Flaton ADDept Center

PEDIATRIC HEALTH HISTORY – Complete all items honestly

ALL ANSWERS ARE CONFIDENTIAL

Child's Name _____ Age _____ Birthday _____ Grade _____

PART A – HEALTH HISTORY

1. Birth History:

a. Birthplace/gender _____

b. Pregnancy complications _____

c. Delivery complications _____ [ ]no

d. Full term baby? ..... [ ]yes [ ]no

e. Birth weight _____

f. Birth length _____

g. Any nursery problems? _____[ ]no

2. Surgeries (Date, provider, procedure): _____

_____

_____

3. Hospitalizations (Date, reason, duration): _____

_____

_____

4. Trauma/Serious Injury (Date, what happened): _____

_____

_____

5. Social History

a. How long has your family lived in this area? _____

b. Where did you live prior to moving to the San Luis Obispo area? _____

c. Stressors? _____

d. Child lives with [ ] both parents [ ] Mother [ ] Father [ ] Other _____

6. Family History

Check and describe if any of your family members have/had any of the following diagnosis or symptoms:

[ ] ADHD [ ] Depression [ ] Anxiety Disorder [ ] Autism
[ ] Manic-Depressive (Bipolar) Disorder [ ] Alcoholism
[ ] Learning Disorder [ ] Addictions [ ] Heart Murmur
[ ] Obsessive-Compulsive Disorder [ ] Pacemaker
[ ] High Blood Pressure [ ] Abnormal Heart Rhythm
[ ] Sudden Death [ ] Heart attack (men before age 50, women before age 60) _____

_____

_____

7. Development

Ages when first sat _____ rolled _____ crawled _____ walked _____ first words _____ full sentence _____ rode a tricycle _____ rode a bike _____

PART B – MEDICAL

1. Has your child had any unusual problems with the following; please check and describe:
[ ]Sleeping [ ]Nightmares [ ]Nail Biting [ ]Bedwetting
[ ]Tics [ ]Anger/rages _____

_____

_____

2. Primary Medical Doctor (Current & past with dates):

_____

Last physical exam _____

3. Dentist _____

4. General Health Survey

a. Check if your child has had any unusual problem with the following; please check/circle and describe:

[ ] G.I. [ ] Eyes [ ] Ears/Nose/Throat [ ] Allergies
[ ] Heart [ ] Lungs [ ] Kidneys [ ] Bladder [ ] Skin
[ ] Bones, Muscle, Joints [ ] Blood [ ] Neurologic

_____

_____

_____

b. Check and describe if your child has ever:

[ ] been dizzy or passed out during exercise
[ ] been unconscious/had a concussion [ ] had a seizure
[ ] high blood pressure [ ] abnormal heart rhythm
[ ] had a heart murmur [ ] other heart problems

_____

_____

_____

5. Medications and Supplements

a. *Current* Medications and Supplements (if for ADHA, list current and past, incl. dates and dosages, using back of this form if additional space is needed):

_____

_____

_____

Last medication written: _____

b. Circle, if your child has taken any of the following:

[ ] greta [ ] azarcon [ ] rueda [ ] litargirio [ ] ghasard
[ ] mahayogaraj gugullu

c. Do you purchase remedies at any "curanderas" or ethnic grocery stores? [ ] yes [ ] no

d. Does your child take Omega 3? [ ] yes [ ]no

If yes, dose: _____

Please complete page 2

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PART B - MEDICAL continued:

6. Is your child up to date on immunizations? [ ] yes [ ] no
7. Testing:

a. Last vision testing date: _____ results: _____

b. Last hearing testing date: _____ results: _____

8. Allergic Reaction to Medication (state Medication):

_____

_____

_____

9. Therapist, Counselor, Psychologist (current/past; dates):

_____

_____

_____

10. Previous ADHD Care Providers (include dates):

_____

_____

_____

11. Psychiatric History (Date, provider, diagnosis):

_____

_____

_____

PART C – SCHOOL

1. Current School

a. School name _____

b. Grade average _____

c. Academic problems _____

d. Behavioral problems _____

_____

_____

2. Accommodations

Does your child have an IEP/504/SST? [ ]yes [ ]no

If yes, date, from where: _____

3. Educational Programs

a. Does your child attend special school/classes? [ ]yes [ ]no

If yes:

(1) Since when _____

(2) Program/Class name _____

(3) Instructor's name _____

(4) Reason for attending _____

PART C - SCHOOL; 'Educational Programs' continued:

b. Has your child been tested for a learning disability or has undergone psycho-education testing? [ ]yes [ ]no

If yes:

(1) Date of testing _____

(2) Name of provider _____

(3) Diagnosis _____

4. School Counseling

Does your child see a school counselor, special teacher, or speech therapist? [ ]yes [ ]no

If yes:

(1) Name _____

(2) Since when _____

(3) Reason for attending _____

PART D – LIFESTYLE

1. Diet [ ]balanced [ ]high in sugars/starches
[ ]breakfast is the best meal _____

_____

2. TV/Technology Time (hrs per day/week) _____
3. Activities/Exercise _____

_____

4. Sleep

a. Time of lights out _____ Falls asleep at _____

b. Ease of initiation _____

c. Bedtime routine? [ ]yes [ ]no
if yes, describe: _____

_____

d. Ease of sleep (awakening, reinitiating, etc.) _____

_____

e. Time of arousal _____ Awakens feeling (rested, sleepy, etc.): _____

_____

5. Behavioral

a. Temperament _____

_____

_____

b. Agitative behaviors _____

_____

_____

c. Peer relationships (friends, siblings, partners) _____

_____

_____