



Rooted Health & Wellness LLC

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General Information

Name _____ Age _____ Today's Date _____

Date of Birth _____ Gender _____

Race/Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Mediterranean
☐ Native American ☐ Northern European ☐ Other _____

Mother's Name _____ Father's Name _____

Home Address _____ City _____ State _____ Zip _____

Parent's Cell Phone _____ Parent's Email _____

Emergency Contact Person (number and relationship)

Allergies _____ Height _____ Weight _____

Primary Care Physician & contact number: _____

Referred to the practice by:

☐ Clinic website ☐ IFM ☐ Practitioner ☐ Family/Friend ☐ Social Media
☐ Other _____

Major health concerns for today's visit:

What have you done so far about your child's health concerns (i.e. medications, supplements, diet):

Past Medical History:

Constitutional	Yes	No	Ear/Nose/Throat (cont)	Yes	No
Fevers	<input type="checkbox"/>	<input type="checkbox"/>	Vision loss	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinus Infections	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Post Nasal Drainage	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	Hoarse Voice	<input type="checkbox"/>	<input type="checkbox"/>
Neurological / Psychological	Yes	No	Gum Disease	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular	Yes	No
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Memory loss	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Heart failure	<input type="checkbox"/>	<input type="checkbox"/>
Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>	Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>
Poor balance	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Frequent falls	<input type="checkbox"/>	<input type="checkbox"/>	Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis (MS)	<input type="checkbox"/>	<input type="checkbox"/>	Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>
Amyotrophic Lateral Sclerosis (ALS)	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>
Attention Deficit Disorder / Hyperactive Disorder (ADD/ADHD)	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary / Respiratory	Yes	No
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
History of abuse	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>
Ear/Nose/Throat	Yes	No	Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>

Gastrointestinal (GI)	Yes	No	Musculoskeletal	Yes	No
Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Bone loss	<input type="checkbox"/>	<input type="checkbox"/>
Other Inflammatory Bowel Disease:	<input type="checkbox"/>	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	<input type="checkbox"/>
Gastritis	<input type="checkbox"/>	<input type="checkbox"/>	Back pain	<input type="checkbox"/>	<input type="checkbox"/>
Peptic Ulcer Disease	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain	<input type="checkbox"/>	<input type="checkbox"/>
GERD (reflux)	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Fatty Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>
Liver Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	Integumentary / Skin	Yes	No
Gallbladder Stones	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Acne	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged Spleen	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>	Systematic Lupus Erythematosus (SLE)	<input type="checkbox"/>	<input type="checkbox"/>
Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>	Psoriatic Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Dry skin	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Poor/brittle nails	<input type="checkbox"/>	<input type="checkbox"/>
GI Bleed	<input type="checkbox"/>	<input type="checkbox"/>	Fungal nails	<input type="checkbox"/>	<input type="checkbox"/>
Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	Basal Cell Carcinoma	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>
Binge eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	Metabolic/Endocrine	Yes	No
Other:	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type 1	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type 2	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary (GU)	Yes	No	Low blood sugars	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	Metabolic Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	<input type="checkbox"/>
Lupus Nephritis	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroidism (underactive thyroid)	<input type="checkbox"/>	<input type="checkbox"/>
Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroidism (overactive thyroid)	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Stones	<input type="checkbox"/>	<input type="checkbox"/>	Pituitary Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Frequent UTI	<input type="checkbox"/>	<input type="checkbox"/>	Pituitary Tumors	<input type="checkbox"/>	<input type="checkbox"/>
Painful Bladder Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Addison's Disease	<input type="checkbox"/>	<input type="checkbox"/>

