PEDIATRIC MEDICAL QUESTIONNAIRE

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will also assist us to formulate a treatment plan.

First Name: _____Middle Name: _____Last Name: _____

Mother's Name: _____ Father's Name: _____

Address:_____ City: _____

State: _____ ZIP: _____ Home Phone :(_____) _____-_____Birth Date:_____/____/____

Age: _____ Place of Birth: _____ (city/state/country) month day year

Primary Care Physician: _____ Phone number: _____

Email address_____--May we send you our newsletter? _____

Height: ___′ ____ ″ Weight: _____ Sex: _____

Referred by: _____ Today's Date _____

What do you hope to achieve in your visit with us?

_____

When was the last time you felt that your child was well?

_____

Did something trigger your child's change in health?

_____

Is there anything that makes your child feel worse?

_____

Is there anything that makes your child feel better?

_____

What do you feel are your child's strengths at this time? _____

_____

Allergies:

Does your child have any allergies? _____ Yes _____ No If yes, please list:

_____

Did your child have any adverse reactions?

_____

Medications: *What medications is your child taking now? Include non-prescription drugs.*

Medication Name	Date started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Supplements: *List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.*

Vitamin/Mineral/Supplement Name	Date started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

TIMELINE:

Please indicate the timing (child's age) of any major events (accidents, injuries, bullying, abuse or other traumatic events). Then indicate the timing (year) of the development of any symptoms, illnesses, surgeries, or other health issues)

Childhood (birth→5 years)

Events_____

Health issues_____

(6 years -12 years)

Events_____

Health issues_____

Birth:

Full Term? _____Premature? _____Required Induction? _____Weight at Birth: _____lbs.
Vaginal Delivery _____ C-Section _____
Breast Fed? _____ How long? _____ Bottle Fed? _____ What kind of Formula? _____

Any issues during the pregnancy or birth?_____

Early Childhood Illnesses:

Number of earaches or other infections in the first two years: _____

Number of times child had antibiotics in the first two years: _____

Does your child's behavior change when on antibiotics? _____

Immunizations:

Is your child up to date with Immunizations: _____ Yes _____ No

If relevant, attach a copy of your child's immunization record.

Description of Developmental Problems:

Has your child had normal development (motor, speech, social)?_____

If your child has developmental problems, at what age did they occur? _____

Sleep/Rest

Average number of hours your child sleeps per night: ___ >12 ___10-12 ___ 8-10 ___ <8

Does your child have trouble falling asleep? _____ Yes _____ No

Staying Asleep? _____ Yes _____ No

Does your child snore? _____ Yes _____ No

Nutritional History:

Does your child follow a special diet or nutritional program? _____ Yes _____ No

Please check all that apply: ___ Yeast Free ___ Feingold ___ Weight Management ___ Diabetic

___ Dairy Free ___Wheat Free ___ Ketogenic ___Specific Carbohydrate ___ Vegetarian

___ Gluten Free/Casein Free ___ Gluten Restricted ___ Vegan ___ Low Oxalate

Food Allergy (ex. Peanuts, Eggs, etc.): _____

_____

Does your child avoid any particular foods? _____ Yes _____ No

Types/Reasons: _____

_____

ENVIRONMENTAL HISTORY:

Is there anything in your child's environment that you feel might be harmful? (e.g. dampness, mold, chemicals, tobacco smoke, well water, insects, pets or carpeting)

_____

_____

Stress/Coping:

Has your child experienced any major life changes that may have impacted his/her health? ____ Yes ____ No

Has your child ever experienced any major losses? _____ Yes _____ No

Has your child ever been abused, a victim of a crime, or experienced a significant trauma? ____ Yes _____ No

_____

_____

Have you ever sought counseling for your child? _____ Yes _____ No

ACTIVITY:

