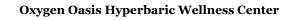




PEDIATRIC PATIENT QUESTIONNAIRE

PLEASE PRINT				Г	DATE://
Child's Name: Fi	rst	Last		MI	_
Parent(s) Name(s):					
Address:		City: _		State:	Zip:
Phone: (_)	Work: <u>(</u>)		Cell: _()	
Email:			Fax: <u>(</u>)		-
Child's Birth Date:	1 1	Sex: M F	Social Securit	:y No. (opt):	
Parents' Occupation(s)	Mother:		Father:		
Siblings:	Name	Sex	(DOB (MM/DD/YY	YY)
		I	I		
PRIMARY CARE PHYS	ICIAN:				
Physician Name:					
Clinic/Hospital (if appli	cable):				
А	ddress:				
	City:		_ State:	Zip:	
	Phone: <u>(</u>)	Cell: _	()	Pager: _	()
Referred by:					
Pharmacy:		_ Phone:		_ Lab:	





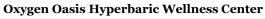
MEDICAL HISTORY (cont.) Signs and Symptoms (cont.)

Date of diagnoses:/
Diagnoses or explanation given to you about your child:
Otherwayahlawa ta ha addusa ad
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 p	regnancy:
Please list any medications during pre	egnancy (not during labor/delivery):
Other complications during pregnance	y:
LABOR/DELIVERY	
Mode of delivery: C-section/Vaginal	
If vaginal did you have Forceps/Vacuu	um?
If C-section, explain why:	
Mother's medication(s) during labor a	and delivery:
Please describe any complications du	ring labor and delivery:
POSTNATAL	
	? (Circle one) How many weeks? (Weeks) Birth Weight:(oz)
Medications given to child during hos	pital stay:
Please describe any complications aft	er delivery:





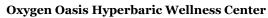
MEDICAL HISTORY (cont.)

Signs and Symptoms (cont.)

DIETARY/NUTRITIONAL HISTORY (cont.)

FAMILY HISTOR

FAIVILLY 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:
raternal Granuparents.
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):
Whele wills Vee/Ne (Circle One) If you harm at what are?
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:

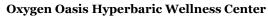




Please describe the approximate intake for these types of food

ood	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							

of typical foods consumed)	Check those that apply, and please give examples
Mostly baby foods:	
Mostly carbohydrates (bread, pasta, etc.):	
Mostly dairy (milk, cheese, etc.):	
Mostly meat:	
☐ Mostly vegetarian (vegetables, fruits, grains, etc.):	
Other (describe):	





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:
Diffier.
Other:
DAY 2:
Breakfast:
Morning snack(s):
Lunch:
Afternoon snack(s):
Dinner:
Out
Other:
Dava
DAY 3:
Breakfast:
Morning snack(s):
Worthing Shack(s).
Lunch:

Afternoon snack(s):
Dinner:
Other:





GASTROINTESTINAL/ELIMINATION Please describe your child's stool pattern (Examples: daily, foul, large, mushy, etc.):							
	•	3 – smooth, soft, well-formed		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 word	ds:	
Pulling to stan	ıd:	
Sitting u	ıp:	
	ng:	
Jumpin	ng:	
Rode 2-wheel bicycl		
Phrases or sentence		
Walkin	ng:	
	· - .	
Walking up/down ste		
Learned to peda	al:	
Put on clothin	ng:	



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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	<i>ı</i> :
i icasc	not an	uncigics	ana	mulcate	3C V CI IL	

<u>TESTS</u>	
Please indicate which tests have been done; provide date and results:	

Evaluation	lest Date	Results (normal, apnormal 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)		
<u>Other</u>		
Please list any additional tests here	2:	



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MEDICAL HISTORY (cont.)
Signs and Symptoms (cont.) MAJOR INJURIESPlease list, date and describe any major injuries (if unsure, include):
SURGERIESPlease 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 Dis	plays 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.)

Signs and Symptoms (cont.)	1	T	
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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	Severity (4=always displays	Duration (How long	Comments [Is it provoked by or improved by anything (such as
Skin/Nails (cont.)	0=never displays)	symptoms present)	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 (suc food, activity, location, time of day, medication etc)? Anythin 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.