Oxygen Oasis Hyperbaric Wellness Center
848 Town Center Drive
Langhorne, PA 19047
215-352-3720 (office)
215-352-3608 (fax)
info@o2oasis.com

PEDIATRIC PATIENT QUESTIONNAIRE

PLEASE PRINT **DATE: ___/___/___**

Child's Name: First _____ **Last** _____ **MI** _____

Parent(s) Name(s): _____ _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: (___)_____ **Work:** (___)_____ **Cell:** (___)_____

Email: _____ **Fax:** (___)_____

Child's Birth Date: ___/___/___ **Sex: M F** **Social Security No.** *(opt)*: _____

Parents' Occupation(s) **Mother:** _____ **Father:** _____

Siblings:

Name	Sex	DOB *(MM/DD/YYYY)*

PRIMARY CARE PHYSICIAN:

Physician Name: _____

Clinic/Hospital *(if applicable):* _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: (___)_____ **Cell:** (___)_____ **Pager:** (___)_____

Referred by: _____

Pharmacy:_____ **Phone:**_____ **LabCorp / Quest (Circle One)**
Compounding Pharmacy: Summit / Hopewell – (Circle one) Phone:_____

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MEDICAL HISTORY (cont.)

Signs and Symptoms (cont.)

Date of diagnoses: ____/____/____

Diagnoses or explanation given to you about your child:

Other problems to be addressed:

Please describe your child, including his/her history. Please be as detailed as possible.

When did you first notice your child's problem?

What did you first notice?

Was the onset of your child's problem sudden or gradual?

Was there any event or illness that you or others think brought on your child's symptoms?

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PRENATAL HISTORY
Maternal age at delivery: _____ years

Please describe any illnesses during pregnancy:

Please list any medications during pregnancy *(not during labor/delivery)***:**

Other complications during pregnancy:

LABOR/DELIVERY
Mode of delivery: C-section/Vaginal

If vaginal **did you have Forceps/Vacuum?**

If C-section**, explain why:**

Mother's medication(s) during labor and delivery:

Please describe any complications during labor and delivery:

POSTNATAL
Was the birth: Full term/Premature? *(Circle one)* **How many weeks? _____ (***Weeks)* **Birth Weight:_____(oz)**

Medications given to child during hospital stay:

Please describe any complications after delivery:

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MEDICAL HISTORY (cont.)

Signs and Symptoms (cont.)

FAMILY HISTORY

List any allergies, major illnesses, genetic diseases or problems for each of the following family members of your child:

Mother:

Father:

Siblings:

Maternal Grandparents:

Paternal Grandparents:

DIETARY/NUTRITIONAL HISTORY

Breast-fed: Yes / No *(Circle One)* **If yes, how long? _____**

Bottle-fed: **Age Started: _____ Age stopped: _____ Brand of formula: _____**

Foods: Age Started _____ First foods *(Please list)*:_____

_____

Whole milk-- Yes/No *(Circle One)* **If yes, begun at what age? _____**

Please list any known allergies to food:

Please list any suspected sensitivities to food:

Please list any food cravings:

DIETARY/NUTRITIONAL HISTORY (cont.)

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Please describe the approximate intake for these types of food.

Food	Daily	3-5 times/wk	1-3 times/wk	Rarely	Never	Used to Eat *(no longer does)*	Comments
Cookies							
Candy							
Sweet foods							
Caffeine *(soda, tea, etc.)*							
Chocolate							
Milk-- Whole							
2 %							
1 %							
Skim							
Cheese							
Ice Cream							
Salty Foods							
Meat							
Pasta							
Bread--White							
Wheat							
Other							

What is the most appropriate description of your child's diet? *Check those that apply, and please give examples of typical foods consumed)*

☐ **Mostly baby foods:**

☐ **Mostly carbohydrates (bread, pasta, etc.):**

☐ **Mostly dairy (milk, cheese, etc.):**

☐ **Mostly meat:**

☐ **Mostly vegetarian (vegetables, fruits, grains, etc.):**

☐ **Other (describe):**

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MEDICAL HISTORY (cont.)