Metabolic/Endocrine (cont)	Yes	No	Cancer (cont)	Yes	No
Graves' Disease	<input type="checkbox"/>	<input type="checkbox"/>	Colon	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Hematologic/Immune/Blood	Yes	No	Ovarian/Endometrial/Cervical	<input type="checkbox"/>	<input type="checkbox"/>
Spontaneous Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Prostate	<input type="checkbox"/>	<input type="checkbox"/>
Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	Bone/Muscular	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Melanoma	<input type="checkbox"/>	<input type="checkbox"/>
Platelet Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
Idiopathic/Immune Thrombocytopenia (ITP)	<input type="checkbox"/>	<input type="checkbox"/>	Lymphoma	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Myeloma	<input type="checkbox"/>	<input type="checkbox"/>
Iron deficiency	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>
Vitamin B12 deficiency	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>
Frequent infections	<input type="checkbox"/>	<input type="checkbox"/>	Dental History	Yes	No
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Frequent cavities	<input type="checkbox"/>	<input type="checkbox"/>
Allergic disorders (food/environmental)	<input type="checkbox"/>	<input type="checkbox"/>	Root canal	<input type="checkbox"/>	<input type="checkbox"/>
Multiple chemical sensitivities	<input type="checkbox"/>	<input type="checkbox"/>	Crowns	<input type="checkbox"/>	<input type="checkbox"/>
Other Autoimmune:	<input type="checkbox"/>	<input type="checkbox"/>	Dentures	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	Implants	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	Yes	No	Mercury/Silver fillings	<input type="checkbox"/>	<input type="checkbox"/>
Brain	<input type="checkbox"/>	<input type="checkbox"/>	Gold fillings	<input type="checkbox"/>	<input type="checkbox"/>
Head/neck	<input type="checkbox"/>	<input type="checkbox"/>	Gingivitis	<input type="checkbox"/>	<input type="checkbox"/>
Breast	<input type="checkbox"/>	<input type="checkbox"/>	Receding gums	<input type="checkbox"/>	<input type="checkbox"/>
Lung	<input type="checkbox"/>	<input type="checkbox"/>	Trouble chewing/jaw pain	<input type="checkbox"/>	<input type="checkbox"/>
Liver	<input type="checkbox"/>	<input type="checkbox"/>	Brush teeth at least twice a day	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatic	<input type="checkbox"/>	<input type="checkbox"/>	Floss teeth daily	<input type="checkbox"/>	<input type="checkbox"/>

Psychosocial

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

Stress/Coping

Have you ever sought counseling for your child? ☐ Yes | ☐ No

Is your child or family currently in therapy? ☐ Yes | ☐ No

If yes, Describe:

Does your child have a favorite toy or object? ☐ Yes | ☐ No

Does your child practice stress release methods? ☐ Yes | ☐ No

If yes, check all that apply: ☐ Yoga ☐ Meditation ☐ Imagery ☐ Breathing ☐ Tai Chi
☐ Prayer ☐ Other: _____

Has your child ever been abused, a victim of a crime, or experienced a significant trauma? ☐

Yes | ☐ No

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

Does your child feel rested upon awakening? ☐ Yes | ☐ No

Does your child snore? ☐ Yes | ☐ No

Roles/Relationship

Please list family members below:

Family Member Name	Relationship	Age	Gender

Who are the main people who care for your child?

What is their employment/occupation?

What are your child's resources for emotional support?

Gynecologic History *(for females only)*

Menstrual History:

Age at first period: _____ Menses Frequency: _____ Length: _____ Pain: ☐ Yes | ☐ No

Clotting: ☐ Yes | ☐ No Has your child's period ever skipped? ☐ Yes | ☐ No

If yes, for how long? _____

Last menstrual period: _____

Does your child use contraception? ☐ Yes | ☐ No

If yes, check all that apply: ☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner Vasectomy

Does your child use hormonal contraception? ☐ Yes | ☐ No

If yes, check all that apply: ☐ Birth control pills ☐ Patch ☐ Nuva Ring

For how long? _____

GI History

Has your child ever traveled to foreign countries? ☐ Yes | ☐ No

If yes, where? _____

Wilderness camping? ☐ Yes | ☐ No

If yes, where? _____

Has your child ever had (check all that apply): ☐ Gastroenteritis ☐ Diarrhea

Patient Birth History

Mother's Past Pregnancies:

Number of Pregnancies: _____ Live births: _____ Miscarriages: _____

Mother's Pregnancy:

