Seattle Healing Arts Center

CHILD HEALTH HISTORY

Child's Name: _____ Date of Birth: ___/___/_____ Today's Date: ___/___/_____

Parent_____Age _____ Parents are: married, divorced,

Parent_____Age_____ domestic partners, other:_____

Other Important Caregivers_____

Brothers' Names & Ages_____

Sisters' Names & Ages _____

Household members? _____

Who takes care of child most of the time?_____Is child: adopted____in foster care____

THIS CHILD'S HEALTH HISTORY

Birth Weight:_____ lbs._____oz.

Length of Pregnancy:_____months _____weeks

Normal Labor? Yes No

Normal Delivery? Yes No

Did child have problems after birth? Yes No*

Surgeries: Date: _____
Type: _____

Injuries:_____

Has child had a problem with any of the following*

_____Vision or Hearing
_____Developmental delays
_____Ear infections
_____Pneumonia or bronchitis
_____Asthma or breathing problems
_____Hay fever or skin rashes
_____Seizures
_____Bed wetting
_____Anemia
_____Kidney or bladder
_____Allergies (what kind?)

Other:_____
*Explain:_____

_____

_____

HEALTH CARE HISTORY

Name of previous doctor or clinic:

_____

Medications:_____

_____

Supplements:_____

_____

Immunizations up to date? Yes No Not sure

Passive smoke exposure? _____

Date of last physical exam: ___/___/_____

Date of last dental exam: ___/___/_____

Check if **family members** have had:

_____Diabetes
_____High Blood Pressure
_____Heart Disease/High Cholesterol
_____Asthma or Hay Fever
_____Depression or Mental Illness
_____Tuberculosis (TB)
_____Seizures
_____Alcohol or Drug Use
_____Violent Behavior
_____Cancer
_____Sickle Cell Disease/Thalesemia
_____Slow Learner/ Mental Retardation
_____Hearing Loss/ Deafness

Other:_____

_____

PARENTAL CONCERNS: do you have concerns about this child's:

Behavior? _____

Development? _____

Nutrition? _____