WHOLE CHILD TEXAS

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New Patient Health Questionnaire

Child's Name:	
Date of Birth:	**Child's Gender: M F**
Form Completed by:	**Date Form Completed:**
Guardian:	**Relationship to Pt:**
Phone (main):	
Phone (alternate):	**Email:**
Address:	
Referred by:	

SPECIALISTS/THERAPISTS WORKING WITH YOUR CHILD

Name:	Name:
Address:	Address:
Phone:	Phone:

SCHOOL INFORMATION

School Name:	Grade:
Address:	Teacher:
Phone:	Fax:

MEDICAL INFORMATION

Please summarize your main concerns at this time:

CHILD'S MAIN MEDICAL DIAGNOSES:

1)	2)	3)

Please check any symptoms/concerns you have about your child at this time:

- ☐ Developmental Differences
- ☐ Behavioral Difficulties
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Frequent infections
- ☐ Seizures
- ☐ Other Neuro issues (i.e. muscle tone)
- ☐ Allergies
- ☐ Sleep Problems
- ☐ Energy Problems
- ☐ Environmental Issues
- ☐ Nutrition
- ☐ Medications/Therapies
- ☐ Vaccinations
- ☐ Sensory Issues
- ☐ Other:

Prenatal (Pregnancy) History:

Full-term
Premature: _____ wks
Breastfed (how long): _____

Vaginal Birth
C-section
Formula-fed (type):

Birth Weight:
Where Born (Hospital, City/State):
Complications/Notes:

_____
_____
_____
_____
_____

Please describe events surrounding the onset of your child's medical problems and the impact it has had on your child and family.

Please describe your child's personality (i.e. happy, stubborn, rigid, easygoing, perfectionistic).

Describe your child's behavioral, developmental and/or emotional strengths and challenges.

Does your child take any medications? No Yes (If yes, please complete

Name of medication	What was it used for?	Dosage and how often?	How long?

Does your child have allergies? No Yes (If yes, please complete)

Name of product/med/food	Age at reaction	Type of reaction

Is your child on a special nutritional diet? If so, please describe:

Is your child taking any medications, herbals, homeopathic remedies, vitamins, or neutraceuticals? You can attach a list if you prefer.

Name	What was it used for?	Dosage and how often?	For how long?

Have you used any alternative or complementary therapies for your child?

Name of Therapy	What was it used for?	How often was it used?	Did it work?	Are you still using it?

VACCINATIONS

Please describe questions or concerns you have, if any, regarding vaccines:

_____

_____

_____

FAMILY INFORMATION

Parents' Education/Occupations:

☐ Married (date:) Separated (date:) Divorced (date:) Never Married
Was your child adopted? No Yes How old was the child at the time of adoption? _____
If separated, child's primary legal residence is with whom? _____

Brothers and Sisters

Name	Age	Grade	Relation to Child ? (full, half, step)	Where Living?	Any concerns?

Please describe family relationships:

_____
_____

Has your child and/or family experienced any recent stressful events? (i.e. arguments with family/friend, peer problems, death, divorce, illness, financial problems) No Yes
If yes, please explain: _____

_____
_____
_____

FAMILY MEDICAL HISTORY

Please check all medical conditions that have occurred in the child's immediate relatives (parents, grandparents, siblings and half-siblings, aunts, uncles and cousins). Indicate whom the person is in the space provided.

Condition	**No**	**Yes**	**Mother's Family**	**Father's Family**
Autistic Spectrum Disorder				
Attention Deficit Disorder (ADHD)				
Mental Retardation				
Learning Disability				
Other Genetic Syndromes				
Asthma/allergies				
Chronic Headaches				
Irritable Bowel Syndrome				
IBD (crohns, colitis)				
Autoimmune disorders				

Condition	No	Yes	Mother's Family	Father's Family
Depression/Bipolar				
Suicide Attempt/Suicide				
Anxiety				
Substance Abuse				
Obsessive Compulsive Disorder				
Other				

EDUCATIONAL INFORMATION

Do you have any specific concerns about your child's school progress (such as academics, social, teacher or peer relationships)?

☐ No Yes, explain ----------

_____

_____

_____

☐ Has your child missed school in the past year?

No 1-10 days 11-25 days 26-50 days 50+ days

Has your child had a school evaluation due to special learning needs? No Yes

Does your child have an Individualized Education Plan (IEP)? No Yes

Does your child have a 504 Plan? No Yes

MEDICAL RECORDS

Please fax us copies of evaluations, laboratory tests, vaccinations received and any other information you feel is important for us to review, to 972-268-9424.