Pediatric Form

Note: Collecting personal information such as gender, religion, complete address, civil status, and other relevant demographics is crucial in the context of medical consultations and implementing holistic advice. Understanding these aspects allows healthcare providers to tailor their approach, ensuring that treatment plans are not only medically sound but also culturally sensitive and aligned with the personal values and beliefs of each patient. For example, gender and cultural background can influence health risks and preferences, while civil status might affect a patient's support system and emotional well-being. By gathering this information, we can create a more comprehensive picture of each patient's unique circumstances, enabling us to offer personalized holistic advice that addresses not only physical health but also mental, emotional, and social factors. Rest assured that all information shared will remain confidential and will be used solely to enhance the quality of care and support we provide. Your participation is vital in helping us deliver a more effective and compassionate healthcare experience.

1. Email *

2. Child's Complete Name

3. Date Today

Example: January 7, 2019

4. Age

5. Birthday

Example: January 7, 2019

6. Biological Sex

Mark only one oval.

- Male
- Female

7. Source of history

Mark only one oval.

- Mother
- Father
- Siblings
- Grandparents
- Caregiver
- Legal guardian
- Others

Health Goals

8. What do you hope to achieve for your child's visit with us?

9. When was the last time the child felt well?

10. Did something trigger the child's change in health?

11. What makes the child better

12. How does the condition affect the child and family?

13. What do you think is happening and why

14. What do you feel needs to happen for your child to get better?If you have a magic wand what are three things you would like to change or erase?

History

Present or Current Illness/Symptoms/Diagnosis

15. Describe the current child's problem/complaint/illness/symptoms here including start or date of onset of symptoms, duration, interventions/medications/remedies, outcome/result and diagnostic/lab test done

Symptoms

Using the drop down menu, please indicate it a symptom is current or past symtom.

16. Abdominal pain Dropdown

Mark only one oval.

- Current
- Past

17. Acid reflux Dropdown

Mark only one oval.

- Current
- Past

18. Anemia Dropdown

Mark only one oval.

- Current
- Past

19. Bad breath Dropdown

Mark only one oval.

- Current
- Past

20. Bed wetting Dropdown

Mark only one oval.

- Current
- Past

21. Bleeding gums Dropdown

Mark only one oval.

- Current
- Past

22. Blood in urine Dropdown

Mark only one oval.

- Current
- Past

23. Body odour Dropdown

Mark only one oval.

- Current
- Past

24. Bruise easily Dropdown

Mark only one oval.

- Current
- Past

25. Canker sores — Dropdown

Mark only one oval.

- Current
- Past

26. Change in appetite — Dropdown

Mark only one oval.

- Current
- Past

27. Congestion — Dropdown

Mark only one oval.

- Current
- Past

28. Constipation — Dropdown

Mark only one oval.

- Current
- Past

29. Cough — Dropdown

Mark only one oval.

- Current
- Past

30. Cry easily — Dropdown

Mark only one oval.

- Current
- Past

31. Diarrhea — Dropdown

Mark only one oval.

- Current
- Past

32. Dizzy spells — Dropdown

Mark only one oval.

- Current
- Past

33. Dry skin — Dropdown

Mark only one oval.

- Current
- Past

34. Eczema — Dropdown

Mark only one oval.

- Current
- Past

35. Excessive fatigue — Dropdown

Mark only one oval.

- Current
- Past

36. Excessive perspiration — Dropdown

Mark only one oval.

- Current
- Past

37. Flat feet — Dropdown

Mark only one oval.

- Current
- Past

38. Frequent headaches — Dropdown

Mark only one oval.

- Current
- Past

39. Gas — Dropdown

Mark only one oval.

- Current
- Past

40. Hearing loss — Dropdown

Mark only one oval.

- Current
- Past

41. Heart murmur — Dropdown

Mark only one oval.

- Current
- Past

42. High fever — Dropdown

Mark only one oval.

- Current
- Past

43. Hives

Dropdown

Mark only one oval.

- Current
- Past

44. Hyperactivity

Dropdown

Mark only one oval.

- Current
- Past

45. Itchy anus

Dropdown

Mark only one oval.

- Current
- Past

46. Itchy nose (or picks nose)

Dropdown

Mark only one oval.

