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CHILDREN - FULL INITIAL INTAKE QUESTIONNAIRE

Name: _____ Date of First Visit: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Cell / Home / Work (Circle One)

Alt. Phone Number: _____ Cell / Home / Work (Circle One)

Email: _____

Date of Birth: _____ Age: _____ Place of Birth: _____

Who Do You Live With (Circle One): Both Parents / Just Mom / Just Dad / Other Family? _____

Foster Parents / Friends / Alone / Other _____

Education Level: _____ School Attended: _____

Emergency Contact/Next of Kin: _____

Relationship to client: _____

Phone Number: _____ Cell / Home / Work (Circle One)

Address: _____

How did you hear about us? _____

Has another family member already been a client with us? Yes / No (Circle One)

If yes, name: _____ Relationship: _____

SUCCESSFUL HEALTH CARE AND PREVENTIVE MEDICINE ARE ONLY POSSIBLE WHEN THE PHYSICIAN HAS A COMPLETE UNDERSTANDING OF THE CLIENT PHYSICALLY, MENTALLY, AND EMOTIONALLY. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE. PRINT ALL INFORMATION AND MARK ANYTHING YOU DON'T UNDERSTAND WITH A QUESTION MARK.

Health History Questionnaire

Are you currently receiving medical or health care? Yes / No (Circle One)

If yes, where & from whom? _____

If no, when & where did you last receive medical or health care?

What was the reason?

List your primary health concerns in order of importance & approximate date when symptoms began:

1) _____

2) _____

3) _____

4) _____

5) _____

Do you have any known contagious diseases at this time? Yes / No (Circle One)

If yes, please explain: _____

Allergies

Are you hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmental influences? _____

Family History

Check all that apply

	Father	Mother	Brother(s)	Sister(s)	Spouse	Child(ren)
Age (if living)						
Health (G = good / P = poor)						
Age at death (if deceased)						
Cause of Death:						
Anemia						
Asthma / Hay Fever / Hives						
Cancer						
Diabetes						
Epilepsy						
Glaucoma						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Mental Illness						
Stroke						
Tuberculosis						

General Information

Weight (lbs.): _____ Weight 1 year ago (lbs.): _____ Desired weight (lbs.) _____

Max. Weight (lbs.): _____ Approx. Date of Max Weight: _____

Height: _____ Blood Type? A / B / AB / O / + / - / Don't know (Please Circle)

What time is your energy at its best? _____ a.m. / p.m.

What time is your energy at its worst? _____ a.m. / p.m.

For the following sections, circle Y (yes), N (no), or P (past)

Childhood Illnesses

Scarlet Fever: Y/N Diphtheria: Y/N Rheumatic Fever: Y/N
Mumps: Y/N Measles: Y/N German Measles: Y/N

Hospitalization & Surgery

What hospitalizations or surgeries have you had?

Special Studies

X-Rays, CAT scans, or other studies you have had:

Electrocardiogram (EKG): Y/N Electroencephalogram (EEG): Y/N Angioplasty: Y/N

Immunizations

Polio: Y/N Pertussis: Y/N Tetanus Shot: Y/N Diphtheria: Y/N
Measles / Mumps / Rubella: Y/N Chicken Pox: Y/N Hep. B: Y/N
Other: _____

Current Medications – Do you take or use the following?

Laxatives: Y/N Pain Relievers: Y/N Antacids: Y/N
Steroids: Y/N Antibiotics: Y/N Appetite Suppressants: Y/N
Tranquilizers: Y/N Sleeping Pills: Y/N Thyroid Medication: Y/N

List any medications (prescription, over the counter, vitamins, or supplements) you are taking and why:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____
- 7) _____
- 8) _____
- 9) _____
- 10) _____

Food / Meals

Number of meals eaten per day: 1 / 2 / 3 / More than 3 Who cooks your food? _____
Where do you usually buy your food? _____
What restaurants do you frequent? _____

Typical Food Intake

Breakfast:

Lunch:

Dinner:

Snacks:

Drinks:

List all your food cravings regardless of nutritional value (i.e., comfort foods)

List the foods you exclude from your diet:

List any foods that do not settle well, or cause an undesired reaction:

Habits

Main interests & hobbies? _____

Do you or have you...

Average 6 – 8 hrs. of sleep? Y / N Sleep well? Y / N Wake rested? Y / N

Have a supportive relationship? Y / N Enjoy work? Y / N Take vacations? Y / N

Spend time outside? Y / N Read? Y / N Diet often? Y / N

Exercise regularly? Y / N

If yes, what kind & how often? _____

Watch television? Y / N

If yes, approximately how many hours a day? _____

Eat out often? Y / N

If yes, how often? _____

Eat refined sugar? Y / N / P Crave sugar? Y / N / P

Crave chocolate? Y / N / P Add salt routinely? Y / N / P

Have/had any major traumas? Y / N / P

If yes or past, please explain: _____

Have/had a history of abuse? Y / N / P

If yes or past, please explain: _____

Use/used recreational drugs? Y / N / P Or been treated for drug dependency? Y / N / P

If yes or past, please explain: _____

Been treated for alcoholism? Y / N / P

If yes or past, please explain: _____

Use/used tobacco? Y / N / P

If yes, how many packs a day and how long? _____

Drink coffee? Y / N / P

Drink black or green tea? Y / N / P

If yes, how many cups per day? _____