How active is your child on a daily basis: _____

What types of activities does your child enjoy? _____

How much time does your child spend watching TV or using the computer? _____

Integrative Medicine Pediatric (12 and under) Review of Systems

** Please indicate if you have had any of the below symptoms in the past 7 days*

Constitutional/General		
Fever	YES	NO
Difficulty Managing Weight	YES	NO
Food Cravings	YES	NO
Poor Appetite	YES	NO
Binge Eating/Drinking	YES	NO
Fatigue	YES	NO
Restlessness	YES	NO
General Weakness	YES	NO
Low Stamina	YES	NO
Skin/Nails		
Rash	YES	NO
Acne	YES	NO
Vitiligo	YES	NO
Rosacea	YES	NO
Eczema	YES	NO
Psoriasis	YES	NO
Itching	YES	NO
Hives	YES	NO
Thin, Cracking or Peeling Nails	YES	NO
Nail Fungus	YES	NO
Discolored Nails	YES	NO
Nails with Ridges	YES	NO
Nails with Pits	YES	NO
HENT		
Hearing Loss	YES	NO
Ringing in Ears	YES	NO
Ear Pain	YES	NO
Sore Throat	YES	NO
Hoarse Voice	YES	NO
Clearing Throat Often	YES	NO
Canker Sores	YES	NO
Dental Cavities	YES	NO
Gums Sore/Swollen	YES	NO
Tongue Sore	YES	NO
Nasal Congestion	YES	NO
Bad Breath	YES	NO
Eyes		
Itching	YES	NO
Watering	YES	NO
Redness	YES	NO
Drainage	YES	NO
Bags Under Eyes	YES	NO
Dark Circles	YES	NO
Eyelid Irritation	YES	NO
Change in Vision	YES	NO
Light Sensitivity	YES	NO
Cardiovascular		
Chest Pain	YES	NO
Palpitations	YES	NO
Respiratory		
Cough	YES	NO
Wheezing	YES	NO
Difficulty Breathing	YES	NO
Gastrointestinal/Abdominal		
Reflux	YES	NO
Belching	YES	NO

Nausea	YES	NO
Vomiting	YES	NO
Cramping	YES	NO
Abdominal Pain	YES	NO
Burning Sensation	YES	NO
Diarrhea	YES	NO
Constipation	YES	NO
Excess Gas	YES	NO
Bloating	YES	NO
Hemorrhoids	YES	NO
Mucus in Stool	YES	NO
Blood in Stool	YES	NO
Black Stools	YES	NO
Rectal Pain	YES	NO
Stool Incontinence	YES	NO
STOOL PATTERN		
How Often		
Color		
Consistency		
Genitourinary		
Frequency	YES	NO
Pain with Urination	YES	NO
Up at Night to Urinate	YES	NO
Incontinence	YES	NO
Blood in Urine	YES	NO
Genital Discharge	YES	NO
Genital Itching	YES	NO
Musculoskeletal		
Joint Pain	YES	NO
Joint Stiffness	YES	NO
Muscle Pain	YES	NO
Muscle Stiffness	YES	NO
Neck Pain	YES	NO

Back Pain	YES	NO
Muscle Cramps	YES	NO
Muscle Twitching	YES	NO
Endo/Heme		
Easy Bruising	YES	NO
Easy Bleeding	YES	NO
Easily over Heated	YES	NO
Cold Intolerant	YES	NO
Breast Abnormality	YES	NO
Irregular Periods	YES	NO
Heavy Periods	YES	NO
PMS Symptoms	YES	NO
Frequent Thirst	YES	NO
Sweating	YES	NO
Hair Loss	YES	NO
Allergy/Immune		
Food Allergies	YES	NO
Environmental Allergies	YES	NO
Frequent Infections	YES	NO
Neurologic		
Headache	YES	NO
Dizziness	YES	NO
Numbness/Tingling	YES	NO
Fainting	YES	NO
Tremor	YES	NO
Memory Loss	YES	NO
Vertigo (Spinning/movement sensation)	YES	NO
Difficulty with Balance	YES	NO
Psychiatric		
Anxiety	YES	NO
Depression	YES	NO

Hallucination	YES	NO