Pediatric Information form Child’s Name______________________Age______DOB_________

Address:____________________________________Phone:___________________Cell_______________________

Pediatrician’s name and phone____

1. Please list all medications and supplements which you child is currently taking or has taken in the last few months:

2. Please list all inoculations and dates or attach copy of record.

3. Please describe any complications during pregnancy, birth or postpartum:

4. History of illnesses including frequent colds: (Use reverse side, if you need more space)

5. Describe your child’s:

Energy____

Sleep____

Cough/sinuses/breathing____

BowelMovements____

Urination (Frequent /Normal; Wets bed?Accidents?)____

Diet (Poor/Good appetite? Three meals? Favorite foods? Won’t touch? Sweets? Fruit juice? Soda? Vegetables? Protein? Dairy? Food Allergies)

Emotions (Easy-going or extremes? Extremes only when sick? Crabby when tired or hungry only? Easily angry? Easily cries? Etc.)

Please add any information on the reverse side which you feel is significant: