STANDARD NEW PATIENT FORM (CHILD)

(PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE)

1. Name: ………………………………………………………………………………………… Date: …………………..
2. Age: ……………………. Date of Birth: ………………… Sex: ………………………… Weight: …………………….
3. Birth order (e.g. 2nd of three children)/Age of siblings:
   ………
   ………
4. Referring Physician/Hospital: ………………………………………………………………………………………….
   ………
5. Problem (any diagnosis?): ……………………………………………………………………………………………
   ………
   ………
6. How and when did it start? ………………………………………………………………………………………….
   ………
   ………
7. What has been done since then?
   a. Treatment by medical profession:
      ………
      ………
   b. Tests done (please provide copies) :
      ………
      ………
   c. Parents and/or Caregivers (native medications, nutritional supplements, etc):
      ………
      ………
8. History of Seizures/Convulsions? (Yes/No, How frequent? Focal or generalized):
   ………
   ………
9. What treatment (medication, physiotherapy) is he/she currently on?
   ………
   ………
10. What can he/she not do?
    a. ………
    b. ………
    c. ………
    d. ………
    e. ………

History

a. Pregnancy, birth and neonatal history:
   1. Where was antenatal care? ....
   2. Where was delivery (which Hospital)? ....
   3. Was pregnancy eventful (any infection, vaginal discharge, fever, high blood pressure, diabetes, allergies?) If yes, state what happened in full YES ☐ NO ☐
   ....
   ....
   ....
   4. Did mother have any infection during pregnancy? YES ☐ NO ☐
   5. Was delivery at term? (mum should describe events) YES ☐ NO ☐
   ....
   ....
   ....
   6. How long was the labour? ....
   7. Did baby cry at birth? YES ☐ NO ☐
   8. Did baby have jaundice at birth? YES ☐ NO ☐
   9. Did he/she attain all the milestones at the right time? YES ☐ NO ☐
   10. Did he/she suck well at birth? YES ☐ NO ☐

b. Gut Health
   1. How healthy is his/her appetite?..
   2. Any constipation?..
   3. What is/are his/her favorite food(s)?
   ....
   4. What food(s) does he/she not tolerate?
   ....
   5. Does he/she get more hyperactive any time he/she eats a particular meal (if yes, which ones)?...
   6. How frequently does he/she stool?..
   7. Is his/her stool hard or soft? ....
   8. Is it sometimes difficult to stool? YES ☐ N0 ☐

c. Immune health:
   1. Any history of recurrent infection(s), e.g. recurrent ear infections/discharge, throat ache, cough, fever? YES NO ☐ ☐
   2. If there is/are infection(s), how frequent?

   ....

3. Any allergies? If yes, parents should describe event(s)

   …….

   ……

d. Home:
   1. Social relations at home (does he play well with siblings and parents ?)

      ……
   2. Adequate eye contact?...
   3. Hyperactive?...
   4. Sleep through out the night?...

e. Any history 0f hearing difficulties?...

   Ear discharge?..

f. Odd behaviors/ Findings
   1. Any unusual strength or tolerance to pain?...
   2. Cry/ Laugh a lot for no apparent reason?...
   3. Prefers to stool, not in toilet but elsewhere? (e.g in closet or wardrobe)…………………………
   4. Ear clapping?...
   5. Head banging?...
   6. Self injury? (e.g. biting)……………………………………………………………………………………………….
   7. Fecal smearing?..
   8. Screaming a lot?..

g. Performance at school:
   1. Interaction with peers?..
   2. Ability to read, write, and pay attention in class?...

What results would parents like to see (e.g. better speech, better sight, etc)?

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Anything else you would like to tell us?

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Doctor's intake note: ……

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