Sellwood Family Medicine, LLC

1567 SE Tacoma St. Portland, OR 97202
Tel: (503) 233-8113 Fax: (503) 239-8937

Name:_____ Birthdate: _____

Mother's Name:_____ Fathers Name:_____

Siblings (and ages):

What are your main health concerns and expectations for this visit?

Who are your main caretakers?

Who is your Primary Care Physician (PCP) and when was your last visit? Why?

Do you have any pre-existing medical conditions or diagnoses?

Were you vaccinated? Which ones and at what age?

What are the major stressors in your life?

When and where have you traveled outside of the country?

Are you taking any medications?

Medication	Dose	Frequency	Reason/ condition

Are you taking any supplements, vitamins or herbs?

Supplement	Dose	Frequency	Reason/ condition

Diet/ Nutrition:

Were you breast fed? Yes/ No If so, for how long? _____

If formula fed, what kind (soy, dairy, nutramagen, etc.) _____

What is your diet like? (Typical breakfast, lunch dinner and snack) Food Cravings?

What kind of pets do you have? (indoor and outdoor)

Do you have a faith/ spirituality and how important is it in your family's life?

What are your favorite toys/ hobbies/ interests?

Are there other things I should know about you?

Autism/ Aspergers/ ADHD/ Neurological Development Intake

Perinatal and Birth History: **Please mark Y or N and elaborate if needed**

Very active before birth?	
Hospital birth or home?	
Needed newborn special care?	
Appeared healthy	
Easily consoled during first month?	
Antibiotics in the first month?	
Any complication during the first month?	

Birth weight (lbs)_____ Apgar Score at 1 minute _____ At 5 minutes?_____

Early Childhood illnesses:

First round of antibiotics at _____ months.
First illness at _____ months.
Number of ear infections in the first 2 years?_____
Number of other infections in the first 2 years?_____
How many rounds of antibiotics in the first 2 years?_____
Any prophylactic antibiotics in the first 2 years?_____ Why?_____

Developmental History:

Are there developmental problems? Yes/ No
What age did the problems appear? _____
Is this impression shared by others caring for your child? (doctors, family, caretakers?)

Is there a strong indication as to when the problems started? Pursuant to what?

Has there been any regression of skills? Yes/ No

Has there been any ***lost language*** skills? When?

When, if any, was there ***lost eye contact***? When?

Please indicate the approximate age in months for the following milestones:

Sitting up	
Crawling	
Pulled to stand	
Potty trained	
Walked alone	
Dry at night	
First words	
Spoke clearly	
Ate solid food	

Please mark Y if any symptoms apply currently, N if never had the symptom or P if the symptom was in the past. Comment if necessary.

SYMPTOM	Y, N or P	COMMENT
Enlarged lymph nodes- neck		
Enlarged nodes elsewhere		
Lymph nodes tender		
Overweight		
Underweight		
Pupils unusually large		
Pupils unusually small		
Dark circles under eyes		
Unusually long eyelashes		
Webbed toes		
SENSORY SYMPTOMS		
Unusually fearful		
Unaware of danger		
Unaware of others' feelings		
Very sensitive to pain		
Insensitive to pain		
Bothered by certain sounds		
Ear pain		
Ear ringing		
Hearing acute		
Hearing loss		
Sensitive to loud noise		
Covers ears		
Excessive ear wax		
Likes head pressed or rubbed		
Intensely aware of odors		
Sniffs things		
Sensory problems with food		
Hates wearing shoes		
Blinking		
Bothered by bright light		
Fails to blink at light		
Likes flickering lights		
Poor vision		
Strabismus (crossed eyes)		
Adopts complicated rituals		
Collects particular things		
Draws only certain things		
Fixated on one topic. (what?)		
Lines objects up precisely		
Repeats phrases/ sentences		
Repetitive play		
BEHAVIOR		
Upset if things change		
Aloof, indifferent, remote		
Bites and chews fingers/hands		
Constant movement		

