

**SECOND NATURE NATUROPATHIC CARE, LLC.**

8 Rockland Place • Nyack NY 10960  
Work: (845) 358-8385 • Fax: (845) 358-2963  
www.SecondNatureCare.com

**INTAKE FORM (6-12 YEARS)**

Name \_\_\_\_\_ Date \_\_\_\_\_  
Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: \_\_\_\_\_ Female \_\_\_\_\_ Male  
Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Telephone # Home: \_\_\_\_\_ Work: \_\_\_\_\_  
If parents are separated, child lives primarily with: \_\_\_\_\_  
How did you hear about this clinic? \_\_\_\_\_

**HEALTH HISTORY QUESTIONNAIRE**

What are your child's most important health problems? List as many as you can in order of importance.

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_

Does your child have a contagious disease at this time? Y N

If yes, what? \_\_\_\_\_

**PREVIOUS ILLNESSES**

Rheumatic fever	Y	N	German measles	Y	N
Chicken pox	Y	N	Measles	Y	N
Tonsillitis	Y	N	approx. number	_____	
Ear infections	Y	N	approx. number	_____	
Other	Y	N	list	_____	

Has your child had any of the following tests?	When	Where	Result
Electroencephalogram (EEG)	_____	_____	_____
Psychological evaluation	_____	_____	_____
Hearing tests	_____	_____	_____
Speech/Language tests	_____	_____	_____

Hospitalizations/ Surgeries/ Injuries  
What hospitalizations, surgeries or major injuries has your child had? \_\_\_\_\_

**IMMUNIZATIONS**

Polio	Y	N	Pertussis	Y	N
Tetanus shot	Y	N	Diphtheria	Y	N
Measles/ Mumps/ Rubella	Y	N	Influenza	Y	N
Any adverse reactions?	Y	N	If yes, what?	_____	

## ALLERGIES

Is your child hypersensitive or allergic to:

Any drugs? \_\_\_\_\_

Any foods? \_\_\_\_\_

Any environmental? \_\_\_\_\_

Breast fed? \_\_\_\_\_ How long? \_\_\_\_\_ Formula? \_\_\_\_\_ Milk/ Soy \_\_\_\_\_

## Typical Food Intake/ Medication

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

To Drink: \_\_\_\_\_

Please list any prescription medications, over the counter medications, vitamins or other supplements your child is taking.

1) \_\_\_\_\_ 5) \_\_\_\_\_

2) \_\_\_\_\_ 6) \_\_\_\_\_

3) \_\_\_\_\_ 7) \_\_\_\_\_

4) \_\_\_\_\_ 8) \_\_\_\_\_

## REVIEW OF SYSTEMS

N = NOW

P = PAST

### MENTAL/ EMOTIONAL

Mood Swings	N	P	Anxiety/ nervousness	N	P
Irritability	N	P	Cries easily	N	P
Hyperactivity	N	P	Unusual fears	N	P
Introvert/ extrovert	N	P	Sleep problems	N	P
Motion/ car sickness	N	P	Nightmares	N	P

### ENDOCRINE

Heat/ cold intolerance	N	P	Fatigue	N	P
Excessive thirst	N	P	Excessive hunger	N	P
Low blood sugar	N	P	High blood sugar	N	P

### SKIN

Rashes	N	P	Eczema, Hives	N	P
Acne, Boils	N	P	Itching	N	P

### HEAD

Headaches	N	P	Head Injury	N	P
Dizzy spells	N	P	High Fevers	N	P

### EYES

Glasses or contacts	N	P	Tearing or dryness	N	P
Eye pain/ strain	N	P			

### EARS

Earaches	N	P	Impaired hearing	N	P
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	N = NOW		P = PAST	
<b>NOSE AND SINUSES</b>				
Frequent colds	N	P	Nose Bleeds	N P
Stiffness	N	P	Hayfever	N P
Sinus problems	N	P	Loss of smell	N P
<b>MOUTH AND THROAT</b>				
Frequent sore throat	N	P	Canker sores	N P
Breath odor	N	P		
<b>RESPIRATORY</b>				
Cough	N	P	Wheezing	N P
Asthma	N	P	Bronchitis	N P
<b>CARDIOVASCULAR</b>				
Heart disease	N	P	Murmurs	N P
<b>URINARY</b>				
Frequent urination	N	P	Bed wetting	N P
<b>GASTROINTESTINAL</b>				
Belching/ passing gas	N	P	Stomachaches	N P
Constipation	N	P	Diarrhea	N P
Describe Bowel Movements:	_____			
How often do they occur:	_____			
<b>MUSCULOSKELETAL</b>				
Joint pain/ stiffness	N	P	Muscle spasm/ cramp	N P
Broken bones	N	P		
<b>BLOOD/PERIPHERAL VASCULAR</b>				
Anemia	N	P	Easy bleeding/ bruising	N P

Is there any information about your child's health that you would like to add?

Welcome! I am glad to be of service for you and your child!

SECOND NATURE NATUROPATHIC CARE, LLC.

105 SHAD ROW SUITE 1B  
PIERMONT, NY 10968  
(845) 358-8385

INTAKE FORM (Birth - 5 years)

Patient's Name \_\_\_\_\_ Date of First Visit \_\_\_\_\_  
Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender: Female \_\_\_\_\_ Male \_\_\_\_\_  
Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Phone # (home) ( ) \_\_\_\_\_ Parents work # ( ) \_\_\_\_\_  
If parents are separated, child lives primarily with: \_\_\_\_\_  
How did you hear about this clinic? \_\_\_\_\_  
Reason for referral or presenting problems: \_\_\_\_\_

MEDICATIONS	Now	Past		Now	Past
Aspirin	___	___	Antibiotics	___	___
Tylenol	___	___	Anti-histamine	___	___
Decongestant	___	___	Other	___	___
Ibuprofen	___	___	Allergies to medicines	___	___

MEDICAL HISTORY

\_\_\_ Chicken pox                      \_\_\_ Scarlet fever                      \_\_\_ Tonsillitis, approx. num.  
\_\_\_ Measles                              \_\_\_ Pneumonia                              \_\_\_ Ear infections, num.  
\_\_\_ Mumps                                \_\_\_ Frequent colds                              other \_\_\_\_\_  
\_\_\_ Rubella                                \_\_\_ Rheumatic fever                              \_\_\_\_\_

