Individualized Healthcare

It's all about the uniqueness of your child

PATIENT INFORMATION

Patient Name: _____ Date: _____

DOB: _____ Age: _____ Sex: ◯ Male ◯ Female

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

Home #: _____ Cell #: _____ email: _____

Where do you prefer to receive calls? _____Home _____Office _____Cell _____No preference

Whom may we thank for referring you to us? _____

RESPONSIBLE PARTY

Name of Person Responsible for Account _____

Relationship to Patient _____ Phone #: _____

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

PRESENT HEALTH CHALLENGES(s):

For what health challenge(s) is your child here for?

_____

What do you feel is the cause of your child's problem?

_____

When did you first notice this sign of body dysfunction?

_____

Is this dysfunction getting progressively worse? ___Yes ___No

If yes, why do you think so?

_____

_____

_____

What are the most significant measures you have taken to date to improve your child's present health challenge?
Please list all the healthcare practitioner's seen, treatments rendered, and any results experienced.

_____

_____

_____

Please list the (3) most significant stressful events in your child's life from the most recent to the most distant. Are any of these situations continuing to impact his/her life? If yes, please explain clearly.

_____
_____
_____

Please list any and all other concerns regarding your child's health and whether or not you feel they are related to your child's primary reason for being seen in our office today.

_____
_____
_____

____ Allergies	____Frequent colds/ congestion	____Upper respiratory Infections	____Asthma
____Ear infections	____Infected/sore Throat	____Tonsillitis	____Laryngitis
____Colic	____Reflux/spitting up	____U-tract infections	____Poor appetite
____Poor digestion/ (constipation/diarrhea)	____Thrush mouth/ Chronic diaper rash	____Eczema/psoriasis/ Other skin rashes	____ADD/ADHD
____Irregular sleep Patterns	____Night terrors	_____Bed wetting	____Headache
____Anxiety	____Mood swings	____Bruising	

Did you know that the persistent use of antibiotics can lead to an early onset of gastrointestinal tract distress leading to overgrowth of intestinal yeast? Did you also know that chronic use of antibiotics can lead to antibiotic resistant bacteria?

Please list any and all prescription medications that your child is presently using and has used on more than one occasion. Please reflect carefully as your child's present health state may be related directly or indirectly to the treatment of a past problem.

_____
_____
_____

Each year a growing number of children are hospitalized due to acetaminophen and ibuprofen poisoning. Has your child taken any of these products that contain these chemical? ____ Yes ____No
If yes, for what reason and for how long?

_____
_____
_____

Has your child ever been hospitalized? ____ Yes ____No
If yes, why and when? (Please list in chronological order)

_____
_____
_____

Accidental trauma is the number one cause of injury to children in the United States each year. Please list any and all injuries experienced by your child, how they occurred and what action was taken to correct them.

_____
_____
_____

Please check any of the following sports activities that your child is engaged in.

____ Football	____ Lacrosse	____ Soccer	____Track/Field
____ Bowling	____ Tennis	____ Hockey	____ Volleyball
____Baseball/Softball	____ Skateboarding	____ Snowboarding	____ Skiing
____ Gymnastics/ Trampoline	____ BMX/Motorcross	____ Swimming	____Golfing

Has your child ever been injured while playing sports? ____ Yes ____No
If yes, what type of injury(s) occurred?
_____
_____
_____

Recent research reveals that 30% of American children are obese with more than 50% of all US children overweight.
On a scale from 1 – 5, please rate the food groups that are most eaten by your child on a daily basis. Use the higher number for the most common foods eaten.

__1 __2 __ 3 __ 4 __ 5	**__1 __2 __ 3 __ 4 __ 5**	**__1 __2 __ 3 __ 4 __ 5**	**__1 __2 __ 3 __ 4 __ 5**
<u>Non-Complex Carbohydrates</u> Bread Products, Cereals, Pizza, Cakes, Cookies, Chocolate, Candy	**<u>Complex Carbohydrates</u>** Fruits & Vegetables	**<u>Protein</u>** Nuts, Seeds, Meats, Eggs	**<u>Fats</u>** Dairy Products

Please list the (3) most common foods eaten by your child each day.
_____ _____ _____

How many times per month does your child eat fast food? _____
What type? _____

What is the primary beverage consumed by your child?_____

How much water does your child drink each day? _____

Does your child drink soda? ___ Yes ___ No If yes, how much on a daily basis? _____

Does your child consume artificial sweeteners such as those found in sugarless, fat free products? ___ Yes ___No
If yes, what type of artificial sweeteners does your child use? _____

Was your child breast fed? ___Yes ___No If yes, for how long? _____

Was your child formula fed? ___Yes ___No If yes, what type and for how long? _____

At what age did you introduce solid foods into your child's diet? _____
What type(s)? _____

Has your child exhibited any tolerance and/or allergy to any specific food? ___Yes ___No
If yes, please list all foods._____

Has your child been tested for allergies? ___Yes ___No
If yes, how were the tests performed? _____

What were the results? _____
_____

If your child does have an allergy, how does it present itself? (Skin rash, hives, ENT/respiratory, digestive symptoms)
_____
_____
_____

Has your child received treatment for any type of allergy? ___Yes ___No
If yes, what type of treatment?
_____
_____
_____

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Parent, Guardian or Personal Representative Date

_____ _____
Print Name of Parent, Guardian or Personal Representative Relationship to patient