Signs and Symptoms (cont.)

DIETARY/NUTRITIONAL HISTORY (cont.)

Please list the foods and beverages normally consumed by your child for three typical days:

DAY 1:

Breakfast:

Morning snack(s):

Lunch:

Afternoon snack(s):

Dinner:

Other:

DAY 2:

Breakfast:

Morning snack(s):

Lunch:

Afternoon snack(s):

Dinner:

Other:

DAY 3:

Breakfast:

Morning snack(s):

Lunch:

Afternoon snack(s):

Dinner:

Other:

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GASTROINTESTINAL/ELIMINATION

Please describe your child's stool pattern (Examples: daily, foul, large, mushy, etc.):

1 – Watery 2 – fluffy/mushy 3 – smooth, soft, well-formed 4 – lumpy with cracks, dry 5 – hard lumps

Frequency:

Description:

DEVELOPMENTAL HISTORY

Please list approximate age when the following skills were mastered and any problems associated with these skills:

	Age *(approx.)*	**Describe any problems**
First words:	_____	_____
Pulling to stand:	_____	_____
Sitting up:	_____	_____
Running:	_____	_____
Jumping:	_____	_____
Rode 2-wheel bicycle:	_____	_____
Phrases or sentences:	_____	_____
Walking:	_____	_____
Crawling:	_____	_____
Walking up/down steps without help:	_____	_____
Learned to pedal:	_____	_____
Put on clothing:	_____	_____

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MEDICAL HISTORY (cont.)

Signs and Symptoms (cont.)

SOCIAL HISTORY

Who lives in the home with your child?

Are any children in your family adopted?

Please list any pets in the house:

Please list any caregivers besides parents:

Please describe any recent major life changes including losses, births, deaths, divorce, separations, remarriage or moves:

Please describe any recent travel:

Is your child involved in any sports, music or other activities? Please describe:

How does your child interact with other children?

How does your child interact with adults?

What type of school program is your child in?

Is this an appropriate learning environment for him/her?

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ALLERGIES

Please list all allergies and indicate severity:

TESTS

Please indicate which tests have been done; provide date and results:

Evaluation	Test Date	Results (normal, abnormal or unsure)
Amino Acids		
Blood Count (CBC)		
Blood Test—Fatty Acid		
Blood Test—Food Allergies - IGg		
CT Scan (specify area)		
Colonoscopy		
EEG		
Genetic Testing		
Hearing Test		
Intestinal Permeability		
MRI (specify area)		
Organic Acids Teat - urine		
PET Scan		
Plasma or Serum Zinc		
RBC Elements		
Stool Culture		
Stool Parasites		
Thyroid Profile		
Urine Tests		
X-Rays (specify)		

Other

Please list any additional tests here:

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MEDICAL HISTORY (cont.)

Signs and Symptoms (cont.)

MAJOR INJURIES--Please list, date and describe any major injuries *(if unsure, include)*: _____

SURGERIES--Please list, date, and describe any surgeries, including results and any complications: _____

PLEASE PROVIDE A COPY OF YOUR CHILD'S CURRENT IMMUNIZATION RECORD

Is there any information that you would like to share with us regarding your child's immunizations? *(Please indicate* any *reactions/behaviors, etc……)* Any information from you about this is important, so no matter how small and insignificant it seems, please include it: _____

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Signs and Symptoms:

Please complete the following charts, **indicating SEVERITY for all symptoms**, duration if known, and comments as appropriate.