<i>Check the box if yes and provide description if applicable</i>	Yes	No
Difficulty getting pregnant (more than 6 months)	<input type="checkbox"/>	<input type="checkbox"/>
Infertility drugs used (if yes, please specify which)	<input type="checkbox"/>	<input type="checkbox"/>
In vitro fertilization	<input type="checkbox"/>	<input type="checkbox"/>
Drink alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Drink coffee	<input type="checkbox"/>	<input type="checkbox"/>
Smoke tobacco	<input type="checkbox"/>	<input type="checkbox"/>
Take Progesterone	<input type="checkbox"/>	<input type="checkbox"/>
Take prenatal vitamins	<input type="checkbox"/>	<input type="checkbox"/>
Take antibiotics (during labor)	<input type="checkbox"/>	<input type="checkbox"/>
Take other drugs (specify which)	<input type="checkbox"/>	<input type="checkbox"/>
Excessive vomiting, nausea (more than 3 weeks)	<input type="checkbox"/>	<input type="checkbox"/>
Have a viral infection	<input type="checkbox"/>	<input type="checkbox"/>
Have a yeast infection	<input type="checkbox"/>	<input type="checkbox"/>
Have amalgam fillings put in teeth	<input type="checkbox"/>	<input type="checkbox"/>
Have amalgam fillings removed from teeth	<input type="checkbox"/>	<input type="checkbox"/>
Number of fillings in teeth when pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Have bleeding? If so, what months?	<input type="checkbox"/>	<input type="checkbox"/>
Have birth problems	<input type="checkbox"/>	<input type="checkbox"/>
Group B strep infection	<input type="checkbox"/>	<input type="checkbox"/>
Have c-section? If so, why?	<input type="checkbox"/>	<input type="checkbox"/>
Use induction for labor (such as Pitocin)	<input type="checkbox"/>	<input type="checkbox"/>
Have anesthesia? If so, what type?	<input type="checkbox"/>	<input type="checkbox"/>
Use oxygen during labor	<input type="checkbox"/>	<input type="checkbox"/>
Have an x-ray	<input type="checkbox"/>	<input type="checkbox"/>
Have Rhogam? If so, how many shots? How many when pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Gestational Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure (pre-eclampsia)	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure/toxemia	<input type="checkbox"/>	<input type="checkbox"/>
Have chemical exposure	<input type="checkbox"/>	<input type="checkbox"/>
Father have chemical exposure	<input type="checkbox"/>	<input type="checkbox"/>
Move to a newly built house	<input type="checkbox"/>	<input type="checkbox"/>
House painted indoors	<input type="checkbox"/>	<input type="checkbox"/>
House painted outdoors	<input type="checkbox"/>	<input type="checkbox"/>
House exterminated for insects	<input type="checkbox"/>	<input type="checkbox"/>

Pregnancy:

Total weight gain during pregnancy: _____ lb Total weight loss during pregnancy: _____ lb

Please describe diet during pregnancy:

Please describe labor:

At what week in pregnancy was your baby born? _____

Was your baby very active before birth? ☐ Yes | ☐ No

Did you birth at a hospital, birthing center, or at home?

Did your child require special newborn care? ☐ Yes | ☐ No

Did your child appear healthy? ☐ Yes | ☐ No

Was your child easily consoled during the first month of life? ☐ Yes | ☐ No

Did your child take antibiotics during the first month of life? ☐ Yes | ☐ No

Did your child experience any complications during the first month of life?

If yes, please describe? _____

What did your child weigh at birth? _____

Apgar score at 1 minute: _____

Apgar score at 5 minutes: _____

Early childhood illnesses

Number of earaches in the first two years: _____

Number of other infections in the first two years: _____

Number of times your child had antibiotics in the first 2 years of life: _____

Number of courses of prophylactic antibiotics in the first 2 years of life: _____

First antibiotic at _____ months

First illness at _____ months

Description of Developmental Problems

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

☐ 0-1 months ☐ 2-6 months ☐ 7-15 months ☐ 16-24 months ☐ After 24 months

Is this the impression shared among parents and others caring for the child? ☐ Yes | ☐ No

If no, please explain: _____

Developmental History

Please indicate the approximate age in months for the following milestones: (example, walking 14 months)

Sitting up: _____ months OR ☐ never

First words (mama, dada, etc.) _____ months

Crawl: _____ months OR ☐ never

OR ☐ never

Pulled to stand: _____ months OR ☐ never

Spoke clearly: _____ months OR ☐ never

Potty trained: _____ months OR ☐ never

Lost language: _____ months OR ☐ never

Walked alone: _____ months OR ☐ never

Lost eye contact: _____ months OR ☐ never

Never dry at night: _____ months OR ☐ never

Medications:

Current Medications:

Medication	Dose	Frequency	Start Date (month/year)	Reason for Use

Past Medications (Last 10 years):

Medication	Dose	Frequency	Start Date (month/year)	Reason for Use

Nutritional Supplements (Vitamins/Minerals/Herbs/Homeopathy):

Supplication & Brand	Dose	Frequency	Start Date (month/year)	Reason for Use

Have medications or supplements caused your child unusual side effects or problems?

