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

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

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

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:

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

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
Crawl: _____ months OR ☐ never
Pulled to stand: _____ months OR ☐ never
Potty trained: _____ months OR ☐ never
Walked alone: _____ months OR ☐ never
Never dry at night: _____ months OR ☐ never

First words (mama, dada, etc.) _____ months OR ☐ never
Spoke clearly: _____ months OR ☐ never
Lost language: _____ months OR ☐ never
Lost eye contact: _____ 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 Grandmothe	Maternal Grandfather	Paternal Grandmothe	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:

☐ Yeast Free	☐ Feingold	☐ Weight Management
☐ Diabetic	☐ Dairy Free	☐ Wheat Free
☐ Ketogenic	☐ Specific Carbohydrate	☐ Gluten Free/Casein Free
☐ Gluten Restricted	☐ Vegetarian	☐ Vegan
☐ 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:

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

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

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 of 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?

_____

_____