The Marlborough Wellness Center
Where Modern and Traditional Medicine Become Integrated
277 Main Street, Ste. 208 • Marlborough, MA 01752

Pediatric Health History Questionnaire

Date: _____

Name (Last,First): _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Daytime Phone: _____

Emergency Contact Name/Phone: _____

Date of Birth: _____

Chronological Age (years, months): _____

Referred By: _____

Has the child been treated by acupuncture/Oriental Medicine before? YES NO

Have they been treated with Sensory Integration treatments before? YES NO

Main concern(s) you would like us to address: _____
_____
When did this begin? _____
How does it interfere with their daily activities (i.e.: work/school, sleep, play)?
_____
Have they been given a medical diagnosis for this problem?
_____
What other treatments have they tried? _____

Family Medical History (circle all applicable) Diabetes Cancer High Blood Pressure Heart Disease Seizures Asthma Allergies stroke Other:

Past Medical History (of the child) - Significant Illnesses (circle all applicable and specific dates): Cancer Diabetes Hepatitis High Blood Pressure Rheumatic Fever/childhood diseases Thyroid Disease Venereal Disease Other:

Surgeries:_____
_____
Significant Trauma (auto accidents, falls, abuse, etc.):_____
_____
Allergies (drugs, metals/chemicals, foods):
_____
Medicines taken in the last 3 months (vitamins, drugs, herbs):

_____

Have they ever been on a restricted diet? If yes, what kind and why?

_____

Please describe their average daily diet:

Morning: _____
Afternoon: _____
Evening: _____
Are they currently on any medications? If yes, describe what and why?

_____

How much water/juice/milk do they drink per day? _____
Are there any other concerns you would like us to address?

_____
_____
_____
_____

In all the areas listed below, please circle if the child has experienced any symptoms in the past 3 months:

General

Fevers Sweat easily Bleed or bruise easily Change in appetite Sudden energy drop (if yes, what time of day?) _____

Poor sleeping/insomnia chills Weight loss/gain Strong thirst Fatigue Night sweats Cravings (if yes, what? _____

Skin and Hair

Rashes Itching Change in hair/skin texture Ulcerations Eczema Hives Loss of hair Acne

Recent moles other: _____

Any childhood diseases? (chickenpox, etc.) If yes, what? _____
Have they had any immunizations? If yes, what and when?

_____

Head/Eyes/Ears/Nose/Throat

Dizziness Glasses Poor/blurry vision Eye strain Eye pain

Eye surgeries (if yes, what? _____)

Color Blindness Floaters (spots in front of eyes) Night blindness Tinnitus (Ringing in ears) Earaches Poor hearing (hearing aids?)

Has the child had a history of ear infections? If yes, how many and what was done to address the problem? _____
Headaches/Migraines (if yes, where located?): _____
Sinus problems Teeth grinding Concussions Nose bleeds jaw clicks
Recurrent sore throats Sores on lips/tongue Other: _____
Do they have a tendency to catch colds/flus regularly? If yes, how frequently per year? _____

Cardiovascular

Blood pressure: high or low Irregular heartbeat cold hands/feet History of blood clots difficulty breathing Swelling of hands/feet Phlebitis chest pain fainting Other: _____

Respiratory

Cough bronchitis difficulty breathing when lying down asthma Production of phlegm (if yes, what color?): _____ Coughing blood pneumonia pain with deep breath Other: _____

Gastrointestinal

Nausea vomiting diarrhea constipation gas belching black stools blood in stools indigestion/"tummy aches" bad breath rectal pain hemorrhoids bleeding gums abdominal pain/cramps other: _____

Are there any food avoidance issues? If yes, what and why (do they experience certain side effects after eating certain foods(: _____
_____

Genitourinary

Pain upon urination frequent urination blood in urine urgency to urinate unable to hold urine night urination (if yes, how frequently and when did it start?): _____
Kidney stones decrease in flow sores on genitals other: _____

Reproductive (complete if applicable for the age of the child)Is the child pregnant? **Yes no**

Is it possible they could be pregnant? **Yes no**

Pregnancies: #_____ Live births: #_____ Miscarriages: #_____

Abortions: #_____ Premature births: #_____ Date of last PAP: _____

Age of first menses: _____ Duration of menses: _____

Irregular periods spotting between periods unusual character (heavy, light)
Painful periods clots vaginal discharge vaginal sores breast lumps

Any changes in body/psyche prior to menses onset (PMS): _____
Does the child Practice birth control (if yes, what kind?) _____

Musculoskeletal (please circle areas where they report the pain)
Neck back/spine hand/wrist shoulder elbow knee ankle hips

Muscle weakness numbness parasthesias (tingling) other: _____

Neuropsychological

Seizures dizziness loss of balance lack of coordination poor memory
Concussion depression anxiety bad temper easily susceptible to stress
Has the child been treated for emotional challenges? **Yes no** Have they ever considered or attempted suicide? **Yes no**
Any other neuropsychological issues? _____

Completed by: _____ (parent/Caregiver)