☐ Yes | ☐ No

If yes, please describe? _____

Has your child had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin?

☐ Yes | ☐ No

Has your child had prolonged or regular use of Tylenol? ☐ Yes | ☐ No

Has your child had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.)?

☐ Yes | ☐ No

Has your child had frequent antibiotics? (>3 times/year) ☐ Yes | ☐ No

Has your child had long term antibiotics? ☐ Yes | ☐ No

Has your child used steroids (prednisone, nasal allergy inhalers) in the past? ☐ Yes | ☐ No

Family History (Check all that apply):

	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
Age if still alive										
Age of death (if deceased)										
Cancer										
Heart disease										
High blood pressure										
Obesity										
Diabetes										
Stroke										
Autoimmune disease										
Arthritis										
Kidney disease										
Thyroid problems										
Psychiatric Disorders										
Anxiety										
Depression										
Addiction										
Substance Abuse										
Asthma										
Allergies										
Eczema										
ADHD										
Autism										
IBS										
Dementia/Alzheimer's										
Genetic disorders										
Other:										

Nutrition History:

Has your child ever had a nutrition consultation? ☐ Yes | ☐ No

Have you made any changes in your child's diet because of health problems? ☐ Yes | ☐ No

If yes, please describe? _____

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

If yes, check all that apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> Yeast Free | <input type="checkbox"/> Feingold | <input type="checkbox"/> Weight Management |
| <input type="checkbox"/> Diabetic | <input type="checkbox"/> Dairy Free | <input type="checkbox"/> Wheat Free |
| <input type="checkbox"/> Ketogenic | <input type="checkbox"/> Specific Carbohydrate | <input type="checkbox"/> Gluten Free/Casein Free |
| <input type="checkbox"/> Gluten Restricted | <input type="checkbox"/> Vegetarian | <input type="checkbox"/> Vegan |
| <input type="checkbox"/> Low Oxalate | | |

Does your child have any food allergies? ☐ Yes | ☐ No

If yes, please describe? _____

Does your child avoid any particular foods? ☐ Yes | ☐ No

If yes, please describe? _____

If your child could eat only a few foods daily, what would they be?

Who does the shopping in your household? _____

Who does the cooking in your household? _____

How many meals does your child eat out per week? ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ >5 meals per week

Check all the factors that apply to your child's current lifestyle and eating habits:

- | | |
|---|--|
| <input type="checkbox"/> Fast eater | <input type="checkbox"/> Use food as a bribe or a reward |
| <input type="checkbox"/> Erratic eating pattern | <input type="checkbox"/> Erratic mealtimes |
| <input type="checkbox"/> Eat too much | <input type="checkbox"/> Most meals eaten at the table |
| <input type="checkbox"/> Dislike healthy food | <input type="checkbox"/> High juice intake |
| <input type="checkbox"/> Time constraints | <input type="checkbox"/> Low fruit/vegetable intake |
| <input type="checkbox"/> Eat more than 50% meals away from home | <input type="checkbox"/> High sugar/sweet intake |
| <input type="checkbox"/> Poor snack choices | <input type="checkbox"/> Drinks soda or diet soda |
| <input type="checkbox"/> Sensory issues with food | <input type="checkbox"/> Cow's Milk 1 2 3+ |
| <input type="checkbox"/> Picky eater | <input type="checkbox"/> Caffeine intake |
| <input type="checkbox"/> Limited variety of foods (<5/day) | <input type="checkbox"/> TV or videos with meals |
| <input type="checkbox"/> Prefers cold food | <input type="checkbox"/> Challenges with food served outside the home (ex. Childcare, friend's home) |
| <input type="checkbox"/> Prefers hot food | |
| <input type="checkbox"/> Every meal is a struggle | |
| <input type="checkbox"/> Most family meals together | |

