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Holistic Pediatric Nurse Practitioner/Holistic Primary Care

Child's Name_____ **Date of Birth** _____

Parent's name _____ **Date of visit** _____

Address _____

Home# _____ **Cell#** _____

Reason for visit? _____

Who referred you? _____

Birth History

Age conception _____ natural/IVF_____ # pregnancies _____

Illness/meds/vaccines during preg _____ #

sonograms during preg _____

Who delivered your baby and where?

_____

Vaginal/c sect_____ # weeks gestation_____ Birth weight

_____

Baby go home with mom or stay in hospital (# of days) _____

Breast fed after delivery?_____ Hep B vaccine at birth? _____

Medications/Supplements/Vaccinations/past medical history

Vaccinations (circle one) up to date delayed schedule religious exemption

Vaccinations - any adverse reactions? _____

Hospitalizations _____

ER visits _____
Surgeries_____

Other providers (including hearing/vision exams) _____

_____

_____

Antibiotics use /how many courses_____

Current medications _____

Current supplements _____

History of recurrent illness? _____
_____

Please list any **active** medical diagnoses/concerns, when symptoms started, and what treatments/medications have been used (if needed use space at end of form):

Please list any **past** diagnoses, when symptoms started and stopped, and what treatments were and were not successful (if needed use space at end of form):

Development

Development: Age when turned over_____sat up_____ crawl_____ walk_____ speech_____

Developmental delays?
_____

Sensory processing disorders? _____

School age only:

Focus/attentive_____ Math(grades) _____ Reading (at or below grade level) _____

Handwriting _____ Socializing_____

Extracurricular activities _____

Parent's Past Medical History (**for both partners**)

Current/past/childhood illness/delays

_____

_____

Current medications/therapies_____

_____

Metal dental fillings _____

History of military work

_____

Diet/sleep/bowel pattern

Breast fed until what age? _____ Type of formula _____

Difficulty feeding/colicky first few months of life? _____

Age solids started? _____ Food sensitivities/allergies? _____

Present diet (include any restrictions; include mom's diet if currently breast feeding): _____

Difficulty falling asleep/staying asleep:

_____

Bowel habit (size, amount, frequency, color, constipation/diarrhea):

_____

_____

Potty trained? _____ Bed wetting? _____

Environment/Electronics

#hours: tv/computer/iphone/ipad etc each day? _____

Use of electronic devices in bedroom? _____

Pets? _____ Smokers in household? _____

Home built before 1978? _____ Recent construction to home?_____

Body cleansers (soap, shampoo, lotions, creams etc) _____

_____

Household cleaners used? _____

Please use the following space for any additional information you would like to add: