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New Patient Health Questionnaire

Child's Name:	
Date of Birth:	Child's Gender: M F
Form Completed by:	Date Form Completed:
Guardian:	Mother's Name:
Phone (main):	Father's Name:
Phone (alternate):	Email:
Address:	Pharmacy:

ADDITIONAL SPECIALISTS/THERAPISTS WORKING WITH YOUR CHILD

Name:	Name:
Address:	Address:
Phone:	Phone:

MEDICAL INFORMATION

Please summarize your main concerns at this time:

CHILD'S MAIN MEDICAL DIAGNOSES:

1)	2)	3)
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Please check any symptoms/concerns you have about your child at this time:

- | | |
|--|--|
| <input type="checkbox"/> Developmental Differences | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Behavioral Difficulties | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Energy Problems |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Environmental Issues |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Nutrition |
| <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Medications/Therapies |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Vaccinations |
| <input type="checkbox"/> Other Neuro issues (i.e. muscle tone) | <input type="checkbox"/> Sensory Issue |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Other: |

Prenatal (Pregnancy) History:

- | | |
|--|--|
| <input type="checkbox"/> Full-term | <input type="checkbox"/> Vaginal Birth |
| <input type="checkbox"/> Premature: _____ wks | <input type="checkbox"/> C-section |
| <input type="checkbox"/> Breastfed (how long): _____ | <input type="checkbox"/> Formula-fed (type): _____ |

Birth Weight:

Where Born (Hospital, City/State):

Complications/Notes:

Please describe events surrounding the onset of your child's medical problems and the impact it has had on your child and family.

Please describe your child's personality (i.e. happy, stubborn, rigid, easygoing, perfectionistic).

Describe your child's behavioral, developmental and/or emotional difficulties.

Has your child and/or family experienced any recent stressful events? (i.e. arguments with family/friend, peer problems, death, divorce, illness, financial problems) No Yes

If yes, please explain: _____

Describe your child's coping style and how effective it is.

Describe what your child likes to do for fun (e.g. hobbies, favorite toys, favorite places)?

Describe what does your do well. What is your child's greatest strength?

NUTRITION

Is your child on a special nutritional diet? If so, please describe:

Do you have any concerns about your child's nutrition? (e.g. Poor food choices, Overeating, picky eater, avoids foods due to textures, skips meals, etc)

FOOD RECORD

This food record will help us evaluate your child's diet. Write down anything your child eats and drinks for one day(including snacks and drinks eaten between meals). Also include condiments such as teaspoons of sugars, mayo, salad dressing etc)

TIME	FOOD OR FORMULA	AMOUNT EATEN (E.g. ½ egg, 10 potato chips, ½ hamburger, 8oz 2% milk)	PREPARATION (baked, fried, boiled etc)

Is your child taking any medications, herbals, homeopathic remedies, vitamins, or neutraceuticals? You can attach a list if you prefer.

Name	What was it used for?	Dosage and how often?	For how long?

Have you used any alternative or complementary therapies for your child?

Name of Therapy	What was it used for?	How often was it used?	Did it work?	Are you still using it?

VACCINATIONS

Please describe questions or concerns you have, if any, regarding vaccines:

FAMILY INFORMATION

Mother’s Education/Occupation:

Father’s Education/Occupation:

Married (date: _____) Separated (date: _____) Divorced (date: _____) Never Married

Was your child adopted? No Yes How old was the child at the time of adoption? _____

If separated, child’s primary legal residence is with whom? _____

Brothers and Sisters

Name	Age	Grade	Relation to Child ? (full, half, step)	Where Living?	Any concerns?

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Please describe family relationships: _____

FAMILY MEDICAL HISTORY

Please check all medical conditions that have occurred in the child’s immediate relatives (parents, grandparents, siblings and half-siblings, aunts, uncles and cousins). Indicate whom the person is in the space provided.

Condition	No	Yes	Mother’s Family	Father’s Family
Autistic Spectrum Disorder				
Attention Deficit Disorder (ADHD)				
Mental Retardation				
Learning Disability				
Other Genetic Syndromes				
Asthma/allergies				
Chronic Headaches				
Irritable Bowel Syndrome				
IBD (crohns, colitis)				
Autoimmune disorders				
Condition	No	Yes	Mother’s Family	Father’s Family
Depression/Bipolar				
Suicide Attempt/Suicide				
Anxiety				
Substance Abuse				
Obsessive Compulsive Disorder				
Other				

SLEEP HISTORY

What time does your child go to bed at night during the week ? _____
 What time does your child fall asleep at night ? _____
 What time does your child get up during the week ? _____
 What time does your child get up during weekends? _____
 How long does it take your child to fall asleep ? _____
 Does you child have breathing pauses or stop breathing while sleeping _____
 Is your child sleepy during the day? _____
 Any other concerns you have about your child and sleep? _____

SCHOOL INFORMATION

School Name:	Grade:
Address:	Teacher:
Phone:	Fax:

EDUCATIONAL INFORMATION

Have you or any teacher had any specific concerns about your child's school progress (such as academics, social, teacher or peer relationships)?

No Yes, explain _____

Has your child missed school in the past year?

No 1-10 days 11-25 days 26-50 days 50+ days

Has your child had a school evaluation due to special learning needs?

No Yes

Does your child have an Individualized Education Plan (IEP)?

No Yes

MEDICAL RECORDS

Please include copies of evaluations, laboratory tests, vaccinations received and any other information you feel is important for us to review.

Thank you,

Dr. Sevilla