

PEDIATRIC HISTORY FORM

Child's name: _____ Birth date: _____ Age: _____
Address: _____ City: _____
State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____
Work Phone: _____
Sex: _____ Weight: _____ Height: _____ Referred By: _____
Name of Parents/Guardians: _____
Purpose for contacting our office? _____
Name of Pediatrician: _____
Other Doctors seen for this condition: _____
Other Doctors names and treatments: _____

Check any of the following conditions that your child currently has or had suffered in the past:

- | | | |
|---|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Asthma/Allergies | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Autism Spectrum Disorder | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Headaches | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Sensory Processing Disorder | <input type="checkbox"/> Chronic Colds | <input type="checkbox"/> Bed Wetting |
| <input type="checkbox"/> Pervasive Developmental Disorder | <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Colic |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Easily Frustrated |
| <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Temper Tantrums | <input type="checkbox"/> Inconsolable Crying |
| <input type="checkbox"/> Impulsive Behavior | <input type="checkbox"/> Head Banging | <input type="checkbox"/> Bone Fracture |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Joint Dislocation | |
| <input type="checkbox"/> Food Allergies- list types _____ | | |
| <input type="checkbox"/> Other _____ | | |

Sensory Screening:

- | | |
|---|--|
| <input type="checkbox"/> Craves Deep Pressure | <input type="checkbox"/> Car Sickness |
| <input type="checkbox"/> Dislikes Being Held or Touched | <input type="checkbox"/> Fearful Of Heights |
| <input type="checkbox"/> Dislikes Messy Play | <input type="checkbox"/> Engages In Spinning, Jumping, Bouncing |
| <input type="checkbox"/> Appears Irritated When Someone Is In Close Proximity | <input type="checkbox"/> Dislikes Loud Sounds |
| <input type="checkbox"/> Thumb Sucking | <input type="checkbox"/> Dislikes Strong Smells |
| <input type="checkbox"/> Biting Objects, People | <input type="checkbox"/> Sensitive To Strong Sunlight |
| <input type="checkbox"/> Difficulty Changing Routines | <input type="checkbox"/> Has Trouble Looking Others In The Eye |
| <input type="checkbox"/> Bothered By Clothing Tags | <input type="checkbox"/> Stares At Reflections Or Spinning Objects |
| <input type="checkbox"/> Clumsy-Bumps Into Things | <input type="checkbox"/> Seems Not To Feel Pain |

Family History: _____
Prenatal History: _____
Birth intervention: Forceps Vacuum Extraction Caesarean Section
Complications during delivery? yes no
Breast fed? yes no
Medications: _____ Vitamins: _____
Vaccination history: _____

Developmental History:

At what age was your child able to:

_____ hold their head up _____ sit up _____ crawl _____ stand alone
_____ walk alone _____ toilet trained

Has your child ever been in an auto accident? _____

Has your child participated in contact or high impact sports? _____

List type: _____

Other traumas/falls: _____

Prior surgery: _____

Child's Interests:

Please check any of the following that your child enjoys:

<input type="checkbox"/> Swinging	<input type="checkbox"/> Toy Trains	<input type="checkbox"/> Toy Dinosaurs
<input type="checkbox"/> Riding A Bike	<input type="checkbox"/> Coloring	<input type="checkbox"/> Game Boy
<input type="checkbox"/> Playing Ball	<input type="checkbox"/> Books	<input type="checkbox"/> Board Games
<input type="checkbox"/> Puzzles	<input type="checkbox"/> Computer Games	<input type="checkbox"/> Toy Cars
<input type="checkbox"/> Lego Toys	<input type="checkbox"/> Dolls	<input type="checkbox"/> Other _____

Does your child have a favorite character? _____

Authorization For The Care Of A Minor

I authorize Dr. Barbara Holub to administer care to my child.

Signed: _____ Date: _____