0=Never Displays 1=Rarely Displays 2=Sometimes Displays 3=Often Displays 4=Always Displays

Behaviors	**Severity** *(4=always displays 0=never displays)*	**Duration** *(How long symptoms present)*	**Comments** *[Is it provoked by or improved by anything (such as food, activity, location, time of day, medication etc…)? Anything else?]*
Aggressiveness (hitting, kicking, biting)	**0 1 2 3 4**		
Always Fidgety in his/her seat	**0 1 2 3 4**		
Bed Wetting/Soiling	**0 1 2 3 4**		
Blinking	**0 1 2 3 4**		
Breath Holding	**0 1 2 3 4**		
Difficulty falling asleep	**0 1 2 3 4**		
Difficulty Waking	**0 1 2 3 4**		
Fears/Anxieties	**0 1 2 3 4**		
Food Cravings	**0 1 2 3 4**		
Grinding Teeth	**0 1 2 3 4**		
Hand/Arm Biting	**0 1 2 3 4**		
Head Banging	**0 1 2 3 4**		
Hyperactivity	**0 1 2 3 4**		
Impulsive	**0 1 2 3 4**		
Inability to Concentrate/Focus	**0 1 2 3 4**		
Irritability/Tantrums	**0 1 2 3 4**		
Low Self-Esteem	**0 1 2 3 4**		
Mood Swings	**0 1 2 3 4**		
Nail Biting	**0 1 2 3 4**		
Nail/Skin Picking	**0 1 2 3 4**		
Night Waking	**0 1 2 3 4**		
Nightmares	**0 1 2 3 4**		
OCD (obsessive compulsive)	**0 1 2 3 4**		
Persistent Colic	**0 1 2 3 4**		
Problems with Social Interactions	**0 1 2 3 4**		
Refusal to Eat	**0 1 2 3 4**		
Rocking	**0 1 2 3 4**		
Self-Stimulation (stimming/repetitive actions)	**0 1 2 3 4**		
Self-Mutilation	**0 1 2 3 4**		
Strategies to put pressure on abdomen	**0 1 2 3 4**		
Tics	**0 1 2 3 4**		
Toe Walking	**0 1 2 3 4**		
Trouble Remembering	**0 1 2 3 4**		

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MEDICAL HISTORY (cont.)

Signs and Symptoms (cont.)

Sensitivities	**Severity** *(4=very severe, 0=no sensitivity)*	**Duration** *(How long symptoms present)*	**Comments** *[Is it provoked by or improved by anything (such as food, activity, location, time of day, medication etc…)? Anything else?]*
Sensitive to Bright Lights	**0 1 2 3 4**		
Sensitive to Crowds	**0 1 2 3 4**		
Sensitive to Insect Bites	**0 1 2 3 4**		
Sensitive to Sounds/Noise	**0 1 2 3 4**		
Sensitive to Texture of Clothes	**0 1 2 3 4**		
Sensitive to Texture of Food	**0 1 2 3 4**		
GI Issues	**Severity** *(4=always displays 0=never displays)*	**Duration** *(How long symptoms present)*	**Comments** *[Is it provoked by or improved by anything (such as food, activity, location, time of day, medication etc…)? Anything else?]*
Anal Itching	**0 1 2 3 4**		
Belching	**0 1 2 3 4**		
Bloating	**0 1 2 3 4**		
Constipation	**0 1 2 3 4**		
Diarrhea	**0 1 2 3 4**		
Difficulty Swallowing	**0 1 2 3 4**		
Mucous/Blood In Stools	**0 1 2 3 4**		
Passing Gas	**0 1 2 3 4**		
Reflux	**0 1 2 3 4**		
Stomach Ache	**0 1 2 3 4**		
Skin/Nails	**Severity** *(4=always displays 0=never displays)*	**Duration** *(How long symptoms present)*	**Comments** *[Is it provoked by or improved by anything (such as food, activity, location, time of day, medication etc…)? Anything else?]*
Acne	**0 1 2 3 4**		
Brittle Nail	**0 1 2 3 4**		
Cracking/Peeling Feet	**0 1 2 3 4**		
Cracking/Peeling Hands	**0 1 2 3 4**		
Dry Skin	**0 1 2 3 4**		
Easy Bruising	**0 1 2 3 4**		
Eczema	**0 1 2 3 4**		
Flushing	**0 1 2 3 4**		
Hives	**0 1 2 3 4**		
Itchy Scalp	**0 1 2 3 4**		
Oily Skin	**0 1 2 3 4**		
Other Rashes	**0 1 2 3 4**		
Pale Skin	**0 1 2 3 4**		

