Kelly Austin, ND
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Pediatric Confidential Health Record

Contact Information

LAST NAME		FIRST NAME		TODAY'S DATE MM DD YY
HOME ADDRESS		CITY	STATE	ZIP
HOME PHONE	WORK PHONE	CELL PHONE	EMAIL ADDRESS	
Permission to leave messages: Y N	DATE OF BIRTH - -	GENDER: FEMALE MALE	AGE	
EMERGENCY CONTACT NAME		PHONE		
Who is filling out this form? (name & relation)		Who does the child live with?		
How did you hear about our clinic?		PRIMARY MEDICAL PHYSICIAN NAME		PHONE

List other healthcare providers with office phone numbers:

CURRENT STATUS

MOST IMPORTANT HEALTH CONCERNS, STARTING WITH THE MOST IMMEDIATE

1	4
2	5
3	6

Usual Health: Excellent Good Fair Poor	Time of highest energy during the day: Morning Afternoon Evening
Energy: Good Fair Poor Varies	Time of lowest energy during the day: Morning Afternoon Evening

Medications: please list prescription medication, over-the-counter medications and supplements taken regularly:

NAME	REASON	DOSE	START DATE	SIDE EFFECTS

PRIME WELLNESS

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DIET

How was your infant fed?

☐ Breast fed. How long? ____________

☐ Formula. Milk/Soy/Other: ____________

Veg: ____________ Fruit: ____________

Grain: ____________ Bean/meat: ____________

Sweets: ____________ Concerns: ____________

____

Did your child ever experience colic? Y N

How severe? mild moderate severe

Describe a typical day's diet:

Breakfast____

Lunch____

Dinner____

Snacks____

Beverages (and total quantity)____________________

____

ELIMINATION

BM Freq: ____________ Appearance: ____________

Urinary freq:__________ Toilet training: ____________

Concerns: ____

SLEEP

Hrs/night: ______ Naps freq: ________ Amt: ______

Where: __________________ Habits: ____________

Concerns: ____

____

GROWTH & DEVELOPMENT

Stand	Y N	Scribble:	Y N
Walk:	Y N	Feed Self:	Y N
Run	Y N	Wave bye bye:	Y N
Dada/mama specific:	Y N	Drink from cup:	Y N
Number of words:	___	Use spoon /fork:	Y N
Imitate speech:	Y N	Remove clothes:	Y N

BEHAVIOR/PERSONALITY

Has your child's genetics been tested? Y N

Do you give our office permission to run genetics? Y N

Describe child: ________________________________

____

Temper tantrums: Y N How managed? ____________

____

Discipline (reasons, methods) ____________________

____

Adaptable Y N Plays well w/others Y N Shares: Y N

Aggressive: Y N How managed: ________________

TV/day: ____________ Read to daily: Y N

Concerns: ____

How would you describe your child's behaviour and performance at school? ____________________________

FAMILY/SOCIAL

Does anyone in the child's household smoke? Y N

Are there animals in the home? Y N

Does anyone in the child's household drink? Y N Who?____

Dental care: Y N

Concerns: ____

DAY CARE

Y N Where: ____

Freq/Length: ____

Concerns: ____

VACCINATION STATUS

1. Is your child up to date on their vaccinations? Y N
2. If not, what vaccinations (if any) have they received?

________________________ Date Received:________

________________________ Date Received:________

________________________ Date Received:________

________________________ Date Received:________

________________________ Date Received:________

________________________ Date Received:________

Environment

What are your child's favorite activities?

____

____

Do you know of any toxins or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.)?

Please describe: ________________________________

How was your child's health in the first year?

Poor Fair Good Excellent Unknown

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Prenatal Health

What was the health of the parents at conception?

Mother   Poor   Fair   Good   Excellent   Unknown

Father   Poor   Fair   Good   Excellent   Unknown

What was the health of the mother during the pregnancy?

Poor   Fair   Good   Excellent   Unknown

What was the mother's age at child's birth? __________

How was the mother's diet during pregnancy?

Poor   Fair   Good   Excellent   Unknown

Did the mother experience any of the following during the pregnancy:

- ☐ Bleeding   ☐ High blood pressure   ☐ Nausea   ☐ Vomiting
- ☐ Diabetes   ☐ Thyroid problems   ☐ Physical or emotional trauma

Other ____

____

Did the mother use any of the following during the pregnancy?

- ☐ Tobacco   ☐ Alcohol   ☐ Recreational drugs: ____
- ☐ Prescription medications: ____
- ☐ Over-the-counter medications: ____
- ☐ Supplements: ____
- ☐ Other: ____

Birth history

Term length: ☐ Full   ☐ Premature: _________ wks   ☐ Late: _________ wks

Length of labour: __________________   Weight at birth _______________

Any complications? ____

Was the birth: Vaginal/C-section   Induced   Forceps   Anesthesia used

Did the child experience any of the following at or shortly after birth?

- ☐ Jaundice   ☐ Rashes   ☐ Seizures   ☐ Birth injuries ________________________________
- ☐ Birth defects ____
- ☐ Other ____

Is there anything that you feel is important that has not been covered?

____

____