Not Sure

If yes, how much? _____ Drinks/week

Does your child smoke? Yes No Not Sure

If yes, how much? _____ Cigarettes/day

Do you know of any other drug use? Yes No Not Sure

If yes, what and how much? _____

Immunizations	Had	Has not had	Dates
DPT Series	_____	_____	_____
Tetanus	_____	_____	_____
Polio	_____	_____	_____
MMR	_____	_____	_____
Chicken Pox	_____	_____	_____
Hepatitis A	_____	_____	_____
Hepatitis B	_____	_____	_____
HPV (Gardasil)	_____	_____	_____
Meningitis	_____	_____	_____
HIB	_____	_____	_____
Pneumococcal	_____	_____	_____
TB Test Date:	_____	Result:	_____



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Medications

Please list all your child's medications including over the counter ones:

	Medication	Dosage	Reason
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Allergies

Does your child have any allergies to food and/or medication? Yes No

If yes, please list allergen and reaction. _____

Nutrition

Is your child on any nutritional supplements? Yes No

If yes, what? _____

Please check any food/fluid/weight struggles that your child is currently experiencing:

- Calorie restriction
- Excessive exercise
- Body image distress
- Binge eating
- Compulsive exercise
- Significant weight changes
- Dieting
- Diet pills
- Frequently weighing self
- Rigid food rules/rituals
- Laxatives (abuse)
- Low weight
- Lack of food variety
- Diuretics (abuse)
- Overweight
- Chewing and spitting
- Purging (vomiting)
- Constipation
- Fluid restriction
- Regurgitation
- Diarrhea
- Fluid loading
- Hiding food
- Reflux
- Excessive caffeine intake
- Calorie counting
- Involuntary vomiting
- Excessive alcohol intake
- Other: _____
- Other: _____

Describe in further detail any concerns circled above (frequency, volume, etc): _____



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To the best of your ability, please write what a typical day of food consumption looks like for your child during the week and weekend. Include eating times and places, with whom, beverages and condiments consumed, and exercise (if applicable).

Weekday

Weekend

General Adjustment

Describe your child's behavior at this time. _____

How is your child doing in school? _____

List any specific problems like frequent absences, detention, suspensions, IEP's:

How does your child get along with people in general? Friends? _____

Adults other than parents? _____

What does your child like to do best? _____

What does your child like to do least? _____

Does your child have any jobs or chores? If so, how does he/she perform them?

Describe any other unusual behavior or personality problems. _____



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Family History

Have any members of your child's natural family, alive or dead, had any of the following problems? (Circle Yes or No) If yes, please state age of the person when diagnosed and the relationship of the person to your child.

	Yes	No	Age Diagnosed	Relationship
Alcoholism/Drug Problem			_____	_____
Allergies/Asthma			_____	_____
Arthritis			_____	_____
Cancer			_____	_____
Diabetes			_____	_____
GI Problems			_____	_____
Hormone Problems			_____	_____
Heart Attack/Stroke before age 55			_____	_____
High Blood Pressure			_____	_____
High Cholesterol			_____	_____
Kidney/Liver/Lung Disease			_____	_____
Developmental Delays/Birth Defects			_____	_____
Mental Illness			_____	_____
Migraines			_____	_____
Obesity/Eating Disorders			_____	_____
Seizure Disorder			_____	_____
Suicide			_____	_____
Thyroid Disorder			_____	_____

Is there anything else you would like to tell us about your child that may assist us in their care?

Parent Signature

Date