Curious, gets into things		
Destructive		
Extremely cautious		
Head banging		
Hyperactive		
Melt downs		
Poor focus/ attention		
Silly		
Toe walking		
Uninterested in pet		
Mean to pets		
Unusual play		
Teases others		
Tries to control others		
Unpredictable		
Poor eye contact		
Finger flicking		
Flaps hands		
Jumps when pleased		
Licking		
Likes spinning objects		
Rhythmic rocking		
Sits and stares		
Tooth tapping		
Looks out of sides of eyes		
Lacks initiative		
Anxiety		
Inconsolable crying		
Phobias? What?		
Mood swings		
COMMUNICATION		
Does not ask questions		
Poor expressive language		
Points to objects, but can't name		
Talks to self		
SLEEP-more or less than normal?		
Awakes at night		
Difficulty falling asleep		
Nightmares		
Sleepwalking		
DIGESTION/ FOOD		
Pica (eats indigestible things)		
Always thirsty		
Behavior worse with food		
Binge eating		
Bread/ Carb craving		
Craving for juice		
Craving for salt		
Diet soda craving		
Poor appetite		
Abdominal bloating/ pain		

Burping		
Constipation		
Diarrhea		
Passing gas		
Foul smelling gas		
Rectal fissure, bleeding		
Geographic tongue (map like)		
Cracks in corners of lips		
Gums bleed		
Cold sores		
Thrush		
Anal itching, redness		
Intestinal parasites		
Acid reflux		
Nausea		
Sore throat		
Stools foul smelling		
Mucous in stool		
Undigested food in stool		
Grinding teeth		
Vomiting		
Headaches		
RESPIRATORY		
Bad odor in nose		
Breath holding		
Bronchitis		
Congestion with seasons		
Cough		
Pneumonia		
Post nasal drip		
Sighing		
Wheezing/ Asthma		
Yawning		
Sinus problems		
SKIN		
Acne		
Athletes foot		
Blotchy skin		
Frequent bug bites		
Cellulite		
Chicken skin		
Birth marks		
Diaper rash		
Ears get red		
Easy bruising		
Eczema		
Conjunctivitis		
Eye crusting		
Flushing		
Lid margin reddness		
Odd body odor/ Sweat odor		

Oily skin		
Psoriasis		
Vitiligo		
Itching frequent? Where??? (Anus, arms, ears, eyes, feet, nose, penis, scalp, vagina???)		
Dry hair		
Dry skin		
Feet cracking		
Foot odor – stinky?		
Nail fungus		
Sweats in sleep/ Nightsweats		
Thick nails		
White spots on nails		
MUSCULAR/ SKELETAL		
Joint pain		
Muscle cramps		
Muscle pain		
Muscle tone tense		
Muscle tone limp		
Muscles twitch		
Tics		
Numbness/ tingling		
REPRODUCTIVE		
Girls: Age of 1st menstruation		
Boys: Undescended testicle		
Early breast development		
Early pubic hair		
URINARY		
Bedwetting after age 4		
Odd urinary odor		
Urinary infections		
Urinary urgency		
Urinary hesitancy		
GENERAL		
Physically Awkward		
Seizures		
Stiffens body when held		
Unusual sound of cry		
Abnormal fatigue		
Moaning		
Heart murmur		
Mitral Valve Prolapse		
Fast heart rate		
Cheek/ ear pink or cold		
Cold all over		
Cold hands and feet		
Cold intolerance		
Hands/ feet sweaty		
Tip of nose pink or cold		

Biological Mother's Pregnancy History

Age of mother at child's birth_____ Age of father at child's birth_____
Mother's # of pregnancies_____ Births_____ Miscarriages_____ Abortions_____

Please mark Yes or No for the following situations occurring during your pregnancy.

Symptom or situation	Y or N?	Comment if needed
Difficulty conceiving (> 6 mos.)		
Infertility drugs used		
In vitro fertilization		
Drink alcohol		
Smoke cigarettes		
Take progesterone		
Take prenatal vitamins		
Take antibiotics		
Take other drugs/ medications		
Excessive nausea or vomiting		
Have a viral infection		
Have a yeast infection		
Have dental fillings put in		
Have dental fillings removed		
Have bleeding (which months)		
Group B strep infection		
C- section		
Pitocin during labor		
Have an X- ray		
Have Rhogam? How many?		
High blood pressure		
Chemical exposure		
Have house exterminated		
Have house painted		
Total weight gain in pregnancy		