# PEDIATRICS
# CONFIDENTIAL HEALTH HISTORY

Today's Date_____

**Dear Patient:** This information is considered confidential. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Last: _____ First:_____ DOB:_____

Referring Physician:_____ Mental Health Professional:_____

Height: ___ Weight: ____ Premature: _____Adopted:_____ Foster: _____

Age started talking?_____ Age started crawling? _____ Age started walking?_____

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Your Primary Concern Today:

_____

Medications:: _____ Allergies:_____

Hospitalizations /Medical conditions:_____

Past Therapy Services: _____

IFSP or IEP? Yes No Vision Screening? Pass Fail Unknown Hearing Screening? Pass Fail Unknown

Does your child spend time out of the home (preschool, grandparents, respite) If yes, explain:_____

_____

**Please answer the following questions based on how you describe your child on most days:**

Does your child "get hungry?" _____ Gags when eating?_____ A "Picky Eater?" _____

Does your child fall asleep easily? _____ Stay Asleep all night?_____ Wake looking rested?_____

Is your child potty trained? _____ Frequent stomach aches? _____ Constipation? _____ Diarrehea? _____

Does your child get headaches? _____ Not always respond to their name? _____ Appear Clumsy? _____

Likes bath? _____ Gets ready in am with no problem? _____ Gets ready in pm with no problem? _____

Shy or Withdrawn?_____ Overly affectionate? ( may hug people they don't know)_____

Ever have Physical Outbursts? _____ Verbal Outbursts?_____ Struggles with friendships?_____

**Please explain any additions concerns:**_____

**Please list strengths in your child and any other information you would like us to know:**