Today's Date: _____ **Pediatric and Teen Intake Forms** Record #: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

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

Preferred Phone: _____ Secondary Phone: _____

Email: _____ Marital Status: ❑ Single ❑ Married SS #: _____

Mom's Name: _____ Mom's Employer: _____

Dad's Name: _____ Dad's Employer: _____

Names of Siblings and Ages: _____

Name & Number of Emergency Contact: _____ Relationship: _____

Referred by: _____

HISTORY of COMPLAINT

What do you hope to achieve with us? _____

_____

What are the top 4 health concerns you would like to focus on? How does each impact you every day?

1. _____
2. _____
3. _____
4. _____

On a scale of **0 - 10** with **10** being highest priority and **zero** being least priority, please rate your above complaints by c***ircling the number*****:**

Primary or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaints is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

What helps you improve? _____

What makes you worse? _____

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

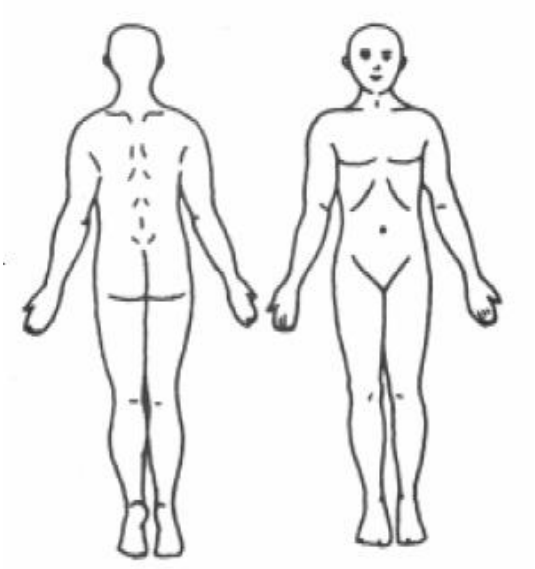
Is your problem the result of ANY type of accident? ☐ Yes ☐ No How did the injury happen? _____

_____

Identify any other **injury(s), minor or major,** that the doctor should know about: _____

_____

***PLEASE MARK / DRAW** the areas on the diagram with the following **letters and** describe the feeling / sensations as best you can:



R = Radiating / Throbbing _____

B = Burning _____

D = Dull _____

A = Aching _____

N = Numbness _____

S = Sharp / **S**tabbing _____

T= Tingling _____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes **If yes,** how many times? _____

When / How did the last episode occur? _____

What you have tried in the past?

Prior Treatment / Approach	Name of Physician / Specialist	Effectiveness (0 – 10)

The next section will prove an in-depth look at your child's overall health from the start of life. Please list and explain each section. Examples include dislocations, broken bones, cancer, tumors, cysts, disabilities, diabetes, heart attacks, surgeries, jobs with a physical / chemical stress, schools / house with mold, mental / emotional / spiritual stress. Simply skip if the question doesn't apply. Please be specific!

PATIENT BIRTH HISTORY

❑ Term ❑ Premature ❑ Vaginal Delivery ❑ C-Section Delivery How long was the delivery? _____

Complications during Pregnancy / Birth? _____

During the pregnancy, baby was exposed to; _____

Was mother given antibiotics during pregnancy / birth? _____

Ultrasounds? _____ Other in utero procedures? _____

Was the Birth Assisted? _____

Were medications given during birth? What? _____

APGAR at birth? _____ APGAR after 5 minutes? _____

Birth weight? _____ Birth length? _____

Alert and responsive within 12 hours? _____

❑ Formula-fed How Long? ____ ❑ Breast-fed How Long? ____ Any reactions to either? _____

Any breastfeeding challenges? _____

Any difficulties bonding? _____

CHILDHOOD HISTORY

Normal growth and development? _____

What age did the child respond to sound? _____ Follow an object? _____

What age did the child hold head up? _____ Vocalize? _____

What age did the child sit up alone? _____ Teethe? _____

What age did the child crawl? _____ Walk? _____

Does the child have 'normal' sleeping patterns? _____

Health issues from mother or father? _____

Health issues that siblings have? _____

Which vaccinations has the child received? _____

Any reactions / response to vaccines? _____

Acquisition of chicken pox naturally? When? _____

Does the child frequently make eye contact? _____

List sounds, tastes, textures etc. child avoids; _____

If relevant, attach an immunization record including types and dates and any reactions.

