New Young Patient Health Questionaire

First Name: ______________________ Middle: __________________ Last: ______________________

Preferred Name/Nickname: ______________________ ☐ Female ☐ Male

Date of Birth: ____________________ Place of Birth: __________________________

Are guardians/custodians biologic parents? ☐ Yes ☐ No

☐ Other relation: ______________________________

Child's genetic background: ☐ African ☐ Asian ☐ European ☐ Mediterranean

☐ Middle Eastern ☐ Native American ☐ Other: ________________________

Primary Address Street/Apartment No.: ____

City: ___________________________ State: _______ Zip: _______________

Best phone to reach you: ________________________ Alternate: _______________________

Preferred email address to discuss your child's health: _______________________________________

How did you hear about our services? ____

If you wish us to communicate with other healthcare providers please provide contact information:

____

____

Email: ____

Mother's Name: ______________________________ Email: _______________________________

Address (if different): _______________________________________ Phone: ___________________

Father's Name: ______________________________ Email: _______________________________

Address (if different): _______________________________________ Phone: ___________________

Preferred Pharmacy: _______________________ Phone: ____________________ City: ________________

Compounding Pharmacy: __________________________ Phone: _____________ City: ________________

What allergies or intolerances does the patient have to medications, airborne allergens, foods and chemicals?

____

____

What medications does she/he currently take? **(Please list: name, dosage, route and routine)**

____

____

What vitamins, herbs and supplements does she/he currently take? **(Please list: name, dosage, route and routine)**

____

____

What forms of therapy is she/he currently undergoing? ____

____

What meds, supplements and therapies were tried in the past? Please list:

____

____

Why discontinued? ____

____

What other health care provider has evaluated and treated the patient?____________________________

____

What, if any, “diagnoses” or explanations have you been given by them?

____

____

What formal testing has she/he had for the current problem?

____

____

If previously treated for Lymes provide detailed treatment (Rx name, route and administration, dose, durations).

____

____

If previously tested for Lyme, please attach/provide all results.

Mother's History

Why did you bring your child for our services?____

____

Please list the 5 things you are most concerned about in your child:

____

____

When did you first suspect that your child was ill or not developing in a typical way?

____

____

When were you sure that your child was ill or not developing in a typical way?

____

____

Did you notice anything noteworthy around the time of onset that gives you reason to suspect it as a possible cause?

____

____

Was your pregnancy at all remarkable?(any injuries, illness, chemical exposures, severe stresses, etc)

____

____

Did anything about your baby seem unusual while you were pregnant? ______________________________

____

Was there anything unusual about the labor and delivery of your baby? ______________________________

____

Did your baby have problems as a newborn?(feeding difficulties/formula intolerance) _________________

____

Was your child breast fed? ☐ Yes ☐ No

Please describe any developmental delays:

____

____

Has your child received their vaccinations as scheduled? Please describe any variance:

____

____

Other Comments or Concerns you have:

____

____

Educational History

What is the patient's current grade level? _____________ Is she/he homeschooled? ☐ Yes ☐ No

Does she/he participate in "special ed"? ☐ Yes ☐ No

Dietary History

Is the patient on a special diet or are there foods that you do not allow her/him to eat? _______________

____

Do you feel that your child has problems with his/her digestion? Please explain.

____

Is she/he a “picky” eater? ☐ Yes ☐ No

Please list the foods she/he likes to eat:

____

Is he/she on a special diet? Please explain:

____

Does she/he have excessive oral tactile sensitivity? ☐ Yes ☐ No

Can she/he take pills/capsules? ☐ Yes ☐ No

Environmental Exposures

Any travel outside the US? ☐ No ☐ Yes: ______________________________

Please list any exposure to potentially hazardous chemicals: ______________________________

____

Any exposure to cigarette smoke? ☐ No ☐ Yes

Any exposure to well water? ☐ No ☐ Yes: ______________________________

Has your child ever been exposed to a place (Home or school) where there was a musty odor, mildew, water leak or known mold growth? Please explain: ______________________________

____

Please list all previous bites from Ticks or Chiggers, reaction to bite and date:

____

Is she/he especially sensitive to: ☐ smells ☐ sound ☐ tastes ☐ touch

☐ visual stimulation ☐ other: ____________________

Surgery

Please list any surgical procedures the patient has had: ______________________________

