CAP WELLNESS CENTER

Infant/Child Health Information Form

Date: _____

Child's First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Child's Birth Date: _____ Age: _____ □ M □ F Ht: _____ in Wt: _____ lb

Siblings names & ages: _____

Parents' Names:_____

Parents' Daytime Phone #: _____

Parents' Cell Phone #:_____

Parents' E-Mail: _____

Parent's occupation_____ Employer_____

How did you hear about our wellness center?_____

What health concerns do you have for your child right now?

_____

When did this situation or concern begin?_____

Has this situation or concern happened before? □ Yes □ No
Please explain: _____

Have you seen other doctors for it? □ Yes □ No

Doctor's name(s):_____

Type(s) of treatment:_____Results:_____

Has this situation or concern: ___ gotten worse ___ stayed constant ___ comes and goes

Does it interfere with (check all that apply): ___ sleep ___ school ___ play
___ social functioning ___ other

Please explain:_____

Prenatal & Birth History

During the pregnancy, did the mother:

- Experience any falls or physical traumas? □ Yes □ No

Describe:_____

- Experience any illness? □ Yes □ No

Describe:_____

- Take any medications? □ Yes □ No

List:_____

- Smoke? □ Yes □ No Consume alcohol? □ Yes □ No
- Use Recreational Drugs? □ Yes □ No

Where did the birth take place? ___ hospital ___ birthing center ___ home ___ other

Was the delivery premature? □ Yes □ No If yes, at _____ weeks and _____ weight

Approximately how long did labor last? _____ hours

Was labor chemically induced? □ Yes □ No Was labor doctor assisted? □ Yes □ No

Was a C-section performed? □ Yes □ No Forceps or vacuum extraction used? □ Yes □ No

Did the delivery doctor pull or twist the baby during delivery? □ Yes □ No □ Don't Know

Were any genetic disorders or disabilities detected? □ Yes □ No

Birth weight: _____ lb_____ oz Birth length: _____ inches APGAR scores: _____ , _____

Check any of the following that the child may have experienced immediately after birth:

___ jaundice ___ respiratory problems

___ feeding problems ___ displaced or broken joints

___ required NICU ___ other condition(s):_____

Child's Health History

Was your child breast-fed? □ Yes □ No For _____ months

Has your child:

- been hospitalized? □ Yes □ No been seen on a Emergency basis? □ Yes □ No
- had any surgeries? □ Yes □ No been in a car accident? □ Yes □ No
- had a severe fall? □ Yes □ No
- been injured in any high impact or contact type sports (soccer, football, baseball, gymnastics, martial arts, etc.)? □ Yes □ No

Explain:_____

Have you chosen to vaccinate your child? □ Yes □ No

If yes, check all vaccinations your child has received:

___ Hepatitis B ___ Rotavirus ___ DTaP ___ Polio ___ MMR ___ Hep A

___ Influenza ___ Varicella ___ Pneumococcal ___ Meningeococcal

Other:_____ _____

Describe any and all reactions to vaccine(s):_____

Please check any of the following conditions that your child has had in the past or has now:

___ Sleeping problems ___ Ear infections ___ Vision problems

___ Breathing problems ___ Tubes in the ears ___ Pink Eye

___ Asthma ___ Frequent colds ___ Headaches

___ Skin problems ___ Digestive problems ___ Attention problems

___ Allergies ___ Colic ___ Hyperactivity

___ Irritability ___ Constipation ___ Bed wetting

___ Other:_____

___ Other:_____

What changes (if any) in your child's health and/or behavior have you seen that might have you concerned?_____

How often does your child "get sick"? _____ times/year How long usually? _____ days

How would you grade the severity of these episodes? □ Mild □ Moderate □ Severe

Has your child ever taken antibiotics? □ Yes □ No How many times?_____

Is your child currently taking any medication? □ Yes □ No

Describe:_____

Does your child have any allergies to any foods, medications, environmental factors, etc.?

□ Yes □ No Describe:_____

What changes (if any) in your child's health and/or behavior would you like to see?

_____

Is there anything else you would like to share about your child or family that will help us to better understand you and why you have chosen us to assist your child in his/her healing?

_____

Authorization of Care for a Minor Child
and Integrated Care Agreement

I, _____ (parent's name) being the parent or legal guardian of _____ (child's name) hereby grant permission for my child to receive care at the Cap Wellness Center.

In the interest of total patient care, I give my permission for the providers of CAP Wellness Center to communicate with each other regarding the treatment and care of my child.
I also give my permission for the providers of CAP Wellness Center to communicate with the providers at CAP Women's Health.

Date: _____

Child's Name: _____

Parent/Legal Guardian's Name: _____

Parent/Guardian's Signature Authorizing Care: _____