Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number (Home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number (Cell): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Method of Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Can the office leave a message? YES / NO

**Emergency Contact:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number (Home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number (Cell): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Contacts:**

Name of Medical Doctor / Family Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Please list any other health care providers (name, specialty, telephone): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information:**

Payment / Copay Options: ☐Cash ☐Check ☐Credit/Debit Card SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Co: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Name: ☐Self ☐Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured Phone: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured DOB: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Relationship to Insured:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured ☐ M ☐ F

Insured Employer & Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

Please list your child’s health concerns in order of importance:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What has your doctor (currently and previously) diagnosed your child with? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list known allergies (environmental, food and medications):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any and all current medications (prescription and over-the counter) & supplements (vitamins, herbs):

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Drug/Supplement | Date Started | Dosage/Frequency | Prescribed for: |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**PREGANCY HISTORY**

Mother's age at child's birth: \_\_\_\_\_\_\_\_\_ Mother's first pregnancy: ☐Y ☐N

Please list any medical problems during pregnancy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Please list any stresses during pregnancy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Did the mother experience any frights or shocks during the pregnancy? ☐Y ☐N

Please describe mother’s nutrition during pregnancy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BIRTH HISTORY**

Term length: ☐Full ☐Premature \_\_\_\_\_\_ weeks ☐Late \_\_\_\_\_\_ weeks

 Birth weight: \_\_\_\_\_\_ lbs. \_\_\_\_\_\_ oz. Birth Length: \_\_\_\_\_\_\_\_\_\_

 Where was your child born? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Method of delivery: ☐Vaginal ☐C-section ☐Other Intervention \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any complications during labor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medical problems during child’s newborn period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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How would you describe the personality of your child as an infant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NUTRITION AND FEEDING**

Was your child breastfed? ☐Y ☐N If so for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were there any problems establishing breastfeeding during the newborn period? ☐Y ☐N
If so please describe: ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was formula used: ☐Y ☐N If so, at what age? \_\_\_\_\_\_\_\_\_ What type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

At what age were solid foods introduced? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child currently have any feeding/dietary problems? ☐Y ☐N
Please specify: ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child currently have any dietary restrictions? ☐Y ☐N
Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DEVELOPMENT**

At what age did your child first:
Develop teeth: \_\_\_\_\_\_\_ Run:\_\_\_\_\_\_\_\_ Sit up: \_\_\_\_\_\_\_ Crawl: \_\_\_\_\_\_\_

Hold head up: \_\_\_\_\_\_\_ Walk: \_\_\_\_\_\_\_\_\_ Talk: \_\_\_\_\_\_\_  Smile: \_\_\_\_\_\_\_

Roll over: \_\_\_\_\_\_\_ Toilet Train: \_\_\_\_\_\_ Girls only, if menstrual period: \_\_\_\_\_\_\_

Do you have any concerns about developmental delays in your child? ☐Y ☐N

If so, please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHILDHOOD ILLNESSES**

☐Ear Infections

☐Strep Throat

☐Colds

☐ Other: \_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐Pertussis

☐Rubella

☐Rheumatic fever

☐Asthma

☐Seasonal Allergies

☐Chicken pox

☐Scarlet fever

☐Measles

☐Mumps

☐Tuberculosis

Total Ear Infections (in 1 year): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Total colds (in 1 year): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total Strep Throats (in 1 year): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 How many times has your child been treated with antibiotics? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**VACCINATION HISTORY**

☐Varicella (chicken pox)

☐Gardasil (HPV)

☐Flu shot

☐Polio

☐Pneumococcal

☐Small pox

☐Hepatitis A

☐Meningococcal
☐RotaVirus

☐DPT (diptheria, pertussis, tetanus)

☐MMR (measles, mumps, rubella)

☐Hepatitis B

☐HIB (haemophilus influenze B)

Did your child ever experience an adverse reaction to a vaccination? ☐Y ☐N

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES**

☐Rectal Itch

☐ Dark/excessive ear wax

☐Ear itching

☐Frequent ear infections

☐Canker sores

☐Dark circles under eyes

☐Frequent stuffy nose

☐Cough

☐Throat clearing

☐Hoarseness

☐Rashes Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐Many respiratory infections

☐Shortness of Breath

☐Complaints of stomach ache between meals

☐Behavior change after eating

Has your child had food allergy sensitivity test? ☐Y ☐N

If so, what were the results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIFESTYLE**

EXERCISE:

Does your child spend time outdoors daily? ☐Y ☐N

What physical activities does your child participate in? ­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Hours per day of:

