Dr. Nagaratina Salem, M.D, P.A.
Adriane Nelson, CPNP
6850 TPC Drive, Suite 100 McKinney, TX 75070
Phone (214) 383-4400 Fax (214) 383-4403
www.CraigRanchPediatrics.com

Patient Name: ___________________________________ **Date of Birth:** ___________

Parent
Name: ____
Address: ____
Phone: ____

Referred by: ____

Diagnosis:
____
____

Previous Care (include specialists, labs, medications and supplements):

____
____

Main Concerns about your child:

____
____

Gastrointestinal

Was your child breastfed? Yes / No
If yes, up to what age?
Was your child a colicky infant? Yes / No
Did your child show any signs of abdominal pain? Yes / No
If yes, at what age?

Child's bowel habits (constipation, diarrhea, frequency, etc. Please be detailed) :
Past:

Patient Name: ___________________________________ Date of Birth: ____________

Current:
Is your child toilet trained? Yes / No

Has your child ever taken antibiotics? Yes / No
If yes, how many courses? ____________________________________
When was the last time? ______________________________________

Allergies
Does your child have seasonal allergies? Yes / No
Does your child have a history of asthma or wheezing? Yes / No
Does your child get dark circles under their eyes? Yes / No
Does your child have a history of eczema? Yes / No
Has your child ever had redness around the anus/diaper rash? Yes / No

Behavior
Is your child: inattentive distractible hyper-focused None

Describe your child's activity level:
hyper-active low energy irritable None

Does your child ever seem foggy or spaced-out? Yes / No

Does your child act more silly/giddy than is expected for their age? Yes / No
Does your child ever have melt-downs or tantrums? Yes / No

Sleep
Child's sleep habits:
Previous: sleeps well difficulty falling asleep night waking
Current: sleeps well difficulty falling asleep night waking

Diet
Please describe any food sensitivities and/or allergies:
____
____

List any foods your child avoids:
____
____

List any foods your child craves:
____
____

Patient Name: ___________________________________ Date of Birth: ____________

Exercise
What form of exercise does your child enjoy and how often do they participate in it a week?

____

____

How does your child spend their leisure time?

____

____

Priorities
Please describe things that make your child better:

____

____

Please describe things that make your child worse:

____

____

Food Diary
Please carefully write down everything that your child eats and drinks for 5 days. Please list what they actually ate, there is no judgment, include portion sizes (small apple, 5 Oreos, etc.).

Day 1:

____

____

____

____

____

____

Patient Name: ___________________________________ Date of Birth: ____________

Day 2:

____

____

____

____

____

____

Day 3:

____

____

____

____

____

____

Day 4:

____

____

____

____

____

____

Day 5:

____

____

____

____

____

____