Dr. Hundt's Walk of Wellness Healing Center

Child Health History Questionnaire

GENERAL INFORMATION

Child's Name _____ Today's Date _____

Age _____ Date of Birth _____ Height _____ Weight _____ Sex: M F

Name of Parents/Guardians: _____

Purpose for Contacting Us? _____

Other Doctors seen for this condition: Y N If yes, please list doctor's name and prior treatments: _____

_____

Previous/Current Pediatrician:_____ Date of Last Visit:_____ Reason:_____

List any hospital procedures/surgeries that your child has had: _____

COMPLAINTS/CONCERNS

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

❑ Ear infections	❑ Digestive problems	❑ Auto Accident	❑ Headaches
❑ Asthma/Allergies	❑ Bed wetting	❑ Chronic Colds	❑ Growing/Back pains
❑ Colic	❑ Seizures	❑ Referring Fevers	❑ Other _____
❑ Scoliosis	❑ ADHD, ADD	❑ Temper Tantrums	❑ Other _____

Please list child's **chief** symptoms in order of severity, starting with the worst one. Please note how long each symptom has been present.

Problem	Onset	Frequency	Severity
1. e.g. Headaches	June 2009	4 times per week	Mild / moderate / severe
2.			
3.			
4.			
5.			
6.			
7.			

SLEEP/REST

Number of Hours Sleeping per Night: _____ Quality of Sleep: Good _____ Fair _____ Poor _____

Does your child wake up tired? Y N Does your child take naps? Y N

ALLERGIES

Medication/Supplement/Food	Reaction

IMMUNIZATION HISTORY

Has your child received any vaccinations in their lifetime? Yes____ No____ If yes, please list. _____

_____

_____

_____

_____

_____

_____

MEDICATIONS

Please list any medications that your child is currently taking or has taken in the last 6 months, including antibiotics, non-prescription drugs, and prescription drugs.

Medication Name	Dosage	Medication Name	Dosage
1.		**5.**	
2.		**6.**	
3.		**7.**	
4.		**8.**	

Total number of doses of antibiotics your child has taken during his/her life: _____

Total number of doses of other prescription medications your child has taken during his/her life: _____

Has any medication ever caused your child unusual side effects or problems? Yes ____ No _____ If yes, please describe:_____

DENTAL HISTORY

Does child currently have any amalgam, silver, metal, and/or gold fillings? Yes____ No____ If yes, how many? _____

If yes, please list which kinds. _____

How long has child had these fillings? _____

PRENATAL HISTORY

Name of obstetrician/midwife: _____ Pediatrician / Family MD: _____

Birth intervention: Forceps_____ Vacuum Extraction: _____ Caesarian Section: _____ Emergency or Planned? (circle)

Ultrasounds during pregnancy? Y N If yes, how many:_____

Medications during pregnancy/delivery? Y N If Yes, please list them:_____

Cigarette/alcohol use during pregnancy? Y N

FEEDING HISTORY

Breast Fed: Y N If yes, how long? _____

Formula Fed: Y N If yes, how long:_____ Was formula soy-based? Y N

Introduced to solids at _____ months. Introduced to cow's milk at _____ months.

Food/juice allergies or intolerances: Y N If Yes, please list:_____

Other allergies or intolerances: Y N If Yes, please list:_____

CHILDHOOD DISEASES

Chicken Pox: Y N Age:_____ Rubeola: Y N Age:_____ Whooping Cough: Y N Age:_____

Rubella: Y N Age:_____ Mumps: Y N Age:_____ Other: _____

LIFESTYLE INDICATORS

Does your child consume any of the following?

Sweets	none	more than twice/day	less than twice/day
Soda/Pop	none	more than twice/day	less than twice/day
White Flour	none	more than twice/day	less than twice/day
Soy	none	more than twice/day	less than twice/day
Juice	none	more than twice/day	less than twice/day
Milk/Dairy Products	none	more than twice/day	less than twice/day
Meats/Fish	none	more than twice/day	less than twice/day

How much water does your child drink each day? _____

Does your child get consistent physical activity? Y N

Are there smokers in your child's home? Y N

FOR CYCLIC GIRL ONLY

Age of onset of first period: _____

Is menstrual cycle regular? Y N Not Always Details: _____

Does your child experience cramping? None Mild Moderate Severe

Does your child have any spotting between periods? Y N