Any antibiotics? What? How many? _____

Age of Introduction of Solid Foods: _____ Dairy: _____ Wheat: _____ Nuts: _____ Formula: _____

Is there candy / sugar in diet? When? _____

Any ear infections, strep throat, asthmas, allergies? _____

Any digestive or urinary problems, colic, bloating, etc? _____

Any emotional / behavioral issues, temper tantrums? _____

Any pets? What? How many? _____

Any smokers in the home? _____ Other chemical stressors? _____

Does the child attend daycare? When? _____

How much screen-time daily? (TV/mobile/games) _____

ALLERGIC REACTION HISTORY

Medication / Supplement / Food	Reaction

GRADE SCHOOL HISTORY

Any serious infections or experience any traumas? _____

Any emotional / behavioral issues? _____

Other health issues? _____

HIGH SCHOOL HISTORY

Acne that required medications? What kind? _____

Any mono / other infections / sicknesses? _____

Other health issues? _____

COLLEGE HISTORY

Other health issues? Antibiotics, Chemical Exposures, Hospitalizations, Trauma, Stress? _____

_____

_____

TRAVEL HISTORY

Foreign Travel? Where? _____

Wilderness Camping? Where? _____

PERSONAL MEDICAL HISTORY

If applicable, check appropriate box and provide date of onset/diagnosis:

GASTROINTESTINAL

❑ Irritable Bowel Syndrome: _____
❑ Inflammatory Bowel Disease: _____
❑ Crohn's: _____
❑ Ulcerative Colitis: _____
❑ Gastritis or Peptic Ulcer Disease: _____
❑ GERD (reflux): _____
❑ Celiac Disease: _____
❑ Other: _____

CARDIOVASCULAR

❑ Heart Attack: _____
❑ Other Heart Disease: _____
❑ Stroke: _____
❑ Elevated Cholesterol: _____
❑ Other: _____
❑ Hypertension: _____
❑ Rheumatic Fever: _____
❑ Mitral Valve Prolapse: _____
❑ Thrombosis: _____
❑ None: _____

METABOLIC / ENDOCRINE

- ❑ Type 1 / 2 Diabetes: _____
- ❑ Weight Gain/Loss: _____
- ❑ Metabolic Syndrome: _____
- ❑ Eating Disorder: _____
- ❑ Endocrine Disorder: _____
- ❑ Polycystic Ovarian Syndrome: _____
- ❑ Pre - Diabetes: _____
- ❑ Hypoglycemia: _____
- ❑ Frequent Weight Fluctuations: _____
- ❑ Hyper/Hypothyroidism: _____
- ❑ Infertility: _____
- ❑ Other: _____

INFLAMMATORY / AUTOIMMUNE

- ❑ Chronic Fatigue Syndrome: _____
- ❑ Immune Dysfunction: _____
- ❑ Autoimmune: _____
- ❑ Immune Deficiency Disease: _____
- ❑ Shingles / Herpes: _____
- ❑ Other: _____

CANCER

- ❑ Cancer and Type: _____

GENITAL / URINARY

- ❑ Kidney Stones: _____
- ❑ Erectile / Sexual Dysfunction: _____
- ❑ Frequent Yeast Infections: _____
- ❑ Gout: _____
- ❑ Frequent Urinary Tract Infections: _____
- ❑ Other: _____

