burien wellness

You were born to be healthy.

PEDIATRIC PATIENT INFORMATION

Date _____

Name _____ _____ _____
Last First Middle Initial

Address _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age_____ Birthday_____/_____/_____

1st Parent / Guardian Name _____

Relationship _____

Contact Number _____

Email _____

2nd Parent / Guardian Name_____

Relationship _____

Contact Number _____

Email _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name _____

Relationship _____

Contact Number _____

Who may we thank for referring you?_____

_____

HOW CAN WE HELP YOU?

What brings you in today? ☐ Wellness ☐ Physical Complaint ☐ Accident

☐ Other, Please describe: _____

PRENATAL HISTORY

Complications during pregnancy? ☐ No ☐ Yes

If yes, what complications did you experience? _____

_____

Maternal vaccinations during pregnancy? ☐ No ☐ Yes

If yes, which vaccinations? _____

_____

Maternal medications during pregnancy? ☐ No ☐ Yes

If yes, what medications? _____

Maternal substance use? ☐ None ☐ Alcohol ☐ Tobacco

☐ Other: _____

Illness or infection during pregnancy? ☐ No ☐ Yes

If yes, please describe _____

_____

Ultrasounds or other testing? ☐ No ☐ Yes

_____

BIRTH HISTORY

Place of Birth	Birth Provider	Type of Birth	Interventions During Labor	
☐ Birth Center	☐ Midwife	☐ Vaginal (Vertex)	☐ Pain Medication	☐ Epidural
☐ Home	☐ OB-GYN	☐ Vaginal (Breech)	☐ Pitocin	☐ Vacuum Extraction
☐ Hospital	☐ Other	☐ C-Section	☐ Forceps	☐ Twisting / Pulling

Was labor induced? ☐ No ☐ Yes If yes, why?_____

Did the child experience: ☐ Misshapen skull ☐ Torticollis ☐ Colic ☐ Other: _____

APGAR score: _____ ☐ Unknown

CHILDHOOD HISTORY

Has your child been vaccinated? ☐ No ☐ Yes

Reason: ☐ Informed Consent ☐ Pediatrician Recommended ☐ I didn't know I had a choice

Did your child have any negative reaction to the vaccines? ☐ No ☐ Yes

If yes, what did they experience? _____

Was this reaction reported? ☐ No ☐ Yes

Does your child have food or seasonal allergies? ☐ No ☐ Yes

If yes, please describe _____

Has your child been on any medications, including antibiotics? ☐ No ☐ Yes

If yes, how often and for what purpose? _____

Has your child ever been hospitalized? ☐ No ☐ Yes, for _____

Does your child participate in any athletics or other extra-curricular activities? ☐ No ☐ Yes

If yes, which and how often? _____

How is your child's diet?
- ☐ Well-Balanced
- ☐ Average
- ☐ Below Average/Highly Processed

How is your child's sleep quality?
- ☐ Excellent
- ☐ Fair
- ☐ Poor

Child's average nightly sleep?
- ☐ >12 Hours
- ☐ 9-12 Hours
- ☐ 6-9 Hours
- ☐ < 6 Hours

BABY / TODDLER (0-5 Years)

Check the box beside any condition your child has had. **Please circle the condition(s) which bother your child the most.**

- ☐ Jaundice
- ☐ Anemia
- ☐ Cyanosis
- ☐ Seizures
- ☐ Tonsillitis
- ☐ Frequent ear infections
- ☐ Colic
- ☐ Frequent diarrhea
- ☐ Frequent constipation
- ☐ Sleeping problems
- ☐ Frequent fevers
- ☐ Frequent colds/viral infections
- ☐ Reflux
- ☐ Fall from a height <4 feet
- ☐ Fall from a height >4 feet
- ☐ Fall down stairs
- ☐ Use of a soft structured carrier
- ☐ Car accident
- ☐ Other: _____

CHILD / TEEN (6-17 Years)

Check the box beside any condition your child has had. **Please circle the condition(s) which bother your child the most.**

- ☐ Fall from a height <4 feet
- ☐ Fall from a height >4 feet
- ☐ Sports accident
- ☐ Car accident
- ☐ Stomach pain/indigestion
- ☐ Hyperactivity/ADHD
- ☐ Autism/Asperger's
- ☐ Leg/knee pain
- ☐ Arm/shoulder pain
- ☐ Growing pains
- ☐ Learning difficulties
- ☐ Bed-wetting
- ☐ Asthma
- ☐ Allergies
- ☐ Headaches/migraines
- ☐ Anxiety/depression
- ☐ Scoliosis
- ☐ Severe menstrual cramps
- ☐ Other: _____

Is there anything else you would like the doctor to know? _____

_____