- Current
- Past

47. Itchy vagina (for girls)

Dropdown

Mark only one oval.

- Current
- Past

48. Jaundice (yellowing of skin or eyes)

Dropdown

Mark only one oval.

- Current
- Past

49. Joint pains

Dropdown

Mark only one oval.

- Current
- Past

50. Migraines

Dropdown

Mark only one oval.

- Current
- Past

51. Motion sickness

Dropdown

Mark only one oval.

- Current
- Past

52. Nervousness Dropdown

Mark only one oval.

- Current
- Past

53. Nightmares Dropdown

Mark only one oval.

- Current
- Past

54. Night sweats Dropdown

Mark only one oval.

- Current
- Past

55. No appetite Dropdown

Mark only one oval.

- Current
- Past

56. Nosebleeds Dropdown

Mark only one oval.

- Current
- Past

57. Painful urination Dropdown

Mark only one oval.

- Current
- Past

58. Parasites Dropdown

Mark only one oval.

- Current
- Past

59. Psoriasis Dropdown

Mark only one oval.

- Current
- Past

60. Rash Dropdown

Mark only one oval.

- Current
- Past

61. Sensitivity to light — Dropdown

Mark only one oval.

- Current
- Past

62. Sleep problem — Dropdown

Mark only one oval.

- Current
- Past

63. Stomach aches — Dropdown

Mark only one oval.

- Current
- Past

64. Sore throat — Dropdown

Mark only one oval.

- Current
- Past

65. Teeth grinding — Dropdown

Mark only one oval.

- Current
- Past

66. Talk in sleep — Dropdown

Mark only one oval.

- Current
- Past

67. Walk in sleep — Dropdown

Mark only one oval.

- Current
- Past

68. Weight gain — Dropdown

Mark only one oval.

- Current
- Past

69. Weight loss — Dropdown

Mark only one oval.

- Current
- Past

70. Wheezing Dropdown

Mark only one oval.

- Current
- Past

71. Vomiting spells Dropdown

Mark only one oval.

- Current
- Past

MEDICAL HISTORY

72. Check all that appl

Check all that apply.

- ADD/ADHD
- Allergies (environmental)
- Allergies (food)
- Asthma
- Autism
- Bronchitis
- Chicken pox
- Dental problems
- Developmental problems
- Ear infections
- Frequent colds
- Impaired speech
- Measles
- Meningitis
- Neural Tube Defect
- Pneumonia
- Rubella
- Rheumatic Fever
- Scarlet Fever
- Tonsillitis
- Whooping cough
- Croup
- Mum

73. Others

74. If you put check on any of the above conditions or disease or put a condition on "Others", can you give us the chronological order from past to present by indicating the year or age of the diagnosis was established if you remember.

75. Nutritional Supplements (please list). Include herbal and homeopathic as well if applicable. Provide brand names, form or preparation (syrup or tablet), dosage and frequency of taking it.

76. List Vitamins/Supplements/Herbals that your child has TRIED BEFORE (specify the Brand/kind, milligram/dosage per day and for how long)

77. Medications (check all that apply, and indicate the length of time the child received each medication)

Check all that apply.

- [ ] Antacids
- [ ] Antibiotics
- [ ] Antidepressants
- [ ] Anti-Histamine
- [ ] Aspirin
- [ ] Clonidine
- [ ] Declectin
- [ ] Decongestant
- [ ] Dextroamphetamine (Dexedrine, Dextrostat, Adderall)
- [ ] Epilepsy medication
- [ ] Ibuprofen
- [ ] Inhaled Steroids
- [ ] Methylphenidate (Ritalin)
- [ ] Oral Steroids
- [ ] Pemoline (Cyclert)
- [ ] Tylenol

78. Other medications (please list)

79. Are you aware of any allergies to medications?

80. Immunizations: (check all that apply)

Check all that apply.

- [ ] Diptheria
- [ ] DPT
- [ ] Hemophilus
- [ ] Hepatitis
- [ ] Hib (Hemophilus influenza)
- [ ] Influenza
- [ ] Measles
- [ ] MENI (Meningococcal disease)
- [ ] MMR (Measles, Mumps, Rubella)
- [ ] Mumps
- [ ] IPV (Polio)
- [ ] Pneu (Pneumococcal disease)
- [ ] Small pox
- [ ] Tetanus
- [ ] VAR (Varicella or chicken pox)
- [ ] BC

81. Immunizations: Other (specify

82. Were there any reactions to immunization(s). If so, at what a?

83. Mother's health during pregnancy: (check all that apply)

Check all that apply.