Breastfed History

Breastfed? ☐ Yes | ☐ No If yes, for how long? _____

Did your child have problems latching on? ☐ Yes | ☐ No

Sucking quality? ☐ Very good ☐ Good ☐ Poor

How long was your child exclusively breastfed for (months)? _____

Bottle Fed History

Bottle fed? ☐ Yes | ☐ No If yes, type of formula? _____ ☐ Soy ☐ Cow's Milk ☐ Low Allergy

Introduction of cow's milk at _____ months Introduction of solid food at _____ months

First foods introduced at _____ months

Introduction of wheat or other grain at _____ months

Choke/Gas/Vomit on milk? ☐ Yes | ☐ No

Refused to chew solids? ☐ Yes | ☐ No

List mother's known food allergies or sensitivities:

Please describe any other eating concerns that you have regarding your child:

What type and amount of activity does your child get daily?

How much time does your child spend watching TV? _____

How much time does your child spend on the computer or playing video games? _____

Environmental History *(Please check appropriate box)*

Exposure	Past	Current	Exposure	Past	Current
Mold in bathroom	<input type="checkbox"/>	<input type="checkbox"/>	Damp cellar	<input type="checkbox"/>	<input type="checkbox"/>
Pest extermination – inside	<input type="checkbox"/>	<input type="checkbox"/>	Pest extermination – outside	<input type="checkbox"/>	<input type="checkbox"/>
Forced hot air heat	<input type="checkbox"/>	<input type="checkbox"/>	Had water in basement	<input type="checkbox"/>	<input type="checkbox"/>
Mold visible on exterior of house	<input type="checkbox"/>	<input type="checkbox"/>	Heavily wooded or damp surroundings	<input type="checkbox"/>	<input type="checkbox"/>
Mold in cellar, crawl space, or basement	<input type="checkbox"/>	<input type="checkbox"/>	Moldy, musty school/daycare	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco smoke	<input type="checkbox"/>	<input type="checkbox"/>	Well water	<input type="checkbox"/>	<input type="checkbox"/>
Carpet in bathroom	<input type="checkbox"/>	<input type="checkbox"/>	Carpet in most parts of house	<input type="checkbox"/>	<input type="checkbox"/>
Feather or down bedding	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>

Parental History:

When were your child's parents married? ☐ Yes | ☐ No If separated, when? _____

If divorced, when? _____ If remarried, when? _____

Custody arrangements:

Mother's age when child was born: _____

Father's age when child was born: _____

Symptom Review

Please check all current symptoms occurring or present in the past 6 months

Strengths

- ☐ Especially attractive
- ☐ Accepts new clothes
- ☐ Cuddly
- ☐ Physically coordinated
- ☐ Happy
- ☐ Pleasant/easy to care for
- ☐ Sensitive/affectionate
- ☐ Wants to be liked
- ☐ Responsible
- ☐ Draws accurate pictures
- ☐ Sensitive to people's feelings
- ☐ OK if parents leave
- ☐ Answers parent
- ☐ Follows instructions

- ☐ Pronounces words well
- ☐ Unusual memory
- ☐ Perfect musical pitch
- ☐ Good with math
- ☐ Good with computer
- ☐ Good with fine work
- ☐ Good throwing and catching
- ☐ Good climbing
- ☐ Strong desire to do things
- ☐ Swimming
- ☐ Bold, free of fear
- ☐ Likes to be held
- ☐ Likes to be swaddled

Sleep

- ☐ Sleeps in own bed

- ☐ Sleeps with parent(s)
- ☐ Awakens screaming/crying
- ☐ Awakes at night
- ☐ Difficulty falling asleep
- ☐ Early waking
- ☐ Insomnia
- ☐ Sleeps less than normal
- ☐ Daytime sleepiness
- ☐ Jerks during sleep
- ☐ Nightmares
- ☐ Sleeps more than normal

Physical

- ☐ Looks sick
- ☐ Glazed look
- ☐ Overweight

- ☐ Underweight
- ☐ Pupils unusually large
- ☐ Unusually long eye lashes
- ☐ Pupils unusually small
- ☐ Dark circles under eyes
- ☐ Red lips
- ☐ Red fingers
- ☐ Red toes
- ☐ Webbed toes
- ☐ Red ears
- ☐ Double jointed
- ☐ High arched palate
- ☐ Lymph nodes enlarged neck
- ☐ Head warm
- ☐ Head sweats
- ☐ Night sweats
- ☐ Abnormal fatigue
- ☐ Failure to thrive
- ☐ Cold all over
- ☐ Cold hands and feet
- ☐ Cold intolerance
- ☐ Hands/feet – very sweaty
- ☐ Head very hot/sweaty
- ☐ Night sweats
- ☐ Perspiration – odd color

