PRE SCHOOLER — PERSONAL & CONFIDENTIAL INFORMATION

(for ages 2 to 5)

PATIENT NAME: _____

Date: _____ A.H.C.I.P.:

Complete Address: _____

MOTHER'S Name: _____ MOTHER'S Work Phone: _____

FATHER'S Name: _____ FATHER'S Work Phone: _____

HOME Phone: _____ NUMBER OF SIBLINGS: Brothers _____ Sisters _____

1. CHILD'S BIRTHDATE: _____ AGE: _____ SEX: M ___ F_____
2. WEIGHT: _____ HEIGHT: _____
3. Reason for CHILD'S visit: _____

LIFESTYLE QUESTIONS

1. CHILD spends most of the day with:

   (a) mother (b) father (c) grandparents (d) sitter (e) daycare

   (f) kindergarten (g) other _____

2. Circle the letter that indicates your child's hand of dominance: (a) Right (b) Left
3. Did your child have prior (earlier) health problems they have outgrown or which have been corrected?

   No ☒ Yes ☒ if yes, please explain _____

4. What is the Child's bedtime? _____ Number of hours of sleep per night: _____
5. Quality of sleep: (a) Good (b) Fair (c) Poor (d) Restless
6. Does your child awaken frequently with a regular complaint? No ☒ Yes ☒
7. Recently, has your child awakened complaining of pain? No ☒ Yes ☒
8. Would you describe your child's health as:

   (a) very robust (b) very good (c) average (d) poor (e) sickly

9. Has there been a recent change in the CHILD'S energy level? No ☒ Yes ☒

   if yes, is it: Higher ☒ or Lower ☒

10. Has there been a recent change in the CHILD'S strength? No ☒ Yes ☒
11. Are there any concerns with the child's diet? No ☒ Yes ☒

    if yes, please explain _____

12. At what age was the child potty trained? _____
13. Are you concerned with any of the following regarding bowel and bladder function?

    (a) Regularity (b) Stool consistency (c) Pain with bowel movements (d) Bedwetting

PRE-SCHOOLER HEALTH HISTORY

1. Please check any of the following if they are a concern to you:

   Mouth breathing ☐ Snoring ☐ Tonsillitis ☐

   Recurrent ear infection ☐ Hoarseness ☐ Recurrent throat infections ☐

   Difficulty breathing ☐ Watery or swollen eyes ☐ Sinus infection - ☐

   Recurrent eye infection ☐

2. Please check any occurrence of Childhood diseases or conditions:

   Mumps ☐ Measles ☐ Chicken pox ☐ German Measles ☐

   Baby Measles ☐ Anaemia ☐ Thrush ☐ Hernia ☐

   Undescended testicles ☐ Other _____

3. Does your child complain of pain or soreness in the legs, knees, ankles, or feet? No ☐ Yes ☐
4. Does your child complain of pain or soreness in the arms, elbows, wrists, or hands? No ☐ Yes ☐
5. Is your Child currently (or recently) taking any of the following medications? No ☐ Yes ☐

   (a) Antibiotics ☐ For what:

   _____

   (b) Tylenol ☐ (c) Aspirin ☐ (d) other medications _____

6. Is your child following an immunization program? No ☐ Yes ☐
7. Has your child had any reaction to the immunization program? No ☐ Yes ☐
8. Has your child had any allergic reaction to any medications? No ☐ Yes ☐
9. Does your child have any problem with dry scaly skin or persistent rashes? No ☐ Yes ☐
10. Is your child showing any signs of having Asthma or Bronchitis? No ☐ Yes ☐
11. Has your child been examined by an allergist? No ☐ Yes ☐
12. Is your child having allergy shots? No ☐ Yes ☐
13. Has your child **ever** been Hospitalized? No ☐ Yes ☐

    if yes, why? _____

14. Has your Child had any broken bones? No ☐ Yes ☐ if yes, what _____
15. Has your child ever experienced a dislocation? No ☐ Yes ☐
16. Has your child ever been involved in a Motor Vehicle accident? No ☐ Yes ☐
17. Has your child ever received any major trauma? No ☐ Yes ☐
18. Has your child ever had any trauma to the spine? No ☐ Yes ☐
19. Has there been a problem in the CHILD'S walking? No ☐ Yes ☐

20. Do you have any concern regarding your child's walking pattern? No ☐ Yes ☐

(a) Limp (b) Toe walking (c) Scoliosis (d) Pain (e) Foot positioning

(f) Unusual shoe wear (g) Other _____

21. Date of last visit to G.P. _____ Name _____

PURPOSE:_____

22. Date of last visit to Paediatrician _____ Name _____

PURPOSE: _____

23. Has your child had any reason to see a Dentist? No ☐ Yes ☐ if yes, please answer below:

Date of last visit to Dentist _____ Name _____

PURPOSE: _____

24. Does your child frequently have a low-grade fever? No ☐ Yes ☐

25. Is there a history of high recurrent fevers? No ☐ Yes ☐

26. Does the child presently have a fever? No ☐ Yes ☐

27. Have you noted a history of frequent, recurrent swollen lymph nodes? No ☐ Yes ☐

28. Does your child have a bloated or distended abdomen? No ☐ Yes ☐

29. Have you noted any changes or difficulty with speech? No ☐ Yes ☐

30. Are there any hereditary health problems? No ☐ Yes ☐

31. Is your child involved in a physical education program? No ☐ Yes ☐

32. Do you have any concerns regarding your child's health that this questionnaire has failed to address? No ☐ Yes ☐

if yes, please state _____

_____