Patient History

Patient Name:____________________________Date of Birth:___________Gender:________Today's Date:___________

Please list all other individuals living in the child's home:

Name	Relationship to Child	Birthdate	Biological Parent Y / N	Adoptive Parent Y / N	Foster Parent Y / N	Other

Are the child's parents: ☐Married ☐Unmarried, living together ☐Separated ☐Divorced ☐Other (specify)____________

If divorced: ☐ Joint Custody ☐ Single Custody

If one or both parents do not live in the home, how often does the child see this parent(s)?__________________________

Are there siblings not listed? Y / N If so, please list their names, birthdates, and where they live:______________________

____

Which languages are spoken regularly in the home?____

Do you have any communication requirements needing vision/hearing support or to help you better understand your visit today?____

Does anyone besides parents provide care for your child? (i.e. relatives, nanny, friend) Y / N

If yes, who:____

Does your child attend daycare?__________________Is your child in school?___________________________________

Are there guns in the home? Y / N If yes, are they locked? Y / N

Are there pets in the home? Y / N If yes, what kinds?____

Is there any tobacco/vaping/marijuana exposure? Y / N

What are the parent's/parents' occupations?____

Does your family have dietary preferences/restrictions (please list)?____

Medical History

Were there any significant complications during pregnancy or delivery for your child?_____________________________

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Does your child have any major medical problems for which they are followed by a doctor or specialist?______________

____

Has your child had any surgeries or hospitalizations?____

Any Emergency Room visits over the past year (for example: concussions, broken bones, or asthma attacks)?__________

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