Skin

- ☐ Paleness, severe
- ☐ Fungus / fingernails
- ☐ Fungus / toenails
- ☐ Dandruff
- ☐ Chicken skin
- ☐ Oily skin
- ☐ Patchy dullness
- ☐ Seborrhea on face
- ☐ Thick calluses
- ☐ Athletes foot
- ☐ Feet – stinky
- ☐ Diaper rash
- ☐ Odd body odor

- ☐ Strong body odor
- ☐ Acne
- ☐ Dark circle under eyes
- ☐ Ears get red
- ☐ Eczema
- ☐ Flushing
- ☐ Red face
- ☐ Sensitive to insect bites
- ☐ Stretch marks
- ☐ Blotchy skin
- ☐ Bugs love to bite your child
- ☐ Cradle cap
- ☐ Dry hair
- ☐ Dry scalp
- ☐ Hair unmanageable
- ☐ Bites nails
- ☐ Nails brittle
- ☐ Nails frayed
- ☐ Nails pitted
- ☐ Nails soft
- ☐ Skin pale
- ☐ Dark birth mark(s)
- ☐ Easy bruising
- ☐ Inability to tan
- ☐ Light birth mark(s)
- ☐ Ragged cuticles
- ☐ Thickening fingernails
- ☐ Thickening toenails
- ☐ Vitiligo
- ☐ White spots or lines in nails
- ☐ Dry skin in general
- ☐ Feet cracking
- ☐ Feet peeling
- ☐ Hands cracking
- ☐ Hands peeling
- ☐ Lower legs dry
- ☐ Skin lackluster
- ☐ Itchy skin in general
- ☐ Itchy scalp

- ☐ Itchy ear canals
- ☐ Itchy eyes
- ☐ Itchy nose
- ☐ Itchy roof of mouth
- ☐ Itchy arms
- ☐ Itchy hands
- ☐ Itchy legs
- ☐ Itchy feet
- ☐ Itchy anus
- ☐ Itchy penis
- ☐ Itchy vagina

Digestive

- ☐ Breath bad
- ☐ Increased salivation
- ☐ Drooling
- ☐ Cracking lip corners
- ☐ Cold sores on lips, face
- ☐ Geographic tongue (map-like)
- ☐ Sore tongue
- ☐ Tongue coated
- ☐ Canker sores in mouth
- ☐ Gums bleed
- ☐ Teeth grinding
- ☐ Tooth cavities
- ☐ Tooth with amalgam fillings
- ☐ Mouth thrush (yeast infection)
- ☐ Sore throat
- ☐ Fecal belching
- ☐ Burping
- ☐ Nausea
- ☐ Reflux
- ☐ Spitting up
- ☐ Vomiting
- ☐ Abdominal bloating
- ☐ Lower abdominal bloating
- ☐ Colic
- ☐ Abdomen distended
- ☐ Abdominal pain
- ☐ Intestinal parasites

- ☐ Pinworms
- ☐ Crampy pain with pooping
- ☐ Constipation
- ☐ Diarrhea
- ☐ Farting – regular
- ☐ Farting – stinky
- ☐ Anal fissures
- ☐ Red ring around anus
- ☐ Stools bulky
- ☐ Stools light color
- ☐ Stools very stinky
- ☐ Stools with blood
- ☐ Stools with mucous
- ☐ Stools with undigested food
- ☐ Flatulence
- ☐ Stool odor foul
- ☐ Stool odor yeasty
- ☐ Stools pale
- ☐ Stools slimy
- ☐ Stools watery

Eating

- ☐ Poor appetite
- ☐ Thirst
- ☐ Extreme water drinking
- ☐ Bingeing
- ☐ Bread craving
- ☐ Craving for carbohydrates
- ☐ Craving for juice
- ☐ Craving for salt
- ☐ Diet soda craving
- ☐ Pica (eating non-edibles)
- ☐ Abnormal food cravings
- ☐ Carbohydrate intolerance
- ☐ Starch/disaccharide intol.
- ☐ Sugar intolerance
- ☐ Salicylate intolerance
- ☐ Oxalate intolerance
- ☐ Phenolics intolerance
- ☐ MSG intolerance