- [ ] Alcohol, cigarettes, drug consumption
- [ ] Anemia
- [ ] Bleeding
- [ ] Dental problems
- [ ] Diabetes
- [ ] Gestational diabetes
- [ ] Hypertension
- [ ] Nausea
- [ ] Physical or Emotional trauma
- [ ] Pre-eclampsia
- [ ] Stress
- [ ] Thyroid problems
- [ ] Uterine infection
- [ ] Exposure to chemicals and toxin

84. Other (specify)

85. Medications while pregnant

86. Medications while nursing (Mother)

87. Age of gestation (at birth)

Mark only one oval.

- ◯ Full term
- ◯ Premature
- ◯ Late

88. Weight at birth

89. Was pregnancy induced?

Mark only one oval.

- ◯ Yes
- ◯ No

90. Mode of Delivery

Mark only one oval.

- ◯ Vaginal
- ◯ C-Section

91. Complications during labor?

92. Medications during or after labor?

93. Nutrition

Mark only one oval.

- Breastfed
- Bottlefed
- Mixed

94. How long was the breastfeeding? Bottle feeding? or Mixed feeding given?

95. When was formula started?

96. When were solid foods first introduced?

97. What were the first foods introduced?

98. Did your baby have any of the following problems

Check all that apply.

- Jaundice
- "Blue Baby"
- Colic
- Diarrhea
- Thrush

99. **Dental and Oral Health History**
Comment about your child's teeth and gums health

100. **Family History**
List all the diseases or conditions that is inherited in the family. If possible, indicate if what age they got the condition and if they are alive or deceased.

Lifestyle Assessment

101. Current Weight in kilogram

102. Current Height in centimetre (or length for infants)

Readiness Assessment

Rate on a scale of 5 (very willing) to 1 (not willing) to improve your health

103. Significantly modify your diet

Mark only one oval.

1	2	3	4	5
◯	◯	◯	◯	◯

104. Take nutritional supplements each day

Mark only one oval.

1	2	3	4	5
◯	◯	◯	◯	◯

105. Keep a record of everything you eat each day

Mark only one oval.

1	2	3	4	5
◯	◯	◯	◯	◯

106. Modify your lifestyle (e.g. sleep habits, computer or screen times)

Mark only one oval.

1	2	3	4	5
◯	◯	◯	◯	◯

107. Practice a relaxation technique

Mark only one oval.

1	2	3	4	5
◯	◯	◯	◯	◯

108. Engage in regular physical activity, play or sports

Mark only one oval.

1	2	3	4	5
◯	◯	◯	◯	◯

109. Rate on a scale of 5 (very confident) to 1 (not confident at all)

Mark only one oval.

1	2	3	4	5
◯	◯	◯	◯	◯

110. If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to follow through?

111. Level of support from people around you. Rate on a scale of 5 (very supportive) to 1 (very unsupportive)

Mark only one oval.

1	2	3	4	5
◯	◯	◯	◯	◯

112. Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact)

Mark only one oval.

1	2	3	4	5
◯	◯	◯	◯	◯

Nutrition

113. How many times a day do you eat?

114. Are you following a special type of diet (specify)?

115. How many times do you eat out in a week with your family & friends?

116. What type of restaurant do you typically go?

117. What food is your favorite

118. Do you have food allergies (specify)?

119. Do you adversely react to: (Check all that apply)

Check all that apply.

- [ ] Monosodium glutamate (MSG)
- [ ] Artificial sweeteners
- [ ] Garlic/onion
- [ ] Cheese
- [ ] Citrus foods
- [ ] Chocolate
- [ ] Sulfite-containing foods (dried fruit, salad bars)
- [ ] Preservatives
- [ ] Food colorings
- [ ] Other food substances

120. Who cooks or prepare the food for you?

121. Check the factors that apply to your current lifestyle and eating habits:

Check all that apply.

