

## Pediatric Health History: Under 13 years old

General Information:

Today's Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent or Guardian name(s): \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phones: Primary: \_\_\_\_\_ other: \_\_\_\_\_

Email: \_\_\_\_\_ Referred by: \_\_\_\_\_

Pediatrician's name and phone: \_\_\_\_\_

Child lives with: \_\_\_\_\_

Allergies (topical and internal): \_\_\_\_\_

Current Medications and Supplements: \_\_\_\_\_

Nightly amount of sleep: \_\_\_\_\_ Activities and interests: \_\_\_\_\_

Average stress level and causes: \_\_\_\_\_

Other alternative therapies child has experienced: \_\_\_\_\_

Please list primary reasons for seeking CST: \_\_\_\_\_

## Child's Health History:

For each system listed below please describe current concerns first and past concerns next. Be sure to include any accidents, illnesses, or chronic problems. (*Examples*).

Gestation/ Birth: (*pre-eclampsia, induced labor*): \_\_\_\_\_

Skeletal/ bones (*broken bones, scoliosis, back pain*): \_\_\_\_\_

Muscle/ Connective Tissue/ muscles, joints (*sprains, torticollis*): \_\_\_\_\_

Eyes, Ears, Nose, Throat/ Mouth (braces, hearing problems, speech, sore throats, ear infections): \_\_\_\_\_

Is s/he wearing?  contact lenses  hearing aids

Respiratory/ Lungs (*asthma, bronchitis, frequent colds, pneumonia*): \_\_\_\_\_

(please continue on other side)

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Circulatory/ Heart, arteries, veins (*hypertension, bleeds or bruises easily, murmurs*): \_\_\_\_\_

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Nervous System/Brain (*concussions, ADD and behavioral issues, seizures, ringing in ears, shooting pains, depression*): \_\_\_\_\_

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Digestive/Elimination, stomach, intestines, bladder (*constipation, irritable bowel, urinary tract infection*): \_\_\_\_\_

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Skin (*rashes, psoriasis, eczema, warts*): \_\_\_\_\_

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Endocrine/Pituitary, hypothalamus, reproductive, thyroid (*growth problems, diabetes*): \_\_\_\_\_

**FOR GIRLS ONLY: Menstrual History**

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Anything else (*significant family history, car accidents*): \_\_\_\_\_

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More details on information listed above: \_\_\_\_\_

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Parent or guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's signature: \_\_\_\_\_ Date: \_\_\_\_\_

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