PRE SCHOOLER PORTRAIT

DATE ______________________________ A.H.C.I.P. ____________________________

PATIENT NAME: ____

Complete Address: ____

MOTHER'S NAME: _________________ MOTHER'S WORK PHONE _________________

FATHER'S NAME: _________________ FATHER'S WORK PHONE _________________

HOME PHONE: ____________ NUMBER OF SIBLINGS: Brothers ____ Sisters ____

1. CHILD'S BIRTHDATE: ________________ AGE: _______ SEX: M ___ F ___

2. WEIGHT: __________________ HEIGHT: ___________________

3. Reason for CHILD'S visit ____

LIFESTYLE QUESTIONS

1. CHILD spends most of the day with:

   a) Mother b) Father c) Grandparents d) Sitter e) Daycare f) Kindergarten g) Other

2. Circle the letter that indicates your child's hand of dominance: (a) Right (b) Left

3. Did your child have any prior (earlier) health problems they have outgrown or have been corrected?

   NO ___ YES ___ if yes, Please explain _______________________________________

4. What is the Child's bedtime? _________ Number of hours of sleep per night: ______

5. Quality of sleep: a) Good b) Fair c) Poor d) Restless

6. Does your child awaken frequently with a regular complaint? NO ___ YES ___

7. Recently has your CHILD awakened complaining of pain? NO ___ YES ___

8. Would you describe your child's health as: a) very robust b) very good c) average d) poor e) sickly

9. Has there been a recent change in the CHILD'S energy level? NO ___ YES ___

   If Yes, is it Higher_____ or Lower______

10. Has there been a recent change in the CHILD'S strength? NO ___ YES ___

11. Are there any concerns with the child's diet? NO ___ YES ___ if Yes,

    Please explain ____

12. At what age was child potty trained? ___________

13. Are you concerned with any of the following regarding bowel and bladder function?

a) Regularity b) Stool consistency c) Pain with bowel movements d) Bedwetting

HEALTH HISTORY

1. Please check any of the following if they are a concern to you:

Mouth breathing ____ Snoring ____ Tonsillitis _____ Recurrent ear infection____

Hoarseness _____ Recurrent throat infections ____ Difficulty breathing ____

Watery or swollen eyes _____ Sinus infection _____ Recurrent eye infection ____

2. Please check any occurrence of Childhood diseases or conditions:

Mumps _____ Measles _____ Chicken pox _____ German Measles _____ Baby Measles _____

Anaemia____ Thrush _____ Hernia _____ Undescended testicles ________________

3. Does your child complain of pain or soreness in the legs, knees, ankles, or feet? NO ____ YES ____

4. Does your child complain of pain or soreness in the arms, elbows, wrists or hands? NO ____ YES ____

5. Is your Child currently (or recently) taking any of the following medication? NO ____ YES ____

a) Antibiotics, for what ____

____

b) Tylenol c) Aspirin d) other medications ______________________________

6. Is your child following an immunization program? NO____ YES____

7. Has your child had any reaction to the immunization program? NO ____ YES ____

8. Has your child had any allergic reaction to any medications? NO ____ YES ____

9. Does your child have any problem with dry scaly skin or persistent rashes? NO____ YES____

10. Is your child showing any signs of having Asthma or Bronchitis? NO ____ YES ____

11. Has your child been examined by an allergist? NO ____ YES ____

12. Is your child having allergy shots? NO ____ YES ____

13. Has the child ever been Hospitalized? NO ____ YES ____ if yes,

Why? ____

NAME ______________________________ DATE ______________

14. Has the Child had any broken bones: NO ____ YES ____ if yes, what ______________

15. Has your child ever experienced a dislocation? NO ____ YES ____

16. Has your child ever been involved in a Motor Vehicle accident? NO ____ YES ____

17. Has your child ever received any major trauma? NO ____ YES ____

18. Has your child ever had any trauma to the spine? NO ____ YES ____

19. Has there been a problem in the CHILD'S walking? NO ____ YES ____

20. Do you have any concern regarding your child's walking pattern? NO ____ YES ____

a) Limp **b)** Toe walking **c)** Scoliosis **d)** Pain **e)** Foot positioning **f)** Unusual shoe wear **g)** Other

21. Date of last visit to G.P. ______________ Name ______________________

PURPOSE: ______________________________

22. Date of last visit to Paediatrician ______________ Name ______________________

PURPOSE: ______________________________

23. Has your child had any reason to see a Dentist? NO ____ YES ____ if yes, please answer below.

Date of last visit to Dentist ______________ Name ______________________

PURPOSE: ______________________________

24. Does your child frequently have a low grade fever? NO ____ YES ____

25. Is there a history of high recurrent fevers? NO ____ YES ____

26. Does the child presently have a fever? NO ____ YES ____

27. Have you noted a history of frequent, recurrent swollen lymph nodes? NO ____ YES ____

28. Does your child have a bloated or distended abdomen? NO ____ YES ____

29. Have you noted any changes or difficulty with speech? NO ____ YES ____

30. Are there any hereditary health problems? NO ____ YES ____

31. Is your child involved in a physical education program? NO ____ YES ____

32. Do you have any concerns regarding your child's health that this questionnaire has failed to address?

NO ____ YES ____ if yes, please state ______________________________

DOCTOR'S INTERVIEW

EXAMINATION