Patient Name:______________________________ **Date of Birth:**____________

(Please complete one form for each child)

Patient Past Medical history

Please mark any of the following that apply to your child: ***(Do not complete if your child is under 6 months of age)***

Condition			Condition		
ADHD	☐ Yes	☐ No	Eating Disorder	☐ Yes	☐ No
Anemia/Blood Disorders	☐ Yes	☐ No	Digestive Problems	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No	GYN Problems	☐ Yes	☐ No
Asthma/Breathing Issues	☐ Yes	☐ No	Head Injury or Concussion	☐ Yes	☐ No
Autism	☐ Yes	☐ No	Headaches	☐ Yes	☐ No
Bedwetting	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No
Behavior Issues	☐ Yes	☐ No	Immune System Problems	☐ Yes	☐ No
Bladder or Kidney Problems	☐ Yes	☐ No	Mental Health Problems	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Muskuloskeletal Problems	☐ Yes	☐ No
Congenital Problems	☐ Yes	☐ No	Prematurity	☐ Yes	☐ No
Constipation	☐ Yes	☐ No	Respiratory Problems	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Seizure Disorder	☐ Yes	☐ No
Developmental Problems	☐ Yes	☐ No	Skin Problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Ear or Hearing Problems	☐ Yes	☐ No	UTI's	☐ Yes	☐ No
Ear Infections			Vision or Eye problems.	☐ Yes	☐ No

Other:____

Family Medical History

Do any family members of the patient have any of the following conditions:					Maternal	Maternal	Paternal	Paternal
Condtion:	Mother	Father	Brother	Sister	Grandmother	Grandfather	Grandmother	Grandfather
ADD/ADHD								
Allergies								
Asthma/Respiratory Problem								
Anema/ Blood Disorder								
Cancer								
Depression								
Developmental Delay								
Diabetes								
Headache/Migraines								
Heart Problems								
High Blood Pressure								
Immune Problems								
Kidney Disease								
Liver Disease								
Mental Health								
Seizure/Neurological Disorder								
Substance Abuse								
Thyroid Problems								
Other								

Please explain any of the above:____

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