Essential Healing Solutions
12 Old Boston Post Rd.
Old Saybrook, CT 06475

CHILD'S NAME: _____

Date of Birth: _____

Mothers Name: _____**Fathers name**_____

Phone numbers: H_____**C**_____

Reason for visit:

_____

_____

Birth weight: _____ Was your baby premature? **Y / N**
Were there any significant medical problems during your pregnancy? **Y / N**
Were there any significant complications during labor or the baby's newborn period? **Y / N**
If yes, to any of the above questions, please explain:

_____

_____

_____

GROWTH AND DEVELOPMENT
Have you or your prior pediatrician ever had any concerns about your child's growth or development (speech/language,
social skills, motor skills, etc.)? **Y / N**
If yes, please explain:

_____

_____

Girls only: Age at first period: _____

PAST MEDICAL HISTORY
HAS YOUR CHILD:
Had any serious medical illness? **Y / N** Had broken bones/frequent or severe sprains? **Y / N**
Had a history of asthma or wheezing? **Y / N** Had any mental or behavioral problems? **Y / N**
Ever used an inhaler or nebulizer? **Y / N** Had a positive tuberculosis skin test? **Y / N**
Had surgery? **Y / N** Been hospitalized overnight? **Y / N**
If yes, to any of the above, please explain:

_____

_____

_____

IMMUNIZATIONS_____

_____

Have you ever refused vaccines for your child? **Y / N**

If yes, why?

_____

_____

MEDICATIONS AND ALLERGIES

Please list current medications, vitamins, and supplements, even those used intermittently:

_____

_____

_____

Major illness in the family (Cancer, MS, Pervasive Developmental Disorder, Autoimmune Disorder)_____

_____

___