CHILD'S NAME _____

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CHILD'S PHYSICAL HEALTH HISTORY

ETHNIC/RACIAL IDENTITY _____ IF NOT BORN IN THE US, AT WHAT AGE DID HE/SHE ARRIVE _____

PRIMARY DOCTOR _____ PHONE # _____

DATE OF LAST VISIT _____

May I exchange pertinent treatment information with his/her doctor? _____

PSYCHIATRIST _____ PHONE # _____

DATE OF LAST VISIT _____

May I exchange pertinent treatment information with his/her psychiatrist? _____

Health issues I should be aware of _____

Was your child adopted? _____ If so, at what age? _____ From where? _____

MEDICATIONS (list dosages, and why they take them, please include over the counter meds)

_____

PAST MAJOR ACCIDENTS/INJURIES	WHEN	MAJOR ILLNESSES/OPERATIONS	WHEN
_____		_____	
_____		_____	
_____		_____	

Do your child take any over the counter medications? (for example to help them sleep, stay awake, suppress appetite, combat headaches, etc.)	yes	no
Have they ever used laxatives or enemas on a regular basis?	yes	no
Do they have frequent bouts of acid indigestion, stomach upset?	yes	no
Do they get severe headaches?	yes	no
Do they see a chiropractor or acupuncturist?	yes	no
Do they have recurring pain anywhere?	yes	no

PARENT'S SIGNATURE _____ DATE _____