Has your child ever had any of the following tests?      When      Where      Results  
Electroencephalogram \_\_\_\_\_  
Psychological evaluation \_\_\_\_\_  
Hearing \_\_\_\_\_  
Speech/ Language \_\_\_\_\_  
Injuries/ Surgeries/ Hospitalizations (please list): \_\_\_\_\_

IMMUNIZATIONS

\_\_\_ Measles                              \_\_\_ Polio                                      \_\_\_ MMR  
\_\_\_ Smallpox                              \_\_\_ Diphtheria                                      \_\_\_ Mumps  
\_\_\_ Tetanus                                \_\_\_ Influenza                                      \_\_\_ DPT  
Others (list): \_\_\_\_\_

Any adverse reactions? Y      N      What? \_\_\_\_\_

FAMILY HISTORY

\_\_\_ Heart disease                      \_\_\_ Diabetes                                      \_\_\_ Birth defects  
\_\_\_ Hypertension                      \_\_\_ Arthritis                                      \_\_\_ Tuberculosis  
\_\_\_ Cancer                                \_\_\_ Allergies                                      \_\_\_ Mental illness

## PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications? \_\_\_\_\_

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Mother's age at child's birth? \_\_\_\_\_

Mother's health during pregnancy?

\_\_\_\_\_ Bleeding

\_\_\_\_\_ Nausea

\_\_\_\_\_ Illnesses

\_\_\_\_\_ Hypertension

\_\_\_\_\_ Physical or emotional trauma

\_\_\_\_\_ Cigarettes, alcohol, drug consumption

\_\_\_\_\_ Medications

\_\_\_\_\_ Thyroid Problems

\_\_\_\_\_ Diabetes

## BIRTH HISTORY

Term: Full \_\_\_\_\_ Premature \_\_\_\_\_ Late \_\_\_\_\_ Weight at birth \_\_\_\_\_

Length of labor \_\_\_\_\_ Complications? \_\_\_\_\_

Did your child have any of the following problems shortly after birth?

\_\_\_\_\_ Birth defects

\_\_\_\_\_ Birth injuries

\_\_\_\_\_ Blue baby

\_\_\_\_\_ Cerebral palsy

\_\_\_\_\_ Seizures

\_\_\_\_\_ Jaundice

\_\_\_\_\_ Colic

\_\_\_\_\_ Fever

\_\_\_\_\_ Rashes

Other (explain): \_\_\_\_\_

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Child's sleep patterns (first year) \_\_\_\_\_

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Food intolerances (if any) \_\_\_\_\_

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Feeding: Breast fed? \_\_\_\_\_ How long? \_\_\_\_\_ Formula? \_\_\_\_\_ Milk / Soy \_\_\_\_\_

Age began solids \_\_\_\_\_ Which foods? \_\_\_\_\_

Age began: Sitting \_\_\_\_\_ Crawling \_\_\_\_\_ Walking \_\_\_\_\_ Talking \_\_\_\_\_

## SYMPTOMS

**N = NOW**

**P = PAST**

Hives	N	P	Burning of urine	N	P	Bloody urine	N	P
Eczema	N	P	Frequent urination	N	P	Cries easily	N	P
Bleeding gums	N	P	Heart murmur	N	P	Nervous	N	P
Nose bleeds	N	P	Vomiting spells	N	P	Sleep problems	N	P
Acne	N	P	Anemia	N	P	Night sweats	N	P
High fevers	N	P	Stomachaches	N	P	Sensitive to light	N	P
Chronic rash	N	P	Jaundice	N	P	Body/ breath odor	N	P
Hearing loss	N	P	Easy bruising	N	P	Motion/ car sickness	N	P
Diarrhea	N	P	Flat feet	N	P	No appetite	N	P
Sore throats	N	P	Constipation	N	P	Nightmares	N	P
Headaches	N	P	Gas	N	P	Canker sores	N	P
Frequent colds	N	P	Bleeding tendency	N	P	Unusual fears	N	P
Wheezing	N	P	Joint pains	N	P	Excessive fatigue	N	P
Cough	N	P	Dizzy spells	N	P	Hair loss	N	P

**DIET**

Please describe your child's typical daily diet:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

To Drink: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Thank you. I look forward to helping your child in any way I can.

**SECOND NATURE NATUROPATHIC CARE, LLC.**

105 SHAD ROW SUITE 1B  
PIERMONT, NY 10968  
(845) 358-8385

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_  
Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Head Circ: \_\_\_\_\_  
Weight %-tile: \_\_\_\_\_ Height %-tile: \_\_\_\_\_ Head Circ. %-tile: \_\_\_\_\_

- Development:**  
**2 - 4 months**
- Makes babbling and cooing sounds.
  - Smiles and responds to people.
  - Begins to see in color.
  - Will follow a slowly moving object with eyes.
  - Sucks on finger or thumb.
  - Opens hand and begins to reach for objects.
  - Holds rattle in hand for a few minutes.
  - Begins to roll from side to side.
  - Lifts head 45° when lying on stomach.

- Activities:**
- Respond to your baby's cooing with a loving tone.
  - Hang a brightly colored mobile over the crib.
  - Put objects into your baby's hand to stimulate grasp.
  - Place your baby on stomach with toys in reach.
  - Massage and exercise limbs.
  - Take short walks outside with your baby.
  - Play soft music and sing for your baby.
  - Include baby in daily activities such as evening meals by placing baby in a carrier on the table.

- Feeding:**
- Breast feed on demand.
  - Formula on demand with water offered twice a day.

- Topics for Discussion:**
- Increasing breast milk.
  - Diaper rash.
  - Infant colic.
  - Alone babysitting.
  - Time for mom and dad.

**Next Check-up:**                      **Age 4 months**

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Weight %-tile: \_\_\_\_\_ Height %-tile: \_\_\_\_\_ Head Circ. %-tile: \_\_\_\_\_

**Development:  
4 - 6 months**

- Laughs, coos and easily responds to people.
- Recognizes faces, especially close family members.
- Verbalizes vowel sounds.
- Sits up with support.
- Learns to roll over in both directions.
- Finds feet and plays with toes.
- Develops social interaction.
- Lifts head up to 90° while lying on stomach.
- Holds head steady when upright.
- Pays attention to very small object, such as a raisin.

**Activities:**

- Repeat songs or nursery rhymes to help learn sounds.
- Dance with your baby.
- Rub your baby's skin with different textures of cloth.
- Let your baby hold things and explore for him/herself.
- Use bath time for play time with soft floating toys.
- Lie your baby on stomach with colorful toys within reach.
- Read favorite children's books to your baby.