- [ ] Fast eater
- [ ] Picky eater
- [ ] Eat too much
- [ ] Late-night eating
- [ ] Dislike healthy foods
- [ ] Time constraints
- [ ] Travel frequently
- [ ] Eat more than 50% of meals away from home
- [ ] Healthy foods not readily available
- [ ] Poor snack choices
- [ ] Family members don't like healthy foods
- [ ] Family members have special dietary needs
- [ ] Love to eat
- [ ] Eat because I have to
- [ ] Have negative relationship to food
- [ ] Struggle with eating issues
- [ ] Emotional eater (eat when sad, lonely, bored, etc.)
- [ ] Eat too much under stress
- [ ] Eat too little under stress

How many servings do you eat in a typical week of these foods?

122. Fruits (not juice)

Mark only one oval.

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

123. Vegetables (not including white potatoes)

Mark only one oval.

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

124. Rice

Mark only one oval.

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

125. Pasta

Mark only one oval.

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

126. Bread

Mark only one oval.

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

127. Oat grains, quinoa

Mark only one oval.

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

128. Legumes (beans, monggo, peas, etc)

Mark only one oval.

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

129. Red meat

Mark only one oval.

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

130. Processed meats (e.g. hot dogs, corned beef, meat loaf, ham, bacon, deli, tocino, sausages)

Mark only one oval.

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

131. Poultry (chicken)

Mark only one oval.

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

132. Eggs

Mark only one oval.

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

133. Fish

Mark only one oval.

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

134. Dairy (cheese, butter, ice cream, milk)

Mark only one oval.

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

135. Dairy free alternatives (almond, soy, rice, hemp seed milk)

Mark only one oval.

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

136. Nuts and seeds

Mark only one oval.

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

137. Fats & Oils (butter, animal fat, olive, avocado, canola, coconut oil)

Mark only one oval.

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

138. Can you specify which oil do you used for cooking?

_____

139. Regular Cans of Soda

Mark only one oval.

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

140. Diet Cans of Soda

Mark only one oval.

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

141. Sweets (candy, cookies, cake, ice cream, kakanin, etc.)

Mark only one oval.

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

142. Chips

Mark only one oval.

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

143. Water (glasses per day)

Mark only one oval.

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

144. Fruit juice (cups per day)

Mark only one oval.

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

145. FOOD RECALL
Provide examples of your typical meals or the food that you had eaten for the last 3 days (specify the amount & timing)

146. Breakfast (Time & What kind of Food):

147. Lunch (Time & What kind of Food):

148. Dinner (Time & What kind of Food):

149. Snacks (Time & What kind of Food):

150. Fluids/Beverages:

Exercise/Movement

151. Specify type of exercise, number of times per week, time/duration (minutes) per day

152. How many hours do you spend sitting in a day?

Mark only one oval.

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

153. Do you feel motivated to exercise?

Mark only one oval.

- Yes
- A Little
- No

154. Are there any problems that limit exercise? Yes/No. If Yes, explain.

Sleep

155. How many hours of sleep do you get each night on average?

Mark only one oval.

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

156. During the day how long do you take naps?

157. What time do you go to bed?

Example: 8:30 AM

158. What time do you wake up?

Example: 8:30 AM

159. Do you have problems falling asleep?

Mark only one oval.

- Yes
- No

160. Do you have problems staying asleep?

Mark only one oval.

- Yes
- No

161. Do you snore?

Mark only one oval.

- Yes
- No

162. Do you have sleep apnea (i.e.breathing stops for 10 seconds)?

Mark only one oval.

- Yes
- No

163. Do you use sleeping aids (specify)?

Stress

164. Have you experienced any trauma (i.e. physical, mental, emotional, sexual) in the past (specify)?

165. What level of stress does your child is experiencing at this time?

Mark only one oval.

1 2 3 4 5 6 7 8 9 10

166. What are the major causes or factors of your child's stress?

Check all that apply.

- [ ] Schoolwork and Grades
- [ ] Overstuffed schedules
- [ ] Learning setbacks
- [ ] Bullying & Peer pressure
- [ ] Frienship conflicts
- [ ] Social media comparison
- [ ] Family conflict or divorce
- [ ] Major life transitions
- [ ] Household instability
- [ ] Loss or illness
- [ ] Puberty & body changes
- [ ] Pain or injury
- [ ] Others

167. Others (specify)

168. How do you manage stress in children? Check that applies.

Check all that apply.

