**Child New Patient Questionnaire**

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Age\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_ Time of birth\_\_\_\_\_\_\_\_ Place of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Form completion date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Person completing form\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Names and phone nos. of parents\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Names and age of siblings\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Significant prior medical issues and surgeries:

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2. Significant medical issues in your family:

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1. Allergies (include reaction)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Please describe the pregnancy and birth:

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1. Describe development:

Crawling\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Talking\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Overall Motor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Saying “I”\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What do you feel your child needs help with? (Please list most important first)

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1. Does the child follow regular daily rhythms? Please describe:

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1. What medications, supplements and/or remedies does your child take? Please include doses. Any other treatments?

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1. Biography: Please describe significant emotional/physical/spiritual events so far in your child’s life and/or your family life?

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1. Does your family follow a spiritual/religious path?

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1. Describe each of the following:

Sleep patterns:

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Digestion (appetite, bowel movements - diarrhea/loose/regular/constipation, gas):

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Breathing:

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Urination:

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Menses (if applicable):

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Skin (rashes, moisture, reactivity to topical treatments):

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Bodily warmth/coolness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Emotional life (feelings/moods/soul life):

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Thinking/Memory (Describe your child’s thinking. Is the child better with details or the overall picture?)

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Food cravings/aversions:

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Eating rhythms (Are they regular etc. ?):

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Movement: Describe your child’s movement. Can your child be still?

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Social life: How does your child relate to peers and the environment?

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Behavior: Do you have concerns regarding your child’s behavior? If so, please describe:

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Transitions:

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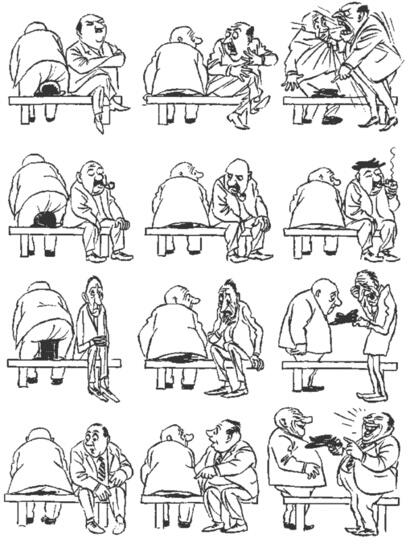
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How does your child react to stress?

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Temperament: Please choose the #1 and #2 reaction that most often fits your child:



1. If old enough, please ask your child to draw a picture of him/herself, your family and the home you live in. Please make all colors of crayons available and bring the drawing to the next office visit.