- ☐ Food coloring intolerance
- ☐ Gluten Intolerance
- ☐ Casein intolerance
- ☐ Specific food(s) intolerance
- ☐ Lactose intolerance
- ☐ Behavior worse with food
- ☐ Behavior better when fasting

Behavior

- ☐ Behavior purposeless
- ☐ Unusual play
- ☐ Uses adult's hand for activity
- ☐ Aloof, indifferent, remote
- ☐ Doesn't do for self
- ☐ Extremely cautious
- ☐ Hides skill/knowledge
- ☐ Lacks initiative
- ☐ Lost in thought, unreachable
- ☐ No purpose to play
- ☐ Poor focus, attention
- ☐ Sits long time staring
- ☐ Uninterested in live pet
- ☐ Watches television long time
- ☐ Won't attempt/can't do
- ☐ Poor sharing
- ☐ Rejects help
- ☐ Curious/gets into things
- ☐ Erratic
- ☐ Unable to predict actions
- ☐ Destructive
- ☐ Hyperactive
- ☐ Constant movement
- ☐ Melt downs
- ☐ Tantrums
- ☐ Self mutilation
- ☐ Runs away
- ☐ Jumps when pleased
- ☐ Whirls self like a top
- ☐ Climbs to high places
- ☐ Insists on what wanted

- ☐ Tries to control others
- ☐ Head banging
- ☐ Falls, gets hurt running climbing
- ☐ Does opposite/asked
- ☐ Teases others
- ☐ Silly
- ☐ Shrieks
- ☐ Holds hands in strange pose
- ☐ Spends time w/pointless task
- ☐ Stares at own hands
- ☐ Toe walking
- ☐ Arched back with bright lights
- ☐ Imitates others
- ☐ Finger flicking
- ☐ Flaps hands
- ☐ Licking
- ☐ Likes spinning objects
- ☐ Likes to flick finger in eye
- ☐ Likes to spin things
- ☐ Rhythmic rocking
- ☐ Slapping books
- ☐ Tooth tapping
- ☐ Visual stims
- ☐ Wiggle finger front of face
- ☐ Wiggle finger side of face
- ☐ Bites or chews fingers
- ☐ Bites wrist or back of hands
- ☐ Chews on things

Mood

- ☐ Apathy
- ☐ Blank look
- ☐ Depression
- ☐ Detached
- ☐ Disinterested
- ☐ Eye contact poor
- ☐ Isolates
- ☐ Negative
- ☐ Fright without cause

- ☐ Always frightened
- ☐ Anguish
- ☐ Discontented
- ☐ Does not want to be touched
- ☐ Inconsolable crying
- ☐ Irritable
- ☐ Looks like in pain
- ☐ Moaning, groaning
- ☐ Phobias
- ☐ Restless
- ☐ Severe mood swings
- ☐ Unhappy
- ☐ Agitated
- ☐ Anxious

Sensory

- ☐ Bothered by certain sounds
- ☐ Covers ears with sounds
- ☐ Ear pain
- ☐ Ear ringing
- ☐ Hearing acute
- ☐ Hearing loss
- ☐ Likes certain sounds
- ☐ Sensitive to loud noise
- ☐ Sounds seem painful
- ☐ Tinnitus
- ☐ Acute sense of smell
- ☐ Examines by smell
- ☐ Intensely aware of odors
- ☐ Blinking
- ☐ Bothered by bright lights
- ☐ Distorted vision
- ☐ Conjunctivitis
- ☐ Eye crusting
- ☐ Eye problem
- ☐ Lid margin redness
- ☐ Examines by sight
- ☐ Fails to blink at bright light
- ☐ Likes fans
- ☐ Likes flickering lights