**Feeding:**

- Breast feed on demand.
- Formula on demand with water offered twice a day.
- Introduce solids at 6 month.

**Topics for Discussion:**

- Teething.
- Introducing a cup.
- Fever, ear infections.
- Getting ready to safety proof the house.
- Sleeping through the night.

**Next Check-up:**

**Age 6 months**

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Weight %-tile: \_\_\_\_\_ Height %-tile: \_\_\_\_\_ Head Circ. %-tile: \_\_\_\_\_

**Development:  
6 - 9 months**

- Teething, fussing and drooling.
- Sits unsupported.
- Pulls self to standing position.
- Keeps head level with body when pulled to sitting.
- Passes object from one hand to another.
- Looks for dropped object.
- Rakes up a small object such as a raisin in fist.
- Feeds self a cracker.
- Turns in direction of a voice.
- Babbles, combining vowels and consonants (ie. da-da, ma-ma).
- May imitate sounds.
- Anxiety when parents leave.

**Activities:**

- Give teething ring or a wet washcloth for teething.
- Let your baby play in front of a mirror.
- Let your baby explore a "safe" room of the house.
- Let your baby play with pots and pans in the kitchen.
- Play peek-a-boo; hide toys under a blanket for your baby to find.
- Read to your baby.
- Wave bye-bye; say "hi".
- Include your baby in mealtimes.
- Take your baby on walks and hikes.

**Feeding:**

- Breast feed on demand.
- Formula on demand with water twice a day (if not breast fed).
- Introduce solid food.

**Topics for Discussion:**

- Safety proofing the house.
- Introduction of solid food.
- Avoid food allergies.
- Sleeping through the night.

**Next Check-up:**

**Age 9 months**

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Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Head Circ.: \_\_\_\_\_

Weight %-tile: \_\_\_\_\_ Height %-tile: \_\_\_\_\_ Head Circ. %-tile: \_\_\_\_\_

**Development:**

**9 - 12 months**

- Creeps and crawls.
- Pulls self up to standing position from sitting.
- Walks holding on to furniture.
- Gets into sitting position from lying on stomach.
- Stands supported, later stands unsupported for a brief moment.
- Picks up tiny objects with fingers.
- Looks for dropped object.
- Works to get a toy that is out of reach.
- Plays peek-a-boo; plays patty-cake.
- Waves bye-bye.
- Understands, not necessarily minds the word "No".
- Begins to feed self with finger food.
- Splashes intentionally in bathtub.

**Activities:**

- Name your baby's nose, mouth and eyes while touching them on the baby and yourself.
- Play "This little piggy went to market".
- Give toys that "nestle" inside one another.
- Show the baby pictures or objects when introducing a new word.
- Read to your child daily, especially before bedtime.

**Feeding:**

- Continue with breast feeding or formula.
- Decrease strained foods, introduce finger foods.
- Start drinking from a cup.

**Topics for Discussion:**

- Directions for home preparation of infant foods.
- Proper nutrition.
- Allergic food reactions.
- Weaning baby off bottle onto cup.
- Care of new teeth.
- The beginnings of discipline.

**Next Check-up:**

**Age 12 months**

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Weight %-tile: \_\_\_\_\_ Height %-tile: \_\_\_\_\_ Head Circ. %-tile: \_\_\_\_\_

**Development:**  
**12-15 months**

- Stands unsupported; lowers self from a standing position without falling.
- Climbs up stairs.
- Walks unsupported.
- Picks up small objects.
- Turns pages of a book.
- Identifies animal in picture books or magazines.
- Seeks approval and tries to avoid disapproval.
- Repeats action for additional praise.
- Cries when scolded.
- Resists napping.
- Reacts sharply to separation from mother.
- Shows preference for one hand over the other.

**Activities:**

- Let your baby feed him/herself with a spoon.
- Use bath time for exploration with tub toys.
- Use peg board and plastic hammer for coordination.
- Roll a ball to your baby (play catch).
- Read to your child daily, especially before bedtime.
- Play singing games such as, "Pop Goes The Weasel".

**Feeding:**

- Continue with breast feeding or formula.
- Feed with fingers and spoon.
- Drink from a cup.

**Topics for Discussion:**

- Weaning from a bottle to a cup.
- Proper nutrition.
- Care of new teeth.

**Next Check-up:**                      **Age 15 months**

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Weight %-tile: \_\_\_\_\_ Height %-tile: \_\_\_\_\_ Head Circ. %-tile: \_\_\_\_\_

**Development:**  
**15 - 18 months**

- Uses spoon, yet still eats with fingers.
- Drinks from cup.
- Towers two cubes.
- Says 3 words other than mama and dada.
- Stands well unsupported.
- Walks without support.
- Stoops and recovers without falling.
- Seats self in chair.

**Activities:**

- Encourage use of crayons, paintbrushes.
- Teach finger games, card games, sorting games.
- Talk to your child about what he/she sees or does.
- Orient your child to new objects by pointing the objects out and repeating their names.
- Read to your child daily.
- Give projects that can be taken apart and put back together.
- Allow space for your child to speak for him/herself.
- Introduce the toothbrush.

**Feeding:**

- Drink primarily from a cup.
- Continue to self feed.
- Encourage spoon feeding.

**Topics for Discussion:**

- Bumps and bruises.
- Proper nutrition in snacks.
- Care of teeth.

**Next Check-up:**                      **Age 18 months**

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Weight %-tile: \_\_\_\_\_ Height %-tile: \_\_\_\_\_ Head circ. %-tile: \_\_\_\_\_

- Development:**  
**18 - 24 months**
- Towers 2-3 cubes.
  - Walks up and down stairs with hand held.
  - Balances on one foot.
  - Draws pictures, scribbles spontaneously.
  - Likes running, jumping, yelling.
  - Often throws temper tantrums.
  - Develops "NO" response.
  - Is shy with strangers.
  - Walks backwards.
  - Says 10 words other than mama and dada.
  - Indicates wants by pointing or pulling.

- Activities:**
- Draw outline of your child's hand.
  - Encourage coloring and drawing.
  - Encourage playing with and stacking blocks.
  - Give information in verbal as well as physical forms, such as when dressing a child, explain what you are doing.
  - Help with self dressing.
  - Help coordination by stringing beads.
  - Help do somersaults.

- Feeding:**
- Nutrition needs slow as growth slows.
  - Nutritional snacks are necessary between meals.
  - Limit sweets (give a food other than sweets for a reward).
  - Overall, appetite decreases.

