Child Health History Form

Name: **Date of Birth:**

How did you hear about us? Or who referred you?

1. ALLERGIES	
Allergen:	**Reaction**:

2. GOALS AND CONCERNS
What do you hope to achieve by coming to Healing Oceans?
Date of last well child visit:
Please list any special issues or questions you would like to have addressed: 1) 2)

3. HOME LIFE
Who lives at home with the child?
Parent's names:
Siblings (names and ages):

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6. MEDICAL HISTORY						
Medical Diagnosis / Problems / Injuries	**New**	**Ongoing**	**Resolved**	**Date Started**	**Surgeries / Hospitalizations**	**Mo/yr:**

5-A. CURRENT MEDICATIONS AND NUTRITIONAL SUPPLEMENTS (ei. herbs, vitamins, homeopathy)			
Medication	**Dose**	**Frequency**	**Reason for use**

5-B. MEDICAL USE AND EFFECTS

Have medications and supplements ever caused unusual side effects? **Yes** **No**

Describe:

Has child had prolonged or regular use of Motrin, Asprin, Tylenol, or NSAIDS (Advil, Aleve, etc.) **Yes** **No**

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6. FAMILY HISTORY						
Simply check the box for any family members that have or had the following health problems						
	Father	**Mother**	**Brother**	**Sister**	**Grandparents**	**Children**
Age if alive						
-or at death						
Diabetes						
Glaucoma						
Colon cancer						
Breast/ovarian cancer						
Other cancer						
Heart attack						
Angina						
Stroke						
High blood pressure						
High cholesterol						
Alcoholism						
Drug abuse						
Depression						
Other mental illness						
Suicide						
Traumatic abuse						
Obesity						
Asthma						
Eczema / Psoriasis						
Food allergies						
Autoimmune disease						
Genetic disorders						
Thyroid						
Arthritis						
Digestive issues						
Other health issues						
Other health issues						

Do you have a family history of:

Heart attack in a sister or mother before the age of 65? **Yes No**

Heart attack in a brother or father before the age of 55? **Yes No**

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7. PREGNANCY HISTORY (*For older children, please enter the following information as best you can)*

Mom's care provider during pregnancy? _____

for labor and birth? _____

Mom's emotional state during pregnancy? _____

during labor and birth? _____

Describe Mom's health during pregnancy _____

Did any complications occur? _____

Did Mom smoke, use alcohol or other drugs? **Yes** **No**

Please explain: _____

Did Mom exercise regularly? _____

Any medications, supplements or shots/vaccines taken? Please list.

_____

Diet during pregnancy: What was a typical day's menu of eating?

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Drinks _____

_____

_____

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8. BIRTH HISTORY (*For older children, please enter the following information as best you can remember)*

Born at how many weeks of pregnancy?_____Birth weight? _____

Where born? _____

Describe:

Any interventions and complications during labor or birth, including c-section, epidural, pitocin.

_____

_____

_____

_____

_____

Any complications that baby had during labor, birth or soon after.

_____

_____

_____

_____

Mom's overall satisfaction with her birth experience.

_____

_____

9. NURSING HISTORY

For how long was baby breastfed exclusively? (Meaning *no* formula or supplemental foods, especially while in the hospital)

At what age did weaning happen?

10. SLEEP

Average number of hours child sleeps each night: _____

Typical bed time:

Typical wake up time:

Has trouble falling asleep?	**Yes**	**No**
Any night waking?	**Yes**	**No**
Uses sleeping aids?	**Yes**	**No**

If yes, explain:

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11. DIET

How many caffeinated drinks does child have per day? ***0 1 2 3 4+***

How many servings of soda does child drink per day? ***0 1 2 3 4+***

Does child use artificial sweeteners? **Yes No**

Ounces of water child drinks in a day? *1 glass = 8 oz, 1 quart = 32 oz* _____

How many meals does your family eat out per week? ***0 1 2 3 4+***

How much food does child eat that is not *fresh* prepared at home? _____% (approx.)

- List the main foods you eat not *fresh* prepared at home:

Do you think your child's weight is healthy? **Yes No**

If your child is on a special diet, explain:

What are your child's favorite foods?

For the past 24 hours, list foods, snacks, and beverages consumed:

Breakfast with beverages	Lunch with beverages	Dinner with beverages	Snacks	Other beverages

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12. VACCINATIONS

Are vaccinations up to date? **Yes** **No**

If no, please explain. (I.E. missed one, religious objection, alternative schedule, etc.)

13. PHYSICAL ACTIVITY

Please list all types of activity, such as playing in the park, jumping rope, etc.

Type	**Duration**	**Frequency**

14. RISK BEHAVIORS

Is child smoking? (Packs per day or per week)

Alcohol? (Amount and frequency)

Other drugs?

15. SCHOOL

Has child had any problems at school in the past or currently?

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16. GYNECOLOGIC HISTORY

If menstruation has not begun, check here ☐

Age at first period:

Number of bleeding days:

Number of days from one menstrual period to the next:

Pain with menses? **Yes** **No**

Has period ever skipped? **Yes** **No**

For how long?

Last menstrual period: (Date)

17. ADDITIONAL NOTES

Is there anything else about your child you would like us to know?

To the best of my knowledge, this is a complete and accurate statement of my child's health.

Signature: _____ Date: _____

Please bring this filled out form as well as any bottles of supplements or medication your child may be on when your child meets Dr. Ginsburg for the first time.

You will find much information about our practice at healing-oceans.com.

We please ask that you do not wear any perfume, cologne or any fragrances to the appointment. Thank you!!