ZIEGLER
INTEGRATIVE HEALTH
Care for the whole person

CONFIDENTIAL PEDIATRIC HEALTH HISTORY FORM

(To be completed by parent/guardian)

Child's Name: _____ Date: _____

Male: _____ Female: _____ Age: _____ Date Of Birth: _____

Home Address: _____
Number & Street

_____

City Prov Postal Code

Parent's Name (s): _____

Home Phone: (___)_____Work Phone: (___)_____

Email: _____

Would you like to receive our quarterly newsletter? Yes No

Please list all other health care providers.

_____
_____
_____

What are your child's health concerns, in order of importance?

1. _____
2. _____
3. _____
4. _____
5. _____

How would you describe your child's general state of health? Excellent Good Fair Poor

List any **Medications**, Herbs, Vitamins, etc. your child is taking and dose:

_____
_____
_____

2146 Robinson Street
Regina, SK S4T 2P7

ph. 306.757.HEAL
www.zieglerhealth.com
allison@zieglerhealth.com

Medical History

How was your child's health in the first year of life? Poor Fair Good Excellent

_____

_____

Has your child ever taken antibiotics? Yes No If yes, for how long and for what condition?

_____

_____

Please list any illnesses, injuries and hospitalizations your child has sustained:

_____

_____

_____

Indicate which of the following your child has had:

	Rubella (German Measles)		Whooping Cough
	Measles		Strep Throat
	Chicken Pox		Impetigo
	Roseola		Mononucleosis
	Mumps		Ear Infections
	Scarlet Fever		

Indicate which immunizations your child has had:

	DPT (diptheria, pertussis, tetanus)		Prevnar
	Tetanus Booster; When?		H1N1
	MMR (measles, mumps, rubella)		Polio
	Chicken Pox		Hepatitis A
	HPV (Guardasil)		Mennigococal
	Haemophilus Influenza B		Rotavirus
	Hepatitis B		Other:
	Influenza		

Did your child experience any adverse reactions to any of the above immunizations? If so, please list to which immunization and reaction.

_____

_____

Does your child have any allergies? Yes No If yes, please indicate to what. _____

_____

_____

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Family History
If any blood relatives have had any of the following please circle.

Diabetes, hypoglycemia, heart disease, kidney disease, cancer, TB, allergies, bleeding disorders, glaucoma, seizures, mental illness, sickle cell anemia.

Grandparents: L=Living D=Deceased

Fathers Side	**Mothers Side**
Grandmother: L/D Age: _____	**Grandmother:** L/D Age: _____
_____	_____
_____	_____
_____	_____
Grandfather: L/D Age: _____	**Grandfather:** L/D Age: _____
_____	_____
_____	_____
_____	_____

Parents: L=Living D=Deceased

Father: L/D Age: _____	**Mother:** L/D Age: _____
_____	_____
_____	_____
_____	_____

List Brothers/Sisters and ages: Medical Problems: L=Living D=Deceased

B/S L/D Age: ____	B/S L/D Age: ____	B/S L/D Age: ____	B/S L/D Age: ____	B/S L/D Age: ____	B/S L/D Age: ____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Prenatal History

What was the health of the parents at conception?

Mother: Poor Fair Good Excellent Unknown

Father: Poor Fair Good Excellent Unknown

How was the health of the mother during pregnancy?

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Poor Fair Good Excellent Unknown

Did the mother receive prenatal medical care? Yes No If yes, list what medical care she received: _____

Please indicate if the mother experienced any of the following during the pregnancy:

	Bleeding		Nausea
	Diabetes		Vomiting
	High Blood Pressure		Physical or Emotional Trauma
	Thyroid Problems		Other:

Please indicate if the mother used any of the following during pregnancy:

	Alcohol
	Tobacco
	Recreational drugs:
	Prescription Medications:
	Over-the-counter Medications:
	Supplements:
	Other:

Birth History

Type of Birth: Vaginal C-Section Induced Forceps Anesthesia used

Term Length: Full Premature:_____ wks Late:_____ wks

Length of Labour: _____ Weight at Birth: _____

Please list any complications during the birthing process: _____
_____

Indicate if your child experienced any of the following at or shortly after birth:

	Jaundice		Birth Injuries:
	Rashes		Birth Defects:
	Seizures		Other:

Nutrition

How was your infant fed?
Breast Fed. How long? _____ Formula. Mild/Soy/Other: _____
Other: _____

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Please indicate which foods were introduced before 6 months of age with approximate month. _____
_____
_____
_____

6-12 months?

_____
_____
_____
_____
_____

Did your child have colic? Yes No

Does your child have any dietary restrictions (religious, vegetarian/vegan, etc)?

_____
_____

What does your child typically eat for:

Breakfast?	Lunch?	Dinner?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What does your child snack on? _____
_____

What beverages does your child consume (including total quantity)? _____
_____

Environment

Is your child in: School Daycare Home Care Other: _____

What are your child's favorite activities? _____
_____

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Does your child exercise regularly? Yes No If yes, how much and how often? _____

_____

Does anyone in your child's household smoke? Yes No

Are there animals in the home? Yes No If yes, what kind? _____

How is the child's home heated? _____

List any toxins or other hazards your child is regularly exposed to:

_____

_____

_____

How would you describe the emotional climate of your child's home?

_____

_____

_____

How is your child's ability to concentrate and focus on tasks at home?

_____

_____

At school?

_____

_____

_____ _____

Parent/Guardian Signature **Date**

_____

Name, Please Print

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