# Pediatric Registration & History Form For Functional Medicine Nutrition

Patient Name: _____ S.S. #:_____
Address: _____ City: _____
State: _____ Zip Code: _____ Home or Mobile Phone #: _____
Birth Date: ___/___/____ Sex: ____ Weight: _____ Height: _____
Names of Parents/Guardians: _____]
Email Address for Contact_____
Referred By: _____

In Case of Emergency Contact: _____ Phone #: _____

**Assignment & Release:**
I, _____the undersigned, give authorization for care of the above named minor child.

Responsible Party Signature: _____ Date: _____

## PATIENT HISTORY

Name of Pediatrician: _____ Date of last visit: _____
Reason for visit: _____
Number of doses of Antibiotics your child has taken:
During the past 6 months: _____
Total during his/her lifetime: _____
Vaccination History: _____

**Circle any of the following conditions your child has suffered from:**

| | | | | |
|---|---|---|---|---|
| Ear infections | Scoliosis | Chronic Colds | Headaches | Seizures |
| Colic | Asthma/Allergies | Digestive Problems | ADHD | Auto Accident |
| Recurring Fevers | Growing/Back Pain | Bed Wetting | Broken Bones | |
| Falls | Esophagitis | Breath Holding | Learning Problems | |
| Injuries | Sleep Problems | Fatigue | Irritability | |
| Rocking | Poor eye contact | Bloody noses | Meningitis | |
| Skin disease | Food Intolerances | Socializing Problems | Autism | |
| Balance Problems | Lyme Disease | Juvenile Arthritis | Anxiety or Depression | |

Other (please list): _____

_____

_____

Please chart a complete 3-day log of all your child's typical meals, snacks, food and drink:

| Breakfast | Lunch | Dinner | Snacks | Snacks |
|---|---|---|---|---|
| | | | | |

**PRENATAL HISTORY**

Name of Obstetrician/Midwife: _____
Complications during pregnancy: Yes No (circle one)
If yes, please list: _____
Ultrasounds during pregnancy: Yes No (circle one)
If yes, how many: _____
Medications during pregnancy/Delivery: Yes No (circle one)
If yes, please list: _____
Cigarette/Alcohol use during pregnancy: Yes No (circle one)
Birth Intervention: Forceps Vacuum Extraction C-Section (circle one) Other_____
Complications during Delivery: Yes No (circle one)
If yes, please list: _____
Genetic disorders or disabilities: Yes No (circle one)
If yes, please list: _____
Birth Weight: _____ Birth Length: _____ APGAR Scores _____, _____

**FEEDING HISTORY**

Breast Fed: Yes No (circle one) If yes, how long: _____
Formula Fed: Yes No (circle one) If yes, how long: _____
Introduced to solid foods _____ months old.
Introduced to cows milk _____ months old.
Food/Juice Allergies or Intolerance Yes No (circle one) If yes, please list:_____

**DEVELOPMENTAL HISTORY**

According to National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, stairs etc.) Was this the case with your child? Yes No (circle one)
Is/has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, baseball, cheer leading, martial arts etc.) Yes No (circle one)
If yes, please list: _____
Has your child ever been involved on an auto accident? Yes No (circle one)

If yes, please list: _____
Has your child been seen on an emergency basis? Yes No (circle one)
If yes, please list: _____
Has your child had any prior surgeries? Yes No (circle one)
If yes, please list: _____

**CHILDHOOD DISEASES**

Has your child ever been diagnosed with any of the following:
Chicken Pox Yes No (circle one) If yes, what age? _____
Mumps Yes No (circle one) If yes, what age? _____
Rubella Yes No (circle one) If yes, what age? _____
Rubeola Yes No (circle one) If yes, what age? _____
Whooping Chough Yes No (circle one) If yes, what age? _____