- Topics for Discussion:**
- Food sensitivities and behavior.
  - Increase need for proper nutrition.
  - Care of teeth.
  - Toilet awareness.

**Next Check-up:                   Age 24 months**

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Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Weight %-tile: \_\_\_\_\_ Height %-tile: \_\_\_\_\_

**Development:**  
**3 - 5 years**

- Prepares own cereal.
- Brushes own teeth.
- Plays board/card games.
- Dresses without help.
- Can draw a person.
- Towers eight or more blocks.
- Speech is understandable most of the time.
- Starts to be able to define words.
- Balances on one foot for 4-5 seconds.

**Activities:**

- “Rough housing” is appropriate at times.
- Encourage play with paper, colors, paints.
- Encourage imagination playing.
- Teach how to ride a bicycle (with training wheels at first).
- Tour the zoo, neighborhood, etc., talking about what you see.
- Let your child help you in the kitchen.
- Teach your child popular songs.
- Use a variety of words, increasingly longer.
- Use complete complex sentences.
- Ask and answer questions.
- Read to your child daily.

**Feeding:**

- Should be eating a balanced diet.
- Limit fruit juices, sugars, simple carbohydrates.
- Increase proteins, complex carbohydrates.

**Topics for Discussion:**

- “Establishing independence”.
- Sharing.
- Care of teeth.
- School.
- Immunizations.

**Next Check-up:**                    **Age 5 - 6**

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**New Patient Children's Questionnaire**

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Child's Age \_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number \_\_\_\_-\_\_\_\_-\_\_\_\_

Child's Last Name \_\_\_\_\_ Child's First Name \_\_\_\_\_ Child's Middle Initial \_\_\_\_\_

Does your child have a name he/she prefers to be called by? \_\_\_\_\_

Child's Mother's Name \_\_\_\_\_

Child's Father's Name \_\_\_\_\_

Child's Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ - \_\_\_\_\_

Phone (Mother's Work) \_\_\_\_\_ (Father's Work) \_\_\_\_\_ (Home) \_\_\_\_\_

Who has primary parental responsibility? \_\_\_\_\_

Are you presently employed? Mother Yes \_\_\_ No \_\_\_ Father Yes \_\_\_ No \_\_\_ If yes, please provide the following.

Mother's Employer \_\_\_\_\_

Address \_\_\_\_\_

Father's Employer \_\_\_\_\_

Address \_\_\_\_\_

Next of kin or person to contact in the event of an emergency \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ - \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ Telephone (Work) \_\_\_\_\_

Do you have other children? Yes \_\_\_ No \_\_\_ If yes, do your other children live with you? Yes \_\_\_ No \_\_\_

If you have children, please list them by name and age? \_\_\_\_\_

\_\_\_\_\_

When did your child last receive medical care? \_\_\_\_/\_\_\_\_/\_\_\_\_

Where did your child last receive medical care? \_\_\_\_\_

What condition was your child treated for? \_\_\_\_\_

Date of your child's last physical exam? \_\_\_\_/\_\_\_\_/\_\_\_\_ Was blood work performed at this time? Yes \_\_\_ No \_\_\_

Do you presently have another health care provider? Yes \_\_\_ No \_\_\_

If yes, who? \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ - \_\_\_\_\_

What is your child's height? \_\_\_\_\_ What is your child's weight? \_\_\_\_\_

**What health concerns would you like to discuss in your initial visit? Please list your concerns in order of importance.**

1 \_\_\_\_\_ 5 \_\_\_\_\_

2 \_\_\_\_\_ 6 \_\_\_\_\_

3 \_\_\_\_\_ 7 \_\_\_\_\_

4 \_\_\_\_\_ 8 \_\_\_\_\_

**What are your thoughts on these concerns? Do you have any ideas as to what might be the underlying cause of your child's symptoms? Please explain. (You may attach additional pages if necessary.)**

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Please write the specific health results you would like to achieve for your child in working with the doctor. \_\_\_\_\_

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What are you willing to do to achieve the health results you just recorded? If your physician were to recommend the following choices which would you and your child be able to follow and comply with or not? Please check YES or NO.

ITEM	YES	NO	ITEM	YES	NO
Make dietary modifications			Take nutritional supplements daily		
Avoid certain foods			Be compliant with the treatment		
Exercise regularly			Stick with the program for at least 6 months		
Read books, handouts or listen to tapes for self education about health			Keep the doctor informed about what part of the program is and is not working for you		

When was the last time your child experienced optimal health? \_\_\_\_\_

How many times a year does your child experience colds, flues, sinusitis, sore throats, bronchitis or other infections? \_\_\_\_

How long do these usually last? \_\_\_\_\_ Are these conditions severe? Yes \_\_\_\_ No \_\_\_\_

**CHILD'S HEALTH HISTORY**

Mother's age at child's birth \_\_\_\_ Previous pregnancies \_\_\_\_ Miscarriages \_\_\_\_ Abortions \_\_\_\_

Mother's health during pregnancy: Bleeding \_\_\_\_ Diabetes \_\_\_\_ Domestic Violence \_\_\_\_ High Blood Pressure \_\_\_\_

Nausea \_\_\_\_ Thyroid problems \_\_\_\_ Trauma \_\_\_\_ Weight Gained \_\_\_\_ Cigarettes \_\_\_\_ Alcohol \_\_\_\_ Drugs \_\_\_\_

Did the child's mother experience any complications during pregnancy? Yes \_\_\_\_ No \_\_\_\_ If yes, please provide specifics.

\_\_\_\_\_  
 \_\_\_\_\_

Term: Full \_\_\_\_ Pre-term \_\_\_\_ Post-dates \_\_\_\_

Length of Labor \_\_\_\_ Vaginal Delivery \_\_\_\_ Forceps \_\_\_\_ Vacuum \_\_\_\_ Pitocin \_\_\_\_ Epidural \_\_\_\_ Cesarean Section \_\_\_\_

Did the child's mother experience any complications during labor and delivery? Yes \_\_\_\_ No \_\_\_\_ If yes, please provide specifics.

\_\_\_\_\_  
 \_\_\_\_\_

Did your child experience any complications during labor and delivery? Yes \_\_\_\_ No \_\_\_\_ If yes please provide specifics.

