NAME: _____ **M F** (circle) **Date of Birth:** _____

Person completing form: **Relationship to child:**

Child Health History
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)

3. Home Life
Who lives at home with your child?
Parent's names:
Siblings (names and ages):

4. Medical History							
Medical Diagnosis / Problems / Injuries	**New**	**Ongoing**	**Resolved**	**Date Started**		**Surgeries / Hospitalizations**	**Mo/yr:**

5-A Current Medications & Nutritional Supplements (Include herbs, vitamins, homeopathy.)			
Medication/Supplement	**Dose**	**Frequency**	**Reason for use**

5-B Medication 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**

6. Family History					
Simply check the box for any family members that have or had the following health problems					
	Father	**Mother**	**Brother**	**Sister**	**Grandparents**
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**

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 _____

- and any complications that occurred. _____

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

Breakfast _____

_____

Lunch _____

_____

Dinner _____

Snacks _____

_____

Drinks

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:

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

12. Vaccinations
Are vaccinations up to date? **Yes No** If no, please explain. (I.E. missed one, religious objection – no vaccines, 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?

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.

Please check the box at each item below to accept them.

- ☐ **I authorize release of any information concerning my child's health care, advice, and treatment provided for the purpose of evaluating and administering claims for health insurance benefits.**
- ☐ **I've read and accept the *Patient Consent to be Treated*.**
- ☐ **I've read and accept the *Notice of Healing Oceans Privacy Practices*.**
- ☐ **I've read and accept the *Office Policies* and *Summary of Charges*.**

Signature _____ **Date:** _____-_____-_____

Fax this to us at 866-786-7919 or view other sending options on our website here.