STOCKTON FAMILY PRACTICE
HISTORY FORM AGES (0-18)

Today's Date_____

Name: _____ Nickname: _____ DOB: _____ Allergies: _____

What is the chief health concern? (Give a brief history if other than routine well care):

_____
_____
_____
_____

Is there a specific practitioner that you would prefer to see at this practice? _____

Please bring or send a copy of immunization records. *Check if not immunized* ☐

FAMILY HISTORY Name Sex (M/F) Date of Birth Health

Mother: _____
Father: _____
Siblings:
1. _____
2. _____
3. _____
4. _____

PRENATAL HISTORY:

Complications during pregnancy: _____ Medications: _____
Illnesses: _____ Dental work: _____
Trauma: _____ Location of Birth: _____

BIRTH & NEONATAL PERIOD:

Duration of Pregnancy: Term: (37-42 wks)_____ Premature (<37 wks):_____ Postmature (>42wks)_____
Labor: Duration:_____ Complications:_____
Delivery: Vaginal:_____ C-Section:_____ Breech:_____ Forceps:_____ Other:_____
Condition at Birth:_____ Apgars (if known): 1-min_____ 5-min_____
Health in first month:_____ Any cyanosis/(blue) or jaundice/(yellow) ___Yes ___No
Birth Weight:_____ Birth Length:_____
Any feeding problems? _____ Breast_____ Formula (type)_____ Vitamins_____ Age started foods?_____

DEVELOPMENTAL LANDMARKS: (list age)

_____Sat Up By Self _____First Words _____Bladder Training
_____Stood Holding On _____Short Sentences _____Bowel Training
_____Rolled Over (back-to-front) _____First Tooth _____Walked Well

SCHOOL PERFORMANCE:

Type of Schooling: _____ Present Grade: _____
Present Grades in School: _____Good _____Average _____Poor
School Behavior Problems: _____
Special Educational Needs: _____
Describe Relationship with Friends/Peers? _____
Favorite Activities: _____ Least Favorite Activities: _____

GENERALLY PREFERRED MEDICAL TREATMENTS:

Prescription Medications	_____Yes	_____No
Natural Medications (herbs)	_____Yes	_____No
Homeopathic Remedies	_____Yes	_____No
Acupuncture	_____Yes	_____No
Chiropractic	_____Yes	_____No
Naturopathic	_____Yes	_____No

Is your child currently taking any form of medication, herbs, homeopathic, vitamins or minerals? _____Yes _____No
Describe: _____

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DIET: (check which applies)	**Child**	**Family in General**
Traditional American Diet	_____	_____
Macrobiotic	_____	_____
Vegetarian	_____	_____
Vegetarian with **(circle)** Cheese/Egg/Poultry/Fish	_____	_____
Vegan	_____	_____
Other	_____	_____
Food Intolerances	_____	_____

FAMILY MEDICAL HISTORY: (parents, grandparents, siblings)

	Who		**Who**
Abuse	_____	Eczema	_____
Alcoholism	_____	Epilepsy/Seizures	_____
Allergies	_____	Gastrointestinal Disease	_____
Arthritis	_____	Hearing Loss	_____
Asthma	_____	Heart Attack (under 50)	_____
Autoimmune Disease	_____	High Cholesterol	_____
Birth Defects	_____	Migraines	_____
Bleeding Disorder	_____	Psychological Illnesses	_____
Cancer	_____	Smoking	_____
DES exposure	_____	Sudden Infant Death	_____
Diabetes	_____	Thyroid Disease	_____
Drug Abuse	_____	Other	_____
Father's Blood Type: _____	RH:_____	Mother's Blood Type:_____	RH:_____

RISK ASSESSMENT: **Explain**

Do all family members use seatbelts all the time? _____
Does child use a bike helmet? _____
Any smokers in the house? _____
Any family history of alcohol excess or drug use? _____
Any firearms in the house? _____
Any family history of abuse in either parent's family? _____

ADOLESCENCE: (Do you believe your adolescent may have had:)

History of Drug Use?	_____Past	_____Present
History of Alcohol Intake?	_____Past	_____Present
History of Smoking?	_____Past	_____Present
History of Abuse?	_____Past	_____Present
History of Eating Problems?	_____Past	_____Present
History of Sharing Needles?	_____Past	_____Present
History of Sexual Intercourse?	_____Past	_____Present

Do you have other concerns? (Please list) _____

(If you have any questions on the following please make a notation so we can discuss them as time allows)

Use of car seats/seatbelts? _____ Any aspects of development? _____
Toddler/child proofing? _____ Vaccine issues? _____
Lead exposure? _____ Bike Helmets? _____
Hyperactivity? _____ Smoking? _____
Coordination? _____ Alcohol? _____
Gross motor development? _____ Drugs? _____
HIV testing? _____ Firearms? _____
Sexually transmitted diseases? _____ Child abuse? _____
Birth control? _____ Eating disorders? _____
Discipline? _____ Other? _____

Stockton Family Practice
Autism Spectrum Disorder History Form

Mother's health:

Describe any health problems in general.

Describe any health problems during this pregnancy.

List any drugs or medications taken during this pregnancy.

Describe any dental work done during this pregnancy.

Have you had a large number of silver fillings?

Child' s health:

Describe any problems during the pregnancy.

Describe any health problems noted at birth.

Describe any health problems noted during the first few days/wks.

Onset of symptoms:

When did you or anyone else begin to suspect a problem?

Please describe the onset of symptoms or behaviors that made you suspect a problem was developing.

Please be sure that we have a complete list of immunizations given and dates.

Please list illnesses and treatments this child has received, include dates where appropriate, however a general statement such as "many ear infections treated with antibiotics" would be satisfactory. Please include any unusual symptoms that you have seen associated with these illnesses or treatments.

Tests and treatments:

Please give a complete list of all tests that have been performed so far in evaluating your child. Attach a separate sheet if necessary.

Please give a complete list of all interventions that have been tried including dietary changes, supplements and pharmaceuticals. Attach a separate sheet if necessary.

Please comment on the results you have seen from each of these interventions, good or bad.