\_\_\_\_\_  
 \_\_\_\_\_

As a baby did your child have any of the following: Blue Baby \_\_\_ Birth Defect \_\_\_ Birth Trauma \_\_\_ Cerebral Palsy \_\_\_\_\_

Colic \_\_\_ Constipation \_\_\_ Diarrhea \_\_\_ Fever \_\_\_ Jaundice \_\_\_ Rash \_\_\_ Seizure \_\_\_

Was the child breast fed? Yes \_\_\_ No \_\_\_ If yes, for what duration? \_\_\_\_\_

Was the child formula fed? Yes \_\_\_ No \_\_\_ If yes, for what duration? \_\_\_\_\_

At what age were solid foods introduced? \_\_\_\_\_ What types of foods were introduced? \_\_\_\_\_

Age your child: Turned Over \_\_\_\_\_ Sat \_\_\_\_\_ Crawled \_\_\_\_\_ Walked \_\_\_\_\_ First Words \_\_\_\_\_ Toilet Trained \_\_\_\_\_

Child's sleep patterns during first year: \_\_\_\_\_

Please indicate any condition(s) of past or present concern:

**NOW PAST CONDITION**

\_\_\_ \_\_\_ Acne  
\_\_\_ \_\_\_ Anemia  
\_\_\_ \_\_\_ Arthritis  
\_\_\_ \_\_\_ Asthma  
\_\_\_ \_\_\_ Bleeding (Excessive or Uncontrolled)  
\_\_\_ \_\_\_ Cancer  
\_\_\_ \_\_\_ Colitis  
\_\_\_ \_\_\_ Constipation  
\_\_\_ \_\_\_ Diabetes  
\_\_\_ \_\_\_ Diarrhea  
\_\_\_ \_\_\_ Digestive Disorders  
\_\_\_ \_\_\_ Eczema  
\_\_\_ \_\_\_ Ear infections  
\_\_\_ \_\_\_ Epilepsy  
\_\_\_ \_\_\_ Gout

**NOW PAST CONDITION**

\_\_\_ \_\_\_ Hay Fever  
\_\_\_ \_\_\_ Headaches  
\_\_\_ \_\_\_ Heart Murmur  
\_\_\_ \_\_\_ Herpes  
\_\_\_ \_\_\_ Injury (Life-Threatening)  
\_\_\_ \_\_\_ Jaundice  
\_\_\_ \_\_\_ Kidney Disease  
\_\_\_ \_\_\_ Liver Disease  
\_\_\_ \_\_\_ Lyme Disease  
\_\_\_ \_\_\_ Mononucleosis  
\_\_\_ \_\_\_ Pneumonia  
\_\_\_ \_\_\_ Seizures  
\_\_\_ \_\_\_ Sinusitis  
\_\_\_ \_\_\_ Thyroid (Hyper or Irregular)  
\_\_\_ \_\_\_ Tonsillitis  
\_\_\_ \_\_\_ Tuberculosis

Please check any illnesses your child has experienced below.

Chicken Pox \_\_\_ Croup \_\_\_ German Measles \_\_\_ Measles \_\_\_ Mumps \_\_\_ Roseola \_\_\_ Scarlet Fever \_\_\_ Whooping Cough \_\_\_

Has your child been immunized? Yes \_\_\_ No \_\_\_

Hepatitis B \_\_\_ Measles \_\_\_ Mumps \_\_\_ Rubella \_\_\_ MMR \_\_\_ Diptheria \_\_\_ Polio \_\_\_ Tetanus \_\_\_ DPT \_\_\_ H. flu \_\_\_

Small Pox \_\_\_ Other \_\_\_

If yes, any reaction(s) to the immunization? Please provide specifics.

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Has your child ever been hospitalized? Yes \_\_\_ No \_\_\_ If yes, please provide specifics where indicated below.

Condition Treated or Surgical Procedure Performed	Date	Hospital
_____	___/___/___	_____
_____	___/___/___	_____
_____	___/___/___	_____
_____	___/___/___	_____

Has your child ever had an X-ray, MRI, CAT, Hearing, Speech, or Psychological evaluation or other special tests?  
Yes \_\_\_ No \_\_\_ If yes, please provide specifics where indicated below.

Procedure Performed	Date	Hospital/Clinic
_____	___/___/___	_____
_____	___/___/___	_____
_____	___/___/___	_____

Has your child ever been tested for allergies? Yes \_\_\_ No \_\_\_ If yes, please provide specifics where indicated below.

Blood IgE environmental/ food \_\_\_ Blood IgG environmental/ food \_\_\_ Cytotoxic \_\_\_ D'Adamo \_\_\_ Elimination \_\_\_

Electroacupuncture \_\_\_ Food intolerance testing \_\_\_ Intradermal \_\_\_ Kinesiology \_\_\_ Scratch \_\_\_ Other \_\_\_

Was this testing helpful? Have you/ your child been able to incorporate what you learned through this testing into your life?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is your child allergic to any foods, drugs or other substances? Yes \_\_\_ No \_\_\_ If yes, please list.

Food\Drug\Substance	Allergic Reaction(s)
_____	_____
_____	_____
_____	_____

Is your child presently taking any prescription(s) or over-the-counter medication(s)? Yes \_\_\_ No \_\_\_ If yes, please list.

Prescription or Medication	Condition Prescribed For	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is your child presently taking any nutritional supplement(s)? Yes \_\_\_ No \_\_\_ If yes, please list.

Vitamin\Mineral\Herb\Nutritional Supplement	Condition Taken For	Recommended By
_____	_____	_____
_____	_____	_____
_____	_____	_____

**FAMILY HEALTH HISTORY**

Has any blood relative or member of your child's immediate family experienced any of the following conditions in the past? Is any blood relative or member of your child's immediate family presently experiencing any of the following conditions? Please use the following codes to denote the person affected. *M* for child's Mother. *F* for child's Father. *B* for child's Brother. *S* for child's Sister. *GM* for child's Grandmother. *GF* for child's Grandfather. *A* for child's Aunt. *U* for child's Uncle.

Now	Past	Condition	Now	Past	Condition
___	___	Alcoholism	___	___	Heart Disease
___	___	Allergies	___	___	Heart Murmur
___	___	Anemia	___	___	Herpes
___	___	Arthritis	___	___	High Blood Pressure
___	___	Asthma	___	___	Injury (Life-Threatening)
___	___	Bleeding (Excessive or Uncontrolled)	___	___	Kidney Disease
___	___	Cancer	___	___	Liver Disease
___	___	Colitis	___	___	Lyme Disease
___	___	Constipation	___	___	Mental Illness
___	___	Diabetes	___	___	Mononucleosis
___	___	Digestive Disorders	___	___	Osteoporosis
___	___	Eczema	___	___	Pneumonia
___	___	Emphysema	___	___	Rheumatism
___	___	Epilepsy	___	___	Seizures
___	___	Glaucoma	___	___	Sexually Transmitted Diseases
___	___	Gout	___	___	Sinusitis
___	___	Hay Fever	___	___	Stroke
___	___	Headaches	___	___	Thyroid (Hyper or Irregular)
___	___	Heart Attack	___	___	Tuberculosis

## HOUSEHOLD

Do you live close to any of the following types of areas? Please check as many as you feel apply.

