

NEW PATIENT QUESTIONNAIRE

Name: _____

Birthdate: _____

Date: _____

FAMILY MEMBERS & THOSE LIVING IN YOUR HOME? <small>(List person completing form first)</small>	RELATIONSHIP TO CHILD	BIRTHDATE	OCCUPATION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

REFERRED TO CHILDREN'S MINNESOTA BY: _____

Please list previous medical clinics at which your child has been seen: _____

Please list schools or daycare your child has attended: _____

YOUR CHILD'S BIRTH HISTORY

Please give any further details below

- Were there any complications during the pregnancy? N Y
- Did the mother smoke? N Y
- Did the mother take drugs or prescribed medications? N Y
- Were there any complications during the labor or delivery? N Y
- Were there any problems after the birth? N Y
- What was your child's gestational age? _____
- What was your child's birthweight? _____ kg and/or _____ lb _____ oz

YOUR CHILD'S HEALTH

- Has your child ever been hospitalized? N Y
- Has your child ever had surgery? N Y
- Has your child had any chronic or serious illnesses? N Y
- Has your child ever had any major injuries? N Y
- Has your child missed any of their immunizations (shots)? N Y
- Is your child on any medications currently? N Y
- Has your child has any reaction or allergy to any medication? N Y
- Does your child use any alternative or complimentary medicine (chiropractic, homeopathic, supplements, etc)? N Y

YOUR CHILD'S NUTRITION

- Did/Does your child have any feeding or eating difficulties? N Y
- Has your child ever been put on a special diet? N Y
- Do you have any concerns about your child's weight or diet? N Y
- Does your child only drink well water, bottled, or filtered water? N Y
- If so, has the fluoride content been checked? Y N

YOUR CHILD'S DEVELOPMENT

- Did/Does your child have any problems or delays in development? N Y
- Has your child ever had any difficulty with any of these areas:
 - Reading? N Y
 - Spelling? N Y
 - Mathematics? N Y
 - Speech? N Y
 - Writing? N Y
 - Coordination? N Y
- Does your child receive any special services at school? N Y
- Does your child have any behavioral or disciplinary problems? N Y

Please give more details to anything marked Yes and list any other questions or concerns that you would like to talk about today.

Parent/Guardian Signature: _____

Provider Signature: _____