reboot center
FOR INNOVATIVE MEDICINE™

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PEDIATRIC HEALTH FORM

Patient name: ______________________________________ Date of birth: _______________

I. Purpose of visit (please be as detailed as possible)

____

____

Physicians most recently consulted regarding the above: _________________________________

Primary Care Physician: ____

Please list symptoms in order of importance: Severity (1=mild, 10=severe)

1. ____ ____________
2. ____ ____________
3. ____ ____________
4. ____ ____________
5. ____ ____________

II. Personal & Family Health History

Please circle each condition that applies to the child or one of his or her family members. Note whether condition is resolved or current. Indicate the relationship, such as "mother", or the word "self" in the "Relationship" column.

Disease	Relationship	Resolved/Current	Disease	Relationship	Resolved/Current
Alcoholism			Heart Disease		
Arthritis			High Blood Pressure		
Asthma/Allergies/Hives			Hip Disorders at Birth		
Autoimmune Disease			HIV/AIDS		
Birth Defects			Kidney Disease		
Bleeding Tendencies			Lazy Eye		
Cancer (*note type*)			Mental Problems		
Chemical Dependency			Strokes		
High Cholesterol			Obesity		
Depression			Suicide		
Diabetes			Thyroid Disease		
Emotional Problems			Tuberculosis		
Epilepsy/Convulsions			Other:		
Gastrointestinal Disease			Other:		

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Please note DOB and state of health of each immediate family member:

	Date of Birth	Ht.	Wt.	State of Health
Father				
Mother				
Sibling				
Sibling				
Sibling				

Date of most recent annual physical exam: ________________________________ Results: ___________________________

Date of most recent dental visit: __________________________ Date of most recent eye exam: ______________________

Any other recent health exams conducted (including labs, diagnostic imaging procedures, acute exams)? Yes No

If yes, please list: ____

Note frequency of occurrence of the following condition(s):

Chicken Pox: ________________ Ear infections: _________________ Eye Problem: _____________________

Tonsillitis: ___________________ Urinary infections: ______________ Heart Murmur: ____________________

Pneumonia: __________________ Bronchitis/Wheezing: ____________ Bedwetting: ______________________

Convulsions: ________________ Asthma: _______________________ Other: __________________________

Any other illnesses, injuries, surgeries, or hospitalizations not described above? Yes No

If yes, please describe: ____

Please indicate all vaccinations administered, including the month/year, and any adverse reactions noted. Attach additional documentation, including a copy of the child's Immunization Record, if available:

____

____

III. Social History & Lifestyle Habits

Marital status of parents: ____

Is there a gun in the home? Yes__ No__

Are there pets in the home? Yes__ No__

Does anyone in the home smoke? Yes__ No__

Are there financial problems in the family? Yes__ No__

Are there family disagreements on how to raise the child? Yes__ No__

Describe the child's typical daily diet:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____ Liquids: ____

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Dietary restrictions or avoidances: ____

Does the child get regular exercise? Yes No

IV. Pregnancy History of the Mother

Has the mother had breast surgery?	Yes___	No___
Did the mother take hormones during pregnancy?	Yes___	No___
Did the mother take any drugs during pregnancy?	Yes___	No___
Did anyone in the home smoke during the pregnancy?	Yes___	No___
Did the mother drink any alcoholic beverages during the pregnancy?	Yes___	No___

V. Birth History of the Child

Circle: Full term pregnancy/premature/adopted   Place of birth:___________________________

Type of delivery: __________________________________   Problems at birth? (*specify*)__________________

Circle: Breast fed/bottle fed   Apgars: _______ _______   Abnormal ultrasound during pregnancy: Yes___ No___

VI. Child's Development

Please list age when the following milestones were reached:

Walked: ________________________ Bladder trained:______________________

First words: _____________________   Bowel trained: _______________________

First teeth: ______________________

Any disabilities? ____

VII. School Performance (if over 6 yrs of age)

Academic performance: ___________________________ Behavior: _____________________________

Has the child ever been in a special education class? Yes No   Has the child had any learning challenges? Yes___ No___

If yes, what type of learning challenge(s)?____

VIII. Medications and Allergies

***Medications** and **supplements** you are currently taking, including **dosage, frequency**, and **how long taken**:*

Medicine: _____________________________ Dose: _____________________ Start date: _______________

Medicine: _____________________________ Dose: _____________________ Start date: _______________

Medicine: _____________________________ Dose: _____________________ Start date: _______________

Medicine: _____________________________ Dose: _____________________ Start date: _______________

Medicine: _____________________________ Dose: _____________________ Start date: _______________

Pharmacy Name: ________________________________ Pharmacy Phone Number: ______________________

Allergies to medications or substances: ____

Food sensitivities/allergies: ____

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IX. Anything Else?

Is there anything else that you feel we need to know in order to provide the best care?

____

X. Signature

I certify that the above information is correct to the best of my knowledge. I will not hold the Reboot Center Practitioners or Staff responsible for any errors or omissions that I may have made in the completion of this form.

Printed Name: ______________________________ **Relationship to Patient:** ________________
(Must be the patient (if able, and age 18+), guardian, or legal representative) (If you are the patient, please write "*Self*")

Signature: ________________________________ **Date:** ________________________________