Heavily-traveled Road \_\_\_ Body of Water \_\_\_ Wooded Area \_\_\_ Power Lines \_\_\_ Microwave Transmitter \_\_\_

Smoke Stack \_\_\_ Dump \_\_\_ Marsh \_\_\_ Wetlands \_\_\_

Is your lawn or are neighboring lawns sprayed with chemicals? Yes \_\_\_ No \_\_\_

Where does your source of electrical power enter your home? \_\_\_\_\_

Any house pets? Yes \_\_\_ No \_\_\_ If yes, what type(s)? \_\_\_\_\_

## HABITS

Does your child exercise? Yes \_\_\_ No \_\_\_ If yes, what types of exercise?

\_\_\_\_\_

If yes, how often per week? \_\_\_\_\_ If yes, for what duration? \_\_\_\_\_

Does your child perspire when he/ she exercises? Yes \_\_\_ No \_\_\_

If yes, how does your child perspire? Please check one of the following: Lightly \_\_\_ Moderately \_\_\_ Heavily \_\_\_

Do you smoke? Yes \_\_\_ No \_\_\_ If yes, how often? \_\_\_\_\_ How long have you been smoking? \_\_\_\_\_

Is your child exposed to second-hand smoke at home or any other place? Yes \_\_\_ No \_\_\_

Does your child consume sodas containing caffeine? Yes \_\_\_ No \_\_\_ If yes, how many cups daily? \_\_\_\_\_

Does your child consume teas, either regular or iced? Yes \_\_\_ No \_\_\_ If yes, how many cups daily? \_\_\_\_\_

On average, how many hours does your child sleep nightly? \_\_\_\_\_

At what time does your child usually fall asleep? \_\_\_\_\_ At what time does your child usually awake? \_\_\_\_\_

How would you characterize your child's sleep? Fitful \_\_\_ Erratic \_\_\_ Calm \_\_\_ Restful \_\_\_ Deep \_\_\_

Upon awakening, does your child feel well-rested and energetic? Yes \_\_\_ No \_\_\_

Does your child nap during the day? Yes \_\_\_ No \_\_\_ If yes, for what duration? \_\_\_\_\_

How would you characterize your child's energy on a daily basis? Low \_\_\_ Moderate \_\_\_ High \_\_\_ Extremely High \_\_\_

Does your child spend time outside daily? Yes \_\_\_ No \_\_\_ How often? \_\_\_\_\_

Which types of water does your child drink, or do you cook with? City Tap \_\_\_ Well \_\_\_ Filtered \_\_\_ Distilled \_\_\_ Spring \_\_\_

How many glasses of water does your child consume daily? \_\_\_\_\_ Is your water fluoridated? Yes \_\_\_\_\_ No \_\_\_\_\_

Does your child consume sugar (in cakes, pies, candies, chocolate, ice cream, soda, junk food, etc)? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, how often? \_\_\_\_\_

Does your child use a toothpaste or oral rinse containing fluoride? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you use mothballs? Yes \_\_\_\_\_ No \_\_\_\_\_ OR chemical pest controls? Yes \_\_\_\_\_ No \_\_\_\_\_

Does your child use laxatives? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what type(s)? \_\_\_\_\_ how often? \_\_\_\_\_

On average, how often do your child's bowels move? \_\_\_\_\_ times daily. \_\_\_\_\_ times weekly

How would you characterize your child's stools? Please use the following codes to denote frequency: *I* for Infrequently. *F* for Frequently. *C* for Constantly. Please mark only those descriptions which apply.

- |   |  |
|---|--|
| <input type="checkbox"/> Small and hard       | <input type="checkbox"/> Dark brown in color                 |
| <input type="checkbox"/> Large and hard       | <input type="checkbox"/> Black in color                      |
| <input type="checkbox"/> Loose but not watery | <input type="checkbox"/> Yellow, light brown or clay-colored |
| <input type="checkbox"/> Diarrhea             | <input type="checkbox"/> Green in color                      |
| <input type="checkbox"/> Difficult to pass    | <input type="checkbox"/> Containing blood or mucus           |
| <input type="checkbox"/> Rarely malodorous    | <input type="checkbox"/> Containing undigested food          |

Does your child:

Have intestinal gas? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, is it? Occasional \_\_\_\_\_ Frequent \_\_\_\_\_ Excessive \_\_\_\_\_ Malodorous \_\_\_\_\_

Have trouble initiating bowel movements for which the stool is neither large or hard? Yes \_\_\_\_\_ No \_\_\_\_\_

Have abdominal discomfort or cramping with bowel movements? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please check all that apply.

Occasionally \_\_\_\_\_ Frequently \_\_\_\_\_ Always \_\_\_\_\_

Has your child ever been diagnosed with a stomach, liver, gallbladder, pancreas, or intestinal disease? Yes \_\_\_\_\_ No \_\_\_\_\_

Does your child respond promptly to urges to defecate? Yes \_\_\_\_\_ No \_\_\_\_\_

Please review the list of attributes below carefully and check **ONLY** those which your child is experiencing **AT PRESENT**.

- |  |  |
|--|--|
| <input type="checkbox"/> Angers easily     | <input type="checkbox"/> Forgetful               |
| <input type="checkbox"/> Cries easily      | <input type="checkbox"/> Memory difficulties     |
| <input type="checkbox"/> Nightmares        | <input type="checkbox"/> Mental confusion        |
| <input type="checkbox"/> Night terrors     | <input type="checkbox"/> Decreased concentration |
| <input type="checkbox"/> Many fears        | <input type="checkbox"/> Decreased comprehension |
| <input type="checkbox"/> Unusual fears     | <input type="checkbox"/> Makes many mistakes     |
| <input type="checkbox"/> Fearless          | <input type="checkbox"/> Critical of self        |
| <input type="checkbox"/> Frequent tantrums | <input type="checkbox"/> Critical of others      |
| <input type="checkbox"/> Head banging      | <input type="checkbox"/> Lacks self-confidence   |
| <input type="checkbox"/> Self mutilation   | <input type="checkbox"/> Suspicious              |
| <input type="checkbox"/> Throws things     | <input type="checkbox"/> Jealous                 |

Please review the list of attributes below carefully and check **ONLY** those which your child is experiencing **AT PRESENT**.

