Rainbows of Healing
Valarie Haag, N.D.
123 W. Maple Ave. Langhorne, PA 19047
(267) 840-8003
www.rainbowsofhealing.com

Child Health History Form

Name_____ Date _____
Age _____ M ☐ F ☐ Date of Birth (M/D/Y) _____/_____/_____
Home Address_____
City _____ State_____ Zip Code _____
Phone # (home)_____ Phone # (cell)_____
Email address: _____
How did you hear of our office? If referred, please indicate by whom _____
_____
Parent/ Guardian Information:
Mother's Name _____Work Phone: _____
Occupation: _____
Father's Name_____ Work Phone: _____
Occupation: _____

Names of Healthcare Providers:
Medical Doctor(s) _____
Other _____

Developmental History
Sat at_____(months) Crawled at _____ Walked at_____ Talked at_____
Regression of speech? ___No ___Yes, at what age?_____
Was child breastfed? ___No ___Yes, if so how long? _____
Formula used? ___No ___Yes, if so introduced at what age?_____
Colic/irritability as baby? ___No ___Yes

Other Health Issues:
Does your child suffer with health problems: ___ Allergies ___ Asthma ___ Eczema
___ Kidney Problems ___ Lung Disease ___ Diabetes ___ Thyroid Disease ___ Seizures
___ Heart Disease ___ Repeated Infections ___Other, please explain_____
Did your child's condition change following an illness or seizure? ___No ___Yes, explain_____
_____

Behavior ☐ Good ☐ Variable ☐ Disruptive

☐ Biting ☐ Hitting ☐ Head banging ☐ Toe- walking
☐ Aggression ☐ Teeth grinding ☐ Hyperactivity ☐ Sideways glancing
☐ Cries easily ☐ Mood swings ☐ Irritability ☐ Pushes on eyes
☐ Excessive spinning ☐ Hand movements ☐ Odd fascinations: describe _____

Sensitivity to: ☐ Sound ☐ Touch ☐ Smells ☐ Lights

Play skills: ☐ Appropriate ☐ Inappropriate/repetitive ☐ Variable
Interaction with other children: ☐ Frequent ☐ Occasional ☐ None

Motor Skills ☐ Delayed gross motor (eg. climbing, running) ☐ Delayed fine motor (eg. printing)
☐ Uncoordinated/clumsy

Sleep ☐Normal ☐ Difficulty falling asleep ☐ Frequent waking
☐Nightmares ☐ Wakes crying/screaming

Digestive Health:
Loose stools or diarrhea ___ Yes ___ No Constipation ____Yes ____No
Offensive/excessive gas ___Yes ___No Bad breath ___Yes ___No
Undigested food in stools ___Yes ___No Mucous or blood in stools ____Yes ____No
Does your child produce formed stools ___Yes ___ No Stomach aches/pain ____ Yes ____No
Bowel movements: # per day _____
Is you child toilet trained? ___Yes ___No

Antibiotic History:
How many courses of antibiotics has your child received: ___ 0-5 ___5-10 ___10-15 ___15-20 ___20+
Reason(s) for antibiotic use: ___Ear Infections ___Bronchitis/Pneumonia ___Sinus Infection
___Intestinal Infection ___Other (please explain)_____

Home Environment:
How old is your current home ____ years
Has your child lived in a home with lead-based paint ___No ___Yes
Has there been exposure to molds ___No ___Yes, explain_____
Is child exposed to outside pesticides or fungicides ___No ___Yes
Please list pets/animals your child is exposed to _____

Mother's Pregnancy and Labor:
Any complications during pregnancy? ___High Blood Pressure ___ Seizures ___ Diabetes
___Infections treated by antibiotics ___Viral Infections (Flu, Mono) _____
Rh status ___ (+ or -) Blood Type _____ Rhogam shot given during pregnancy? ___No ___Yes
Any vaccinations during pregnancy ___No ___Yes, which ones _____
Any vaccinations after pregnancy while breastfeeding ___No ___Yes
Was your child delivered _____ vaginal ___ or C-section Forceps or suction used _____
Was birth premature ___ No ____ Yes. If yes, how many weeks gestation _____
Any birth trauma? Describe_____
Complications/infections of baby? _____

Did Mom have silver fillings present during pregnancy? ____ No ____ Yes. If yes, how many?_____
Did Mom have any dental work done during pregnancy ___No ___Yes
Did mom have any fillings removed while breastfeeding child ___No ___Yes
Does child have amalgam/silver fillings? ___No ___Yes

Vaccination Status:
Has child received all recommended vaccinations for their age? ____ No ____ Yes
If no, has child received any of the following: ___DPT ___Hib ___Hep B ___Polio ___ MMR
___Pneumococcal ___Varicella (Chicken Pox) ___Flu shot ___Meningococcal
Did your child receive any vaccinations when they were sick ___No ___Yes, please explain_____
Did your child suffer any vaccine reactions: ___Fever ___ Inconsolable screaming ___Rash
___Excessive lethargy ___Vomiting ___Seizures ___Behavior change

Medication Usage:
List medication child is currently taking: _____
Has child received chelation therapy ___No ___Yes, Any benefits?_____
Has child ever had steroid or anti-fungal drugs? ____ No ___Yes

Supplements:
Please list all supplements (herbal, vitamins, minerals, homeopathic) child is currently taking, including dosages: _____
_____
_____

Diet:
Has child been on a Gluten/Casein Free Diet? ___No ___Yes, if so how long?_____
Was any benefit observed from GF/CF diet? ____No ___Yes
Have any other special diets been tried? Describe _____

Please describe your child's typical daily diet:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Drinks: _____
Cravings/ favorite foods _____

Current Height _____ Weight _____ (lb/ kg)

☐ Addiction _____	☐ Genetic Disorders _____
☐ Allergies_____	☐ Heart Disease_____
☐ Anxiety_____	☐ High Blood Pressure_____
☐ Asthma_____	☐ Kidney Disease_____
☐ Autoimmune disease (eg. lupus, rheumatoid arthritis) _____	☐ Learning/Developmental disabilities _____
☐ Autism/Aspergers_____	☐ Bipolar Disorder_____
☐ Blood disorders eg. hemophilia, stroke _____	☐ Diabetes _____
☐ Cancer_____	☐ Headaches/Migraines _____
☐ Celiac disease _____	☐ Obsessive-Compulsive _____
☐ Crohn's/ ulcerative colitis	☐ Multiple Sclerosis _____

Family History: Check if a blood relative had any of the following and indicate relationship to child.

What are your goals in seeking treatment?

1._____

2._____

3._____

Thank you. I look forward to working together to help your child.