GW CENTER FOR INTEGRATIVE MEDICINE
TOGETHER WE CARE, HEAL, EDUCATE

GW Center for Integrative Medicine
908 New Hampshire Ave NW, Ste 200
Washington, Washington, D.C., US - 20037

Pediatric Questionnaire

Pediatric Questionnaire

Referred by _____

Mother

Name _____

Age _____

Birth Date _____

Address _____

Phone _____

Fax _____

E-mail _____

Biological Mother? ☐ Yes ☐ No

If no, please explain _____

Father

Name _____

Age _____

Birth Date _____

Address _____

Phone _____

Fax _____

E-mail _____

Biological Father? ☐ Yes ☐ No

If no, please explain

Siblings

Names, Gender and Ages

Chief Complaint

History of Current Problem

Child

Current Weight

Height

Birth Place

Type of Delivery

Difficulty

Condition at Birth

APGAR

Weight

Any complications during pregnancy and delivery

☐ Yes ☐ No

If yes, please explain

Please provide documentation of vaccinations and exclusions

Vaccination adverse reactions

☐ Yes ☐ No

If yes, explain

Breast Fed ☐ Yes ☐ No

If yes, for how long

Formula Used ☐ Yes ☐ No

If yes, advise names

First Foods introduced : When / Frequency

Toddler Eating Patterns

Current Eating Patterns

Past Medical History

Check family members that apply

Allergies	☐ Child	☐ Brothers	☐ Sisters
	☐ Father	☐ Mother	☐ Grandparent
Asthma	☐ Child	☐ Brothers	☐ Sisters
	☐ Father	☐ Mother	☐ Grandparent
Bronchitis	☐ Child	☐ Brothers	☐ Sisters
	☐ Father	☐ Mother	☐ Grandparent
Chicken Pox	☐ Child	☐ Brothers	☐ Sisters
	☐ Father	☐ Mother	☐ Grandparent
Diabetes	☐ Child	☐ Brothers	☐ Sisters
	☐ Father	☐ Mother	☐ Grandparent
Ear Aches	☐ Child	☐ Brothers	☐ Sisters
	☐ Father	☐ Mother	☐ Grandparent
Epilepsy, Seizures	☐ Child	☐ Brothers	☐ Sisters
	☐ Father	☐ Mother	☐ Grandparent
GI Disturbances	☐ Child	☐ Brothers	☐ Sisters
	☐ Father	☐ Mother	☐ Grandparent

German Measles	☐ Child	☐ Brothers	☐ Sisters
	☐ Father	☐ Mother	☐ Grandparent
Hepatitis	☐ Child	☐ Brothers	☐ Sisters
	☐ Father	☐ Mother	☐ Grandparent
Measles	☐ Child	☐ Brothers	☐ Sisters
	☐ Father	☐ Mother	☐ Grandparent
Mononucleosis	☐ Child	☐ Brothers	☐ Sisters
	☐ Father	☐ Mother	☐ Grandparent
Mumps	☐ Child	☐ Brothers	☐ Sisters
	☐ Father	☐ Mother	☐ Grandparent
Pneumonia	☐ Child	☐ Brothers	☐ Sisters
	☐ Father	☐ Mother	☐ Grandparent
Rheumatic Fever	☐ Child	☐ Brothers	☐ Sisters
	☐ Father	☐ Mother	☐ Grandparent
Scarlet Fever	☐ Child	☐ Brothers	☐ Sisters
	☐ Father	☐ Mother	☐ Grandparent
Other	☐ Child	☐ Brothers	☐ Sisters
	☐ Father	☐ Mother	☐ Grandparent

List Antibiotics, Antifungals and Antivirals Taken...Include Dates

Surgeries? ☐ Yes ☐ No

If yes, advise details

Dental Fillings Type / Number

Toilet and Stool Patterns : Frequency/Consistency Past/Present

Sleep Patterns

Nightmares

Developmental History : Early/Late Talking/Walking/Social Skills

Schooling : Academics/Social/Learning Disabilities ☐ Yes ☐ No

If yes, explain

Regression of skills noted ☐ Yes ☐ No

If yes, explain

General Personality Description

Mood Swing ☐ Yes ☐ No

If yes, explain

Temper Tantrums ☐ Yes ☐ No

If yes, explain

Adult Relations ☐ Yes ☐ No

If yes, explain

Motor Development ☐ Yes ☐ No

If yes, explain

Affect ☐ Yes ☐ No

If yes, explain

Repetitiousness ☐ Yes ☐ No

If yes, explain

Food Dislikes ☐ Yes ☐ No

If yes, explain

Sense of Humor ☐ Yes ☐ No

If yes, explain

Hyperactive ☐ Yes ☐ No

If yes, explain

Inconsolable Crying ☐ Yes ☐ No

If yes, explain

Imagination Patterns ☐ Yes ☐ No

If yes, explain

Handedness ☐ Yes ☐ No

If yes, explain

Alertness ☐ Yes ☐ No

If yes, explain

Fears ☐ Yes ☐ No

If yes, explain

Reaction to Change ☐ Yes ☐ No

If yes, explain

Self Sufficiency ☐ Yes ☐ No

If yes, explain

Hypoactive ☐ Yes ☐ No

If yes, explain

Makes Friends Easily ☐ Yes ☐ No

If yes, explain

Imaginary Friends ☐ Yes ☐ No

If yes, explain

Eye Contact ☐ Yes ☐ No

If yes, explain

Favorite Activities ☐ Yes ☐ No

If yes, explain

Favorite Foods ☐ Yes ☐ No

If yes, explain

Favorite Objects ☐ Yes ☐ No

If yes, explain

Prescription Drugs Past and Present

Note : Please specify your entries in the format of "Medication Name / Date Started / Date Stopped / Dosage / #per day"

1.

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2.

3.

4.

5.

Current Supplements, Vitamins, Minerals, and Herbs

Other Over the Counter Drugs

Note : Please specify your entries in the format of

"Name / Date Started / Date Stopped / Dosage / #per day"

1.

2.

3.

4.

5.

Any adverse reaction to therapies? ☐ Yes ☐ No

If yes, please explain

Diagnostic Tests Previously Performed

Note : Please specify your entries in the format of

"Test name / Date"

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1.	
2.	
3.	
4.	
5.	
Any additional information which you feel is important can be provided here	