- ☐ Looks out of corner of eye
- ☐ Poor vision
- ☐ Puts eye to bright light or sun
- ☐ Strabismus (crossed eye)
- ☐ Fearful of harmless object
- ☐ Fearful of unusual events
- ☐ Unaware of danger
- ☐ Unaware of peoples' feelings
- ☐ Unaware of self as person
- ☐ Upset if things change
- ☐ Upset if things aren't right
- ☐ Adopts complicated rituals
- ☐ Car, truck, train obsession
- ☐ Collects particular things
- ☐ Draws only certain things
- ☐ Fixated on one topic
- ☐ Lines objects precisely
- ☐ Repeats old phrases
- ☐ Repetitive play/objects
- ☐ Fingertip squeezing
- ☐ Hates wearing shoes
- ☐ Insensitive to pain
- ☐ Likes head burrowed
- ☐ Likes head pressed hard
- ☐ Likes head rubbed
- ☐ Likes head under blanket
- ☐ Likes to be held upside down
- ☐ Likes to be swung in the air
- ☐ Very insensitive to pain
- ☐ Very sensitive to pain

Neuromuscular

- ☐ Clumsiness
- ☐ Coordination
- ☐ Fine motor poor
- ☐ Gross motor poor
- ☐ Holds bizarre posture
- ☐ Hyperactivity
- ☐ Physically awkward
- ☐ Rocking

- ☐ Stiffens body when held
- ☐ Calf cramps
- ☐ Foot cramps
- ☐ Muscle pain
- ☐ Muscle tone tense
- ☐ Muscle twitches
- ☐ Fist clenching
- ☐ Jaw clenching
- ☐ Poor muscle tone/limp
- ☐ Tics
- ☐ Muscle tone low trunk
- ☐ Muscle weakness, atrophy
- ☐ Muscle tone low all over
- ☐ Tremors

- ☐ Cognitive delays
- ☐ Memory poor
- ☐ Poor attention, focus
- ☐ Slow and sluggish
- ☐ Expressive language delay
- ☐ Seizures - focal
- ☐ Seizures - generalized
- ☐ Seizures - grand mal
- ☐ Seizures - petit mal
- ☐ Unusually fast heartbeat
- ☐ Heart murmur
- ☐ Headaches
- ☐ Joint pains
- ☐ Leg pains
- ☐ Muscle pains

Speech

- ☐ Never spoke
- ☐ Occas. words when excited
- ☐ Expressive language poor
- ☐ No answers simple questions
- ☐ Points to objects/can't name
- ☐ Speech apraxia
- ☐ Does not ask questions
- ☐ Babbling
- ☐ Asks using "you" not "I"

- ☐ Answers by repeating question
- ☐ Receptive language poor
- ☐ Says "I"
- ☐ Says "no"
- ☐ Says "yes"
- ☐ Lost language @ 12-24 months
- ☐ Lost language after 24 months
- ☐ Scripting
- ☐ Stuttering
- ☐ Talks to self
- ☐ Poor auditory processing
- ☐ Unusual sound of cry
- ☐ Uses one word for another
- ☐ Rigid behaviors
- ☐ Poor confidence

- ☐ Timid
- ☐ Corrects imperfections
- ☐ Tidy

Respiratory

- ☐ Pneumonia
- ☐ Bad odor in nose
- ☐ Breath holding
- ☐ Bronchitis
- ☐ Congestion chg. season
- ☐ Congestion in the fall
- ☐ Congestion in the spring
- ☐ Congestion in the summer
- ☐ Congestion in the winter
- ☐ Cough
- ☐ Postnasal drip
- ☐ Runny nose
- ☐ Sighing
- ☐ Sinus fullness

- ☐ Wheezing
- ☐ Yawning

Reproductive

- ☐ Girls: Early first period
- ☐ Boys: Large testicles
- ☐ Early breast development
- ☐ Early pubic hair
- ☐ Girls: vaginal odor

Urinary

- ☐ Frequent urination
- ☐ Bed wetting after age 4
- ☐ Odd urinary odor
- ☐ Urinary hesitancy
- ☐ Urinary tract infections
- ☐ Urinary urgency
- ☐ Dry at night

Readiness Assessment and Health Goals

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

In order to improve your child's health, how willing is the patient in:

Significantly modifying diet	
Take several nutritional supplements each day	
Keep a record of everything you eat each day	
Modify your lifestyle (work demands, sleep habits)	
Practice relaxation techniques/stress reduction	
Engage in regular exercise	

HEALTH GOALS

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

Do you think something triggered your child's health to change?

When was the last time you remember your child feeling well?

What makes your child feel worse?

What do you think is happening and why?

What do you feel needs to happen for your child to get better?