MUSCULOSKELETAL / PAIN

- ❑ Fibromyalgia: _____
- ❑ Osteoarthritis: _____
- ❑ Car Accidents: _____
- ❑ Stenosis/Spondylolisthesis: _____
- ❑ Spinal Fusion: _____
- ❑ Chronic Pain: _____
- ❑ Other: _____
- ❑ Scoliosis: _____
- ❑ Degenerative Discs: _____
- ❑ Other: _____

RESPIRATORY

- ❑ Asthma: _____
- ❑ Chronic Sinusitis: _____
- ❑ Bronchitis: _____
- ❑ Emphysema: _____
- ❑ Pneumonia: _____
- ❑ Tuberculosis: _____
- ❑ Sleep Apnea: _____
- ❑ Other: _____

SKIN

- ❑ Eczema: _____
- ❑ Psoriasis: _____
- ❑ Acne: _____
- ❑ Other: _____

NEUROLOGICAL / MOOD

- ❑ Depression: _____
- ❑ Anxiety: _____
- ❑ Bipolar Disorder: _____
- ❑ Headaches/Migraines: _____
- ❑ Alzheimer's: _____
- ❑ Other: _____
- ❑ ADD / ADHD: _____
- ❑ Autism: _____
- ❑ Parkinson's: _____
- ❑ Seizures: _____
- ❑ Epilepsy: _____
- ❑ None: _____

DENTAL

- ❑ Silver Mercury Fillings and Number: _____
- ❑ Root Canals and Number: _____
- ❑ Tooth Pain: _____
- ❑ Gingivitis: _____
- ❑ Problems Chewing / TMJ: _____
- ❑ Gold Fillings: _____
- ❑ Implants: _____
- ❑ Bleeding Gums: _____
- ❑ Do You Floss Regularly: _____
- ❑ Other: _____

WOMEN'S / OBSTETRIC ONLY

- ❑ Age of First Menstruation: _____
- ❑ Days of Cycle: _____
- ❑ Last Menstruation Date: _____
- ❑ Contraceptive Patch and Length: _____
- ❑ Other Contraceptive Use: _____
- ❑ Previous Pregnancy Number: _____
- ❑ Frequency of Cycle: _____
- ❑ Has Your Cycle Skipped and How Long: _____
- ❑ Birth Control Pills and Length: _____
- ❑ Nuva Ring and Length: _____
- ❑ Currently Pregnant and Due Date: _____
- ❑ Miscarriages: _____

❑ Vaginal Deliveries: _____ ❑ C-Section Deliveries: _____
❑ Abortion: _____ ❑ Number of Living Children: _____
❑ Post-Partum Depression: _____ ❑ Gestational Diabetes: _____
❑ Breast-Feeding History: _____

MEN'S ONLY

❑ PSA Exam and Result: _____ ❑ Prostate Enlargement / Infection / Surgery: _____
❑ Impotence: _____ ❑ Libido Level Rated 0-10: _____
❑ Difficulty Obtaining / Maintaining Erection: _____ ❑ Urination at Night and Number: _____
❑ Urgency/Hesitancy/Change in Urinary Stream: _____ ❑ Loss of Urinary Control: _____
❑ Decrease in Physical Stamina / Strength: _____ ❑ Other: _____

PREVENTIVE TESTS AND DATE OF LAST TEST

❑ Full Physical Exam: _____ ❑ Hemoccult (blood in stool): _____
❑ Bone Density: _____ ❑ MRI / CT / X-rays: _____
❑ Colonoscopy: _____ ❑ Upper Endoscopy: _____
❑ Cardiac Stress Test: _____ ❑ Ultrasound: _____
❑ EKG: _____ ❑ Mammogram/Thermal Scan: _____