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Skin/Nails *(cont.)*	**Severity** *(4=always displays 0=never displays)*	**Duration** *(How long symptoms present)*	**Comments** *[Is it provoked by or improved by anything (such as food, activity, location, time of day, medication etc…)? Anything else?]*
Psoriasis	**0 1 2 3 4**		
Ridges/Pitting of Nails	**0 1 2 3 4**		
Seborrhea (cradle cap)	**0 1 2 3 4**		
Soft Nails	**0 1 2 3 4**		
Thickening of Nails	**0 1 2 3 4**		
White spots/lines on nails	**0 1 2 3 4**		
Other Medical	**Severity** *(4=always displays 0=never displays)*	**Duration** *(How long symptoms present)*	**Comments** *[Is it provoked by or improved by anything (such as food, activity, location, time of day, medication etc…)? Anything else?]*
Acute Sense of Smell	**0 1 2 3 4**		
Bad Breath	**0 1 2 3 4**		
Canker Sores	**0 1 2 3 4**		
Cold Hands/Feet	**0 1 2 3 4**		
Cold Intolerance	**0 1 2 3 4**		
Congestion	**0 1 2 3 4**		
Cough	**0 1 2 3 4**		
Dark Circles/Puffiness Under	**0 1 2 3 4**		
Dizziness	**0 1 2 3 4**		
Dripping Nose	**0 1 2 3 4**		
Dry Lips/Mouth	**0 1 2 3 4**		
Earaches	**0 1 2 3 4**		
Eye Discharge	**0 1 2 3 4**		
Fatigue	**0 1 2 3 4**		
Geographic Tongue	**0 1 2 3 4**		
Headaches	**0 1 2 3 4**		
Heat Intolerance	**0 1 2 3 4**		
Hoarseness	**0 1 2 3 4**		
Muscle Cramps/Spasms	**0 1 2 3 4**		
Night-blindness in	**0 1 2 3 4**		
Nose Bleeds	**0 1 2 3 4**		
Numbness/Tingling	**0 1 2 3 4**		
Poor Coordination	**0 1 2 3 4**		
Problems with buttons, ties,	**0 1 2 3 4**		
Processing Problems (visual,	**0 1 2 3 4**		
Recurrent/Chronic Fever	**0 1 2 3 4**		
Ringing In Ears	**0 1 2 3 4**		

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Other Medical*(cont.)*	**Severity** *(4=always displays 0=never displays)*	**Duration** *(How long symptoms present)*	**Comments** *[Is it provoked by or improved by anything (such as food, activity, location, time of day, medication etc…)? Anything else?]*
Seizures	**0 1 2 3 4**		
Sore Throats	**0 1 2 3 4**		
Stiffness	**0 1 2 3 4**		
Strong Body Odor	**0 1 2 3 4**		
Strong Stool Odor	**0 1 2 3 4**		
Strong Urine Odor	**0 1 2 3 4**		
Swollen Gums	**0 1 2 3 4**		
Tremors	**0 1 2 3 4**		
Weakness	**0 1 2 3 4**		
Wheezing	**0 1 2 3 4**		

Please list your child's current therapies and their progression with them.

Type of therapy	**How long?**	**Progression?**

Please list any past therapies and your child's progression with them.

Type of therapy	**How long?**	**Progression?**

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Medications and Supplements

Please list your child's current medications and supplements:

Name	Brand	Dose	How long taken?	Results	Comments

Please list any supplements/medications that your child has been on in the past:

Name	Brand	Dose	How long taken?	Results/Why stopped?	Comments

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Please use this space and the back of this page to tell us ANYTHING (event, action, symptom, behavior pattern, etc…) that you think is significant/unique about your child. Remember, the smallest detail could lead us to a potential remedy or other helpful information.