- |   |   |
|---|---|
| <input type="checkbox"/> Lashes out at others                               | <input type="checkbox"/> Affectionate         |
| <input type="checkbox"/> Restlessness                                       | <input type="checkbox"/> Intimate with others |
| <input type="checkbox"/> Excessive worry                                    | <input type="checkbox"/> Shy/ Timid           |
| <input type="checkbox"/> Despair  | <input type="checkbox"/> Sensitive to odors   |
| <input type="checkbox"/> Discontent   | <input type="checkbox"/> Sensitive to noises  |
| <input type="checkbox"/> Depression   | <input type="checkbox"/> Sensitive to light   |
| <input type="checkbox"/> Loneliness   | <input type="checkbox"/> Responsible          |
| <input type="checkbox"/> Prefers to be left alone                           | <input type="checkbox"/> Organized            |
| <input type="checkbox"/> Afraid when left alone                             | <input type="checkbox"/> Neat                 |
| <input type="checkbox"/> Prefers to be with company                         | <input type="checkbox"/> Assertive            |
| <input type="checkbox"/> Doesn't seek out company                           | <input type="checkbox"/> Powerful             |
| <input type="checkbox"/> Would rather be alone when not feeling well        | <input type="checkbox"/> Confident            |
| <input type="checkbox"/> Would rather be with company when not feeling well | <input type="checkbox"/> Secure               |
| <input type="checkbox"/> Mood swings  |   |
| <input type="checkbox"/> Suicidal thoughts                                  |   |
| <input type="checkbox"/> Suicide attempts                                   |   |

Please review the list of conditions below carefully and check **ONLY** those which your child is experiencing **AT PRESENT**.

- |  |   |
|--|---|
| <input type="checkbox"/> Rough, Dry or Scaly Skin          | <input type="checkbox"/> Fever or Chills                    |
| <input type="checkbox"/> Psoriasis or Eczema               | <input type="checkbox"/> Intolerance to Heat                |
| <input type="checkbox"/> Itching Skin                      | <input type="checkbox"/> Intolerance to Cold                |
| <input type="checkbox"/> Pimples                           | <input type="checkbox"/> Excessive Hunger                   |
| <input type="checkbox"/> Brittle Nails                     | <input type="checkbox"/> Inability to Gain Weight           |
| <input type="checkbox"/> Burning Skin                      | <input type="checkbox"/> Change or Loss of Sensation        |
| <input type="checkbox"/> Boils or Canker Sores             | <input type="checkbox"/> Loss of Balance                    |
| <input type="checkbox"/> Skin Rash                         | <input type="checkbox"/> Seizures or Epilepsy               |
| <input type="checkbox"/> Skin Color Change                 | <input type="checkbox"/> Shaking or Trembling               |
| <input type="checkbox"/> Hair Color Change                 | <input type="checkbox"/> Lightheadedness upon Standing      |
| <input type="checkbox"/> Numbness                          | <input type="checkbox"/> Severe Headaches                   |
| <input type="checkbox"/> Paralysis                         | <input type="checkbox"/> Fainting Spells                    |
| <input type="checkbox"/> Lack of Coordination              | <input type="checkbox"/> Trauma or Injury to the Head       |
| <input type="checkbox"/> Loss of Memory                    | <input type="checkbox"/> Unexplained Fever                  |
| <input type="checkbox"/> Nervousness                       | <input type="checkbox"/> Burst of Energy Following Exercise |
| <input type="checkbox"/> Anxiety                           | <input type="checkbox"/> Difficulty Concentrating           |
| <input type="checkbox"/> Depression                        | <input type="checkbox"/> Difficulty Sleeping                |
| <input type="checkbox"/> Mood Swings                       | <input type="checkbox"/> Difficulty Relieving Stress        |
| <input type="checkbox"/> Restlessness                      | <input type="checkbox"/> Dizziness                          |
| <input type="checkbox"/> Fitful Sleep                      | <input type="checkbox"/> Pain in Ears                       |
| <input type="checkbox"/> Hallucinations                    | <input type="checkbox"/> Ringing in Ears                    |
| <input type="checkbox"/> Muscle Cramps                     | <input type="checkbox"/> Excessive Earwax                   |
| <input type="checkbox"/> Muscle Weakness                   | <input type="checkbox"/> Frequent Ear Infections            |
| <input type="checkbox"/> Joint Pain, Stiffness or Swelling | <input type="checkbox"/> Discharge from Ears                |
|  | <input type="checkbox"/> Loss of Hearing                    |
|  | <input type="checkbox"/> Sensitivity to Noise               |

Please review the list of conditions below carefully and check **ONLY** those which your child is experiencing **AT PRESENT**.