SURGERIES

❑ Appendectomy: _____ ❑ Heart / Bypass Surgery: _____
❑ Hysterectomy +/- Ovaries: _____ ❑ Angioplasty or Stent: _____
❑ Gall Bladder: _____ ❑ Pacemaker: _____
❑ Hernia: _____ ❑ GI Surgery: _____
❑ Tonsillectomy: _____ ❑ C-Section: _____
❑ Dental: _____ ❑ Other: _____
❑ Metal Joint Replacement/Implant (Knee / Hip): _____ ❑ None: _____

BLOOD TYPE

❑ A ❑ B ❑ AB ❑ O ❑ Rh+ ❑ Unknown

HOSPITALIZATIONS

Date	Reason

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date (MM/YY)	Reason For Use

Pharmacy Name: _____ Phone: _____

Address: _____

PREVIOUS MEDICATIONS – Last 10 Years

Medication	Dose	Frequency	Start Date (MM/YY)	Reason For Use

CURRENT NUTRITIONAL SUPPLEMENTATIONS – Vitamins, Minerals, Herbs, Homeopathy

Supplement and Brand	Dose	Frequency	Start Date (MM/YY)	Reason For Use

NUTRITIONAL HISTORY

Current height and weight? _____ Usual or normal weight range (+/- 5 lbs.)? _____

Ever had a nutritional consultation? Why? _____

Are you following a special diet or nutritional program? Why? _____

❑ None ❑ Low Fat ❑ Low Carb ❑ High Protein ❑Low Sodium ❑ Diabetic ❑ Dairy-Free

❑ 100% Gluten-Free ❑ Gluten-Limited ❑ Vegetarian ❑ Vegan ❑ Paleo ❑ Other: _____

How willing are you to change your diet rated 0 to 10, 0 being not at all and 10 being extremely ready and willing? _____

Do you avoid any particular foods? Why? _____

How many meals are you eating on average each day? _____ Do you eat a full breakfast each day? _____

Are you eating snacks between meals? What? _____

Do you read food labels? _____ How many meals do you eat out per week? _____

How many ounces of water do you consume daily? _____ How many alcoholic beverages do you consume daily? _____

How many caffeinated beverages do you consume daily? _____ Do you feel dependent on them? _____

Do you drink soda? _____ What size and how many each day? _____ What is your favorite brand? _____

Do you add sweeteners to your food/beverages? Type? _____

Do you buy organic or conventional fruits and veggies? _____ Organic animal products? _____

How many servings of fruit are you getting daily? _____ Serving of veggies daily? _____

List the three worst foods you eat during an average week: _____

List the three healthiest foods you eat during an average week: _____

How often do you crave salt or sweets? How often? _____ Do you eat a lot after dinner? _____

Are you irritable if meals are missed? _____ How often are meals missed during an average week? _____

Do you feel you digest your food well? _____ Difficulty digesting anything in particular? _____

Do you feel bloated after meals? _____ Excessive gas after meals? _____

Do you experience reflux? _____ From what types of foods? _____

Do you use antacids? Which brand? _____ Do you get relief from them? How long? _____

Excessive belching or burping? _____ Do you have offensive breath? _____

Abdominal pain after meals? _____ Constipation / Diarrhea? _____

How many bowel movements on a daily basis? _____ How many days between bowel movements? _____

Do you have fatigue after meals? Which ones? _____

The most important thing I should change about my diet to improve my health is: _____

_____

PHYSICAL / FITNESS HISTORY

What is your current exercise / physical fitness program?

