A Touch of Health

Confidential Pediatric Health Record

CHILD'S NAME: _____ **MOTHER'S NAME:** _____
LAST FIRST MIDDLE LAST FIRST MIDDLE

FATHER'S NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____ **CITY/TOWN:** _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **MOTHER'S WORK PHONE:** _____ **FATHER'S WORK PHONE:** _____

BIRTH DATE: ____/____/____ **AGE:** ____ **BIRTH WEIGHT:** _____ **CURRENT WEIGHT:** _____

SEX: _____ **NO. OF SIBLINGS:** _____ **BIRTH LENGTH:** _____ **CURRENT LENGTH:** _____

TYPE OF BIRTH: **NORMAL VAGINAL** _____ **FORCEPS** _____ **BREECH** _____ **CESAREAN** _____

HOME: _____ **BIRTHING CENTER:** _____ **HOSPITAL:** _____

\WAS THERE PRESENCE AT BIRTH OF: _____ **JAUNDICE (YELLOW)** _____ **CYANOSIS (BLUE)**

CONGENITAL ANOMALIES/DEFECTS: _____

PURPOSE OF THIS APPOINTMENT: _____

INFANT FEEDING: **BREAST** _____ **BOTTLE** _____ **FORMULA:** _____

NO. OF HOURS OF SLEEP PER NIGHT: _____ **QUALITY OF SLEEP: GOOD** _____ **FAIR** _____ **POOR** ____

OBSTETRICIAN/MIDWIFE: _____
NAME LOCATED AT

PEDIATRICIAN/FAMILY MD: _____
NAME LOCATED AT

DATE OF LAST VISIT TO MD: _____ **PURPOSE:** _____

IMMUNIZATION HISTORY: _____ **NORMAL** _____ **DELAYED** _____ **NONE**

HAS YOUR CHILD BEEN TREATED ON AN EMERGENCY BASIS?: _____

DESCRIBE: _____

AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE A TOUCH OF HEALTH, LLC. AND IT'S DOCTOR(S) TO PROVIDE CARE AS THEY SO DEEM NECESSARY TO MY SON/DAUGHTER/WARD.

SIGNED: _____ **WITNESSED:** _____ **DATE:** _____

I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS OFFICE AND THAT I WILL PAY FOR ALL SERVICES AS THEY ARE PERFORMED.

DATE: _____ **SIGNATURE:** _____

6255 Barfield Rd. Suite 145, Atlanta, GA 30328
Phone: (404) 920-8492 Fax: (404) 920-8641

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PEDIATRIC CASE HISTORY

PREGNANCY HISTORY: _____

_____

_____

_____

DELIVERY/BIRTH HISTORY: _____

_____

_____

_____

DEVELOPMENTAL HISTORY: AT WHAT AGE DID THE CHILD…

_____ RESPOND TO SOUND
_____ FOLLOW AN OBJECT WITH HIS/HER EYES
_____ HOLD HEAD UP
_____ SIT ALONE
_____ CRAWL
_____ STAND
_____ WALK ALONE

CHILDHOOD DISEASES:

_____ CHICKENPOX
_____ MUMPS
_____ MEASLES
_____ RUBELLA
_____ RUBEOLA
_____ WHOOPING COUGH

OTHER: _____

HAS THIS CHILD EVER SUFFERED FROM:

☐ Dizziness	☐ Backaches	☐ Heart Trouble	☐ Chronic Earaches
☐ Diabetes	☐ Tuberculosis	☐ Hypertension	☐ Colds/Flu
☐ Arthritis	☐ Headaches	☐ Asthma	☐ Allergies
☐ Neuritis	☐ Digestive Disorders	☐ Sinus Trouble	☐ Constipation
☐ Anemia	☐ Rheumatic Fever	☐ Orthopedic Problems	☐ Diarrhea
☐ Poor Appetite	☐ Hyperactivity	☐ Sugar Concentration	☐ Behavioral Problems
☐ Bed Wetting	☐ Convulsions	☐ Paralysis	☐ Muscle Jerking
☐ Fainting	☐ Walking Problems	☐ Broken Bones	☐ Ruptures/Hernias
☐ Neck Problems	☐ Arm Problems	☐ Leg Problems	☐ “Growing Pains”
☐ Joint Problems			

PRESENT HISTORY: _____

_____

_____

_____

SURGERY: _____

MEDICATIONS: _____

ACCIDENTS: _____

FAMILY HISTORY: _____

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