- |  |  |
|--|--|
| <input type="checkbox"/> Upper Back Pain                                     | <input type="checkbox"/> Dry Eyes  |
| <input type="checkbox"/> Lower Back Pain                                     | <input type="checkbox"/> Damp Eyes   |
| <input type="checkbox"/> Backache  | <input type="checkbox"/> Caked or Crusted Eyelids                          |
| <input type="checkbox"/> Frequent Fracturing of Bones                        | <input type="checkbox"/> Sensitivity to Light                              |
| <input type="checkbox"/> Unexplained Weight Gain or Loss                     | <input type="checkbox"/> Poor Eyesight                                     |
| <input type="checkbox"/> Overweight  | <input type="checkbox"/> Double Vision                                     |
| <input type="checkbox"/> Chronic Fatigue                                     | <input type="checkbox"/> Blurred Vision                                    |
| <input type="checkbox"/> Increased Thirst                                    | <input type="checkbox"/> Loss of Vision                                    |
| <input type="checkbox"/> Night Sweats  | <input type="checkbox"/> Eye Pain  |
| <input type="checkbox"/> Wounds Slow to Heal                                 | <input type="checkbox"/> Sore Gums   |
| <input type="checkbox"/> Swelling of Neck                                    | <input type="checkbox"/> Sore Throat                                       |
| <input type="checkbox"/> Stiff Neck  | <input type="checkbox"/> Sore Mouth or Tongue                              |
| <input type="checkbox"/> Neck Pain   | <input type="checkbox"/> Sensitive Teeth                                   |
| <input type="checkbox"/> Goiter  | <input type="checkbox"/> Impairment or Loss of Sense of Taste              |
| <input type="checkbox"/> Unusual Growths of Hair                             | <input type="checkbox"/> Increase or Decrease of Saliva                    |
| <input type="checkbox"/> Post Nasal Drip                                     | <input type="checkbox"/> Persistent Hoarseness                             |
| <input type="checkbox"/> Sinusitis   | <input type="checkbox"/> Difficulty Speaking                               |
| <input type="checkbox"/> Discharge from Nose                                 | <input type="checkbox"/> Constipation                                      |
| <input type="checkbox"/> Discharge from Nose During or After Meals           | <input type="checkbox"/> Diarrhea  |
| <input type="checkbox"/> Nose Bleeds   | <input type="checkbox"/> Rectal Pain                                       |
| <input type="checkbox"/> Difficulty Breathing Through Nose                   | <input type="checkbox"/> Hemorrhoids                                       |
| <input type="checkbox"/> Obstruction of Nose                                 | <input type="checkbox"/> Jaundice  |
| <input type="checkbox"/> Impairment or Loss of Sense of Smell                | <input type="checkbox"/> Hepatitis   |
| <input type="checkbox"/> Frequent or Daily Coughs                            | <input type="checkbox"/> Gallbladder Problems                              |
| <input type="checkbox"/> Frequent Colds                                      | <input type="checkbox"/> Difficulty Swallowing                             |
| <input type="checkbox"/> Shortness of Breath at Play                         | <input type="checkbox"/> Vomiting  |
| <input type="checkbox"/> Wheezing  | <input type="checkbox"/> Vomiting Blood                                    |
| <input type="checkbox"/> Shortness of Breath at Rest                         | <input type="checkbox"/> Loss of Appetite                                  |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Irritable if Late for a Meal                      |
| <input type="checkbox"/> Bronchitis  | <input type="checkbox"/> Frequently Awake at Night Hungry                  |
| <input type="checkbox"/> Tuberculosis  | <input type="checkbox"/> Sudden Cravings for Sweets                        |
| <input type="checkbox"/> Discharge from Throat Containing Blood and/or Mucus | <input type="checkbox"/> Headaches or Tremors Relieved by Consuming Sweets |
| <input type="checkbox"/> Chest Pain at Rest                                  | <input type="checkbox"/> Frequent Heartburn or Indigestion                 |
| <input type="checkbox"/> Chest Pain at Play                                  | <input type="checkbox"/> Frequent Stomach or Abdominal Pain                |
| <input type="checkbox"/> Heart Murmur  | <input type="checkbox"/> Frequent or Excessive Belching                    |
| <input type="checkbox"/> Heart Palpitations                                  | <input type="checkbox"/> Frequent or Severe Nausea                         |
| <input type="checkbox"/> Swelling of Ankles                                  | <input type="checkbox"/> Discomfort After Fatty or Greasy Meals            |
| <input type="checkbox"/> Rheumatic Fever                                     | <input type="checkbox"/> Inertia or Lack of Energy After Meals             |
| <input type="checkbox"/> Sleep in an Upright Position                        | <input type="checkbox"/> Yellow Stools                                     |
| <input type="checkbox"/> Frequently Awake at Night Short of Breath           | <input type="checkbox"/> Black Stools                                      |
|  | <input type="checkbox"/> Blood in Stools                                   |

Please review the list of conditions below carefully and check **ONLY** those which your child is experiencing **AT PRESENT**.

- |  |   |
|--|---|
| <input type="checkbox"/> Frequent Urination                            | <input type="checkbox"/> Malodorous Stools  |
| <input type="checkbox"/> Frequent Night Urination                      | <input type="checkbox"/> Anal Itching   |
| <input type="checkbox"/> Frequent Urgent Urination                     |   |
| <input type="checkbox"/> Painful Urination                             | <input type="checkbox"/> Discharge from Penis                                     |
| <input type="checkbox"/> Difficulty Holding Urine                      | <input type="checkbox"/> Lumps, Swelling or Pain in Testicles or Groin            |
| <input type="checkbox"/> Difficulty Initiating Urination               |   |
| <input type="checkbox"/> Frequent Urinary Infections                   |   |
| <input type="checkbox"/> Kidney Stones                                 | <input type="checkbox"/> Cold Hands and/ or Feet                                  |
|  | <input type="checkbox"/> Troubling Veins in Legs                                  |
|  | <input type="checkbox"/> Pain in Legs   |
| <input type="checkbox"/> Abdominal Bloating                            |   |
| <input type="checkbox"/> Excessive Lower Bowel Gas                     | <input type="checkbox"/> Swollen or Painful Lymph Nodes                           |
| <input type="checkbox"/> Stomach Pain 5 - 6 Hours After Meals          | <input type="checkbox"/> Easily Bruised   |
| <input type="checkbox"/> (Usually at Night)                            | <input type="checkbox"/> Bleeding   |
| <input type="checkbox"/> Symptoms Above Relieved by Drinking Milk      | <input type="checkbox"/> Anemia   |
| <input type="checkbox"/> Symptoms Above Aggravated by Worry or Tension |   |
|  |   |
| <input type="checkbox"/> Discharge from Vagina                         | <input type="checkbox"/> Clots in Menstrual Flow                                  |
| <input type="checkbox"/> Mood Swings with Menstruation                 | <input type="checkbox"/> Mood Changes with Menstruation                           |
| <input type="checkbox"/> Menstrual Flow is Excessive/Decreased/Absent  | <input type="checkbox"/> Increased Acne, Irritability or Weight with Menstruation |
| <input type="checkbox"/> Bleeding or Spotting Between Periods          | <input type="checkbox"/> Pelvic Pain  |
| <input type="checkbox"/> Pain Before, During and/ or After Periods     | <input type="checkbox"/> Lumps or Pain in Breasts                                 |
| <input type="checkbox"/> PMS (Cramping, Headaches, Water Retention)    | <input type="checkbox"/> Discharge from Breasts                                   |
| <input type="checkbox"/> Must Sleep in Upright Position                |   |

Menstrual Period: Period every \_\_\_\_\_ days. Period lasts \_\_\_\_\_ days.

Number of Tampons or Pads Used Daily? \_\_\_\_\_ Date of Last Period? \_\_\_\_/\_\_\_\_/\_\_\_\_ Age at Onset \_\_\_\_\_