____

Family History

Is there any history from parents, grandparents, aunts, uncles, brothers, sisters, or first cousins of any of the following:

☐ Addiction ☐ ADHD ☐ Alcoholism ☐ Aspberger's syndrome ☐ Asthma

☐ Autism ☐ Autoimmune disease ☐ Arthritis ☐ Cancer ☐ Dementia

☐ Depression ☐ Diabetes ☐ Food allergies ☐ Heart attack ☐ Inflammatory bowel

☐ Irritable bowel ☐ Migraine ☐ Multiple sclerosis ☐ Obesity ☐ Panic disorder

☐ Parkinsons ☐ Psychiatric disorder ☐ Schizophrenia ☐ Seizures ☐ Severe allergies

☐ Stroke ☐ Suicide ☐ Thyroid disorder

List of Symptoms in Past 60 Days

Digestive: ☐ Abdominal Pain ☐ Belching ☐ Constipation ☐ Diarrhea

☐ Flatulence ☐ Food cravings ☐ Heartburn/Reflux ☐ No daily stool

☐ Poor appetite

Endocrine: ☐ Early puberty ☐ Growth delay ☐ Sleeplessness/Insomnia

☐ Weight gain ☐ Weight loss

Skin: ☐ Big response to bugbites ☐ Eczema ☐ Fine bumps ☐ Hives

☐ Easy bruising ☐ Excess itching/scratching ☐ Perianal irritation

☐ Poor wound healing ☐ Rash ☐ Unusual blushing/redness

Heme/ Immune: ☐ Almost always sick ☐ Almost never sick ☐ Bleeds excessively

☐ Bruises easily/excessively ☐ Frequent ear infections ☐ Parasite

☐ Seasonal allergies ☐ Strep infections ☐ Swollen glands

☐ Unexplained fevers ☐ Unusual infection

ENT: ☐ Cough ☐ Dark circles under eyes ☐ Decreased hearing

☐ Dental problems ☐ Dizziness ☐ Ear ringing ☐ Frequent nose bleed

☐ Frequent sinus infection ☐ Frequent sore throat ☐ Imbalance

☐ Itchy eyes ☐ Mouth breather ☐ Red eyes ☐ Shortness of breath

☐ Sinus infection ☐ Sneezing ☐ Snoring ☐ Swollen eyes

☐ Wheezing

Neurological: ☐ Dyslexia ☐ Hand flapping ☐ Headaches ☐ Head banging

☐ High pain tolerance ☐ High sensitivity ☐ Increased pain tolerance

☐ Low pain tolerance ☐ Low sensitivity ☐ Migraines ☐ Other pain

☐ Poor auditory processing ☐ Poor coordination ☐ Poor handwriting

☐ Poor muscle tone ☐ Program speech ☐ Seizure-like activity ☐ Speech delay

☐ Staring spells/zone-outs ☐ Tics ☐ Toe walking ☐ Trouble running

☐ Trouble walking ☐ Uncontrolled movements ☐ Vocal stims ☐ Weakness

Behavioral/Emotional: ☐ Addiction ☐ Aggression ☐ Cravings ☐ Depressed

☐ Discusses self-injury ☐ Excessively anxious ☐ Excessive tantrums ☐ Fearful

☐ Fearless ☐ Hyperactive ☐ Inappropriate affection ☐ Injures other

☐ Intellectually gifted ☐ Limited play ☐ Phobias ☐ Poor eye contact

☐ Poor transition tolerance ☐ Poor problem solving ☐ Prefers solitude

☐ Repetitive play ☐ Ritual/highly ordered behavior ☐ Short attention

☐ Social aloofness ☐ Social awkwardness ☐ Threatens injury to others

☐ Unusual fears ☐ Violent behavior ☐ Very impulsive

☐ Violates personal space ☐ Very easily distracted ☐ Very short attention

☐ Video addiction ☐ Very stubborn

Speech: ☐ Delayed speech ☐ Does not talk ☐ Echolalia/parrot-like speech

☐ High loudness variability ☐ Hums to self ☐ Nonsensical speech

☐ Poor speech ☐ Sound deletion/substitution ☐ Shrieks frequently

☐ Sings to self ☐ Understanding ☐ Very difficult to understand