



## GROWTH & DEVELOPMENT

Infant feeding:  Breast  Bottle  Formula

Number of hours of sleep each night: \_\_\_\_\_ Quality of sleep: \_\_\_\_\_

At what age did the child: \_\_\_\_\_

Respond to sound: \_\_\_\_\_ Crawl: \_\_\_\_\_ Hold head up: \_\_\_\_\_

Stand: \_\_\_\_\_ Sit unsupported: \_\_\_\_\_ Walk unsupported: \_\_\_\_\_

## CHILDHOOD DISEASES, ILLNESSES & VACCINATIONS

Has your child had (check all that apply)?:

- Chicken Pox  Measles  Rubioli  
 Mumps  Rubella  Pertussis/Whooping Cough

Has your child ever suffered from (check all that apply)?:

- Allergies  Broken Bones  Digestive Issues (constipation/diarrhea)  Hypertension  Orthopedic Problems  
 Anemia  Chronic Ear Aches  Juvenile / Rheumatoid Arthritis  Paralysis  
 Arm Problems  Colds/Flu  Dizziness  Joint Problems  Poor Appetite  
 Asthma  Colic  Fainting  Leg Problems  Ruptures/Hernias  
 Back Aches  Convulsions/Seizures  Headaches  Neck Problems  Sinus Trouble  
 Bed Wetting  Delayed Speech  Heart Trouble  Neuritis  Tuberculosis  
 Behavioral Problems  Diabetes  Hyperactivity  Walking Problems

Have you vaccinated your child?

- No  Yes  As Scheduled  Delayed Schedule

## ALLERGIES, MEDICATIONS, SURGERIES & FAMILY HISTORY

ALLERGIES (list)

\_\_\_\_\_  
\_\_\_\_\_

MEDICATIONS (list)

\_\_\_\_\_  
\_\_\_\_\_

SURGERIES (list)

\_\_\_\_\_  
\_\_\_\_\_

FAMILY HISTORY (list)

\_\_\_\_\_  
\_\_\_\_\_

## SIBLINGS

How many children do you have? \_\_\_\_\_ Number of pregnancies: \_\_\_\_\_

Children's Ages: \_\_\_\_\_ Are you currently pregnant?  No  Yes, I'm due: \_\_\_\_\_

Children's health concerns: \_\_\_\_\_ Health concerns regarding this pregnancy? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### Authorization for Care of Minor

I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

Signed: \_\_\_\_\_ Witnessed: \_\_\_\_\_ Date: \_\_\_\_\_