 Television: \_\_\_\_\_\_\_ Homework: \_\_\_\_\_\_\_ Computers: \_\_\_\_\_\_\_ Video Games: \_\_\_\_\_\_\_

Do you have concerns about your child’s level of activity? ☐Y ☐N

SLEEP:

Where does your child sleep at night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours of sleep per night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check all that apply:

☐ Take naps

☐ Nightmares

☐ Restlessness

☐ Insomnia

☐ Wakes at night

☐ Talks/Yells in sleep

☐ Snore

☐ Bedwetting

☐ Grinds Teeth

How would you describe your child’s energy level? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

TOLIET HABITS:

Difficulties toilet training? ☐Y ☐N Bedwetting? ☐Y ☐N History of altering constipation and diarrhea? ☐Y ☐N

Bowel movements: How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Consistency? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Color? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mucous? ☐Y ☐N Blood? ☐Y ☐N

PERSONALITY / MOOD:

How would you describe your child’s personality?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check all that apply?

☐Likes to stay alone for long periods of time

☐ Trouble getting along with others

☐ Trouble being alone

☐ High stressed

☐ Apathetic

☐ Trouble leaving house

☐ Ritualistic behavior

☐ Perfectionist

☐ Oppositional

☐ Impulsive

☐ Crying spells

☐ Feel worthless

☐ Hurt self in past

☐ Feels like killing self

☐ Feels like victim

☐Feeling of rage/violence

☐ Depression

☐ Anxiety

☐ Excessive worry

☐ Easily angered

☐ Nervous

☐ Fearful

☐ Mood swings

☐ Vengeful

Has your child lost someone close to them either a death or separation? ☐Y ☐N

Has your child ever experienced abuse? ☐Y ☐N Has your child ever witnessed violence? ☐Y ☐N

**FAMILY HISTORY**

|  |  |  |
| --- | --- | --- |
|  | Age at Death(if living leave blank) | Health Conditions |
| Mother |  |  |
| Father |  |  |
| Siblings |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| Maternal Grandmother |  |  |
| Maternal Grandfather |  |  |
| Paternal Grandmother |  |  |
| Paternal Grandfather |  |  |

**REVIEW OF SYSTEMS (check all that apply)**

|  |  |  |
| --- | --- | --- |
| **GENERAL**☐Chills☐Fever☐Dizziness/vertigo☐Light-headedness☐Forgetfulness☐Fatigue☐Hair loss☐Headache☐Nervousness☐Anxiety/depression☐Sweating☐Numbness☐Loss of sleep☐Weight loss or gain**SKIN**☐Easy bruising☐Hives/itching☐Moles☐Rash☐Scars/keloids☐Sores/ulcers**GENITO-URINARY**☐Painful urination☐Frequent urination☐Lack of bladder control☐Change in urine odor☐Frequent UTI☐Blood in urine | **CARDIOVASCULAR**☐Arrhythmia/murmur☐Atherosclerosis☐Chest pain☐Palpitations ☐Shortness of breath☐High blood pressure☐Low blood pressure☐Cold extremities☐Swelling in hands/feet☐Varicose veinsOther:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**GASTROINTESTINAL**☐Poor appetite☐Gas/Bloating/belching☐Foul odor in stool/gas☐Change in bowels☐Constipation☐Diarrhea☐Excessive thirst☐Excessive hunger☐Ingestion/heartburn☐Nausea/vomiting☐Hemorrhoids☐Stomach pain/discomfort☐Blood in stool | **EYE/EAR/NOSE/THROAT**☐Visual floaters☐Increased tearing or dryness ☐Blurred/double vision☐Glaucoma/cataract☐Earache☐Ear discharge ☐Ringing in the ears☐Hearing loss☐Stuffy or runny nose☐Nosebleeds☐Sinus problems☐Teeth or gum problems ☐Dry mouth☐Bleeding gums☐Hoarseness☐Bad breath☐Difficulty swallowing☐Persistent cough ☐Tonsil removal**NEUROLOGIC**☐Loss of coordination☐Seizures/epilepsy☐Fainting ☐Paralysis/weakness☐Brain fog/memory difficulties |

Why did you choose to come to this office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you know about Dr. D’Agata’s approach? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What three expectations do you have from this visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What expectations do you have of me as your child’s physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate lifestyle? (Rate from 1 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

What behaviors or lifestyle habits do you currently have in place that you believe **support** your child’s health?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What behaviors or lifestyle habits do you currently have in place that **impairs** your child’s health? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What **potential obstacles**do you foresee that would interfere with the implementation of changes for your child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How do you, as a caregiver, need to be supported to make these beneficial changes for your child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What does your child LOVE to do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Thank you for taking the time to fill out this intake!