PRE TEEN — PERSONAL & CONFIDENTIAL INFORMATION

(for ages 6 to 12)

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

Patient Name: _____

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 the CHILD'S visit: _____

LIFESTYLE QUESTIONS

1. CHILD spends most of the day with: (a) mother (b) father (c) grandparents

   (d) public school (e) home school (f) private school
2. Circle the letter that indicates your child's hand domination: (a) Right (b) Left
3. Did your child have prior (earlier) health problems that 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. Has your family experienced strong emotional distress such as:

   (a) None of the following (b) separation (c) divorce (d) loss of parent (mother / father)

   (e) loss of a sibling (sister / brother) (f) recent death of someone close (g) near fatal disease

   (h) strong emotional upset (i) other _____
7. Does your child awaken frequently with a regular complaint? No ☒ Yes ☒
8. Recently, has your child awakened complaining of pain? No ☒ Yes ☒
9. Would you describe your child's health as:

   (a) very robust (b) very good (c) average (d) poor (e) sickly
10. How is your child's schooling progressing:

    (a) No concerns (b) poorly (c) average (d) doing well
11. Has there been a recent change in the child's energy level? No ☒ Yes ☒

    if yes, is it: Higher ☒ Lower ☒

12. Does your child seem to be developing as you would expect:

    regarding size, strength and co-ordination? No ☐ Yes ☐

13. Are there any concerns with the child's diet? No ☐ Yes ☐

    if yes, please explain _____

14. 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

HEALTH HISTORY

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

    Mouth breathing ☐ Snoring ☐ Tonsillitis ☐ Adenoids ☐

    Recurrent ear infection ☐ Tubes in ears ☐ 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 ☐ Appendix ☐ Other _____

3. Does your child have or complain of frequent HEADACHES? No ☐ Yes ☐
4. Does your child complain of pain or soreness in the legs, knees, ankles, or feet? No ☐ Yes ☐
5. Does your child complain of pain or soreness in the arms, elbows, wrists, or hands? No ☐ Yes ☐
6. 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 _____

7. Is your child following an immunization program? No ☐ Yes ☐
8. Has your child had any reaction to the immunization program? No ☐ Yes ☐
9. Has your child had any allergic reaction to any medications? No ☐ Yes ☐
10. Does your child have any problem with dry scaly skin or persistent rashes? No ☐ Yes ☐

11. Is your child showing any signs of having Asthma or Bronchitis? No ☐ Yes ☐

12. Has your child been examined by an allergist? No ☐ Yes ☐

13. Is your child having allergy shots? No ☐ Yes ☐

14. Has your child ever been Hospitalized? No ☐ Yes ☐

    if yes, why? _____

15. Has your child had any broken bones? No ☐ Yes ☐ if yes, what _____

16. Has your child ever experienced a dislocation? No ☐ Yes ☐

17. Has your child ever been involved in a Motor Vehicle accident? No ☐ Yes ☐

18. Has your child ever received any major trauma? No ☐ Yes ☐

19. Has your child ever had any trauma to the spine? No ☐ Yes ☐

20. Have you noticed any unusual shoe wear? No ☐ Yes ☐

21. 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 _____

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

    PURPOSE: _____

23. Date of last visit to Paediatrician _____ Name _____

    PURPOSE: _____

24. 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: _____

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

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

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

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

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

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

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

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

33. Is your child having any visual problems? No ☐ Yes ☐

34. Has an optometrist or an ophthalmologist checked your child's eyes? No ☐ Yes ☐

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

    if yes, please state _____

    _____