- [ ] None
- [ ] Physical activity
- [ ] Healthy Sleep routines
- [ ] Time in nature
- [ ] Predictable routines
- [ ] Open dialogue
- [ ] Emotion labeling
- [ ] Unstructured play and joy
- [ ] Belly breathing
- [ ] Guided imagery
- [ ] Journaling or drawing

169. Are they currently seeing a psychotherapist/counsellor?

Mark only one oval.

- ◯ Yes
- ◯ No

170. Any hobbies or leisure activities that your child like to do?

Relationship and Social Connections

171. Who is the primary care giver of the child?

172. How is the relationship of your child towards you as parent, towards siblings, friends, teachers and classmates in general?

173. Types of attachment you think your child has?

Check all that apply.

- [ ] Secure: Child feels safe and trusts the parent or caregiver
- [ ] Avoidant: Child acts independent and avoids seeking comfort
- [ ] Ambivalent: Child feels unsure and very clingly
- [ ] Disorganized: Child shows confused or fearful responses to the parent or caregiver

174. Does your child connects with family, peers and friends, school and educators or community groups? If yes, give example (s).

175. What is your family's faith, religion or spiritual practices?

Substances & Environmental Toxins

176. If applicable, tell me about your child smoking, alcohol and recreational drug habits (specify the age they start and stop including the kind, amount and frequency)?

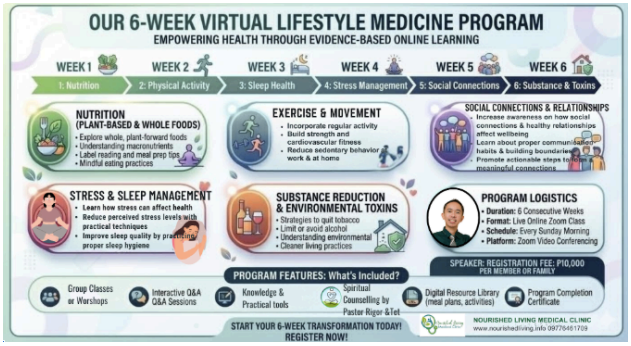
177. In your child's home or school environment regularly exposed to (check all that apply)

Check all that apply.

- [ ] Mold
- [ ] Water leaks
- [ ] Renovations
- [ ] Chemicals
- [ ] Car smoke
- [ ] Electromagnetic radiation
- [ ] Damp environments
- [ ] Carpets/rugs
- [ ] Dust
- [ ] Old paints
- [ ] Stagnant/stuffy air
- [ ] Smokers
- [ ] Pesticides
- [ ] Herbicides
- [ ] Harsh chemicals (solvents, glues, gas, acids, etc)
- [ ] Cleaning chemicals
- [ ] Heavy metals (lead, mercury, etc)
- [ ] Paints
- [ ] Hair dye/cosmetics/nail colors
- [ ] Animal/pets
- [ ] Plastic bottles
- [ ] Large fishes (e.g. Tuna)
- [ ] Grilled foods
- [ ] Unfiltered tap water
- [ ] Non-organic foods or produce
- [ ] Street foods
- [ ] Raw meat/fish (e.g. kinilaw, sushi, sashimi)
- [ ] Toxic free personal and body care products
- [ ] Silver-mercury dental fillings

178. Would the family be interested on a weekly lifestyle medicine class/coaching? This comprises of the following:
1. Nutrition: Building Foundational Habits
2. Exercise: Embracing Movement
3. Sleep: Cultivating Restful Nights
4. Stress management: Cultivating Calm
5. Social connections/Positive healthy relationship: Building Your Support Network
6. Reducing toxins and risky substances: Protecting Your Wellbeing

It will be conducted on a weekly basis every Sunday (specific time subject to change and approval) via zoom.
Total duration: 6 weeks
Price for the whole program is P10,000.



Mark only one oval.

- ◯ Yes
- ◯ No

179. Would you like to receive latest medical information, research, commentary or articles everyday through email (at least 3 per day) for free?

Mark only one oval.

- ◯ Yes
- ◯ No

180. Congratulations! You have reached the end of this form

Kindly give us your preferred date and time of your appointment. If you have relevant labs, kindly send them to nourishedliving.holistic@gmail.com

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