Activity	Number of Sessions/Week	Duration

How willing are you to change your exercise routine, rated 0 to 10, 0 being not at all and 10 being extremely ready and willing? _____

List problems that limit physical activity: _____

Are you happy with your current level of physical ability? _____ How long has exercise been a part of your life? _____

The most important thing I should change about my exercise routine to improve my health is: _____

_____

SOCIAL HISTORY

Are you currently smoking? _____ How many years? _____ Packs per day? _____

How many attempts to quit? _____ What worked or didn't work? _____

Did you previously smoke? _____ How many years? _____ Packs per day? _____

Are you currently using any recreational drugs? Type: _____

Have you ever used IV or inhaled recreational drugs? Type: _____

PSYCHOSOCIAL / FAMILIAL HISTORY

Are you happy? _____ Do you feel like your life has meaning and purpose? _____

Do you like the work you do? _____ Have you sought counseling? _____

Are you currently in therapy? What type? _____

Do you feel you have excessive stress in your life? _____ Do you handle it well? _____

Do you have a safe outlet for fun? What? _____

Number your daily stressors, rated 0 to 10, 0 being not at all and 10 being the worst and most damaging:

Work	Family	Social	Finances	Health	Others

Do you practice meditation, prayer, or other relaxation techniques? Type and frequency: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Gay/Lesbian ❑ Long Term Partner ❑ Widow

Are you nervous, emotional, anxious, uptight, crabby or short-fused? _____

Do you have resources for emotional support? Type: _____

The most important thing I should change about my stress/coping/emotional routine to improve my health is: _____

_____

SLEEP HISTORY

Do you feel well rested? Why or why not? _____

Average number of hours you sleep per night: _____ Do you have trouble sleeping? _____

Can't get to sleep? _____ How long does it take to fall asleep? _____ Can't stay asleep? _____

What time do you go to bed? _____ What time do you wake up? _____ Do you use sleeping aids? _____

Slow starter in the morning? _____ Afternoon fatigue? When? _____ What helps? _____

Sleep apnea? Mask? _____ Night sweats? When? _____

ENVIRONMENTAL / TOXICITY HISTORY

Have you ever had any major exposure to a known toxic substance? _____

Do you smell odors when others can't? Which? _____

Do you have a sudden onset of symptoms (headache, skin rashes, nauseas, etc) when exposed to perfume/cologne, cleaning supplies, mold, dust or other allergens? Explain: _____

Please list all known chemical allergies / sensitivities: _____

_____

Are you exposed to new construction (paint, carpet, flooring, etc.) in your current and/or past residence? _____

Are you exposed to new construction (paint, carpet, flooring, etc.) in your current and/or past occupation? _____

Have you worked at/ near any industry that regularly emitted waste into the air/water (golf course, dry cleaner, plant, farm, shipyard, mine, chemical factory, landfill)? _____

Have you ever lived in or worked in a place with mold? When? _____

Are pesticides/herbicides/fertilizer used at your home? _____ Do you live by an airport or highway? _____

Do you wear dry cleaned clothing? _____ Do you have any pets? Type? _____

Do you use candles in your house? _____ Do you use air fresheners in your house/car? _____

Do you heat food in a microwave? _____ Do you a cell phone? How many hours daily? _____

Do you use WiFi in your house? _____ Do you live near a cell phone tower? _____

Do you regular get hair coloring, permanents or acrylic fingernails in a beauty shop? How often? _____

Do you use fabric softeners, scented soaps, detergents, perfumes, cleaning supplies? _____

Has your home ever been treated for fleas, tics or bed bugs? When? _____

Have you ever worked with chemicals related to a hobby (paints, solvents, stains, etc)? _____

Please list any other relevant information including but not limited to metal or plastic pipes, paint, pets, asbestos, power lines, gasoline storage, smoke, construction, mold, unrepaired water leaks, etc. _____

_____

READINESS ASSESSMENT

In order to improve your health, how willing are you to;

Significantly modify your diet, if needed?	0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Take several nutritional supplements each day, if needed?	0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Keep a record of everything you eat certain days?	0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Modify your lifestyle (work demands, sleep habits, exercise routine)?	0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Practice a relaxation technique?	0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Engage in communication with this office?	0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Comments: _____

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities? _____

At the present time, how supportive do you think the people in your life will be to your implementing the above changes? _____

_____

MEDICAL TEAM

Doctor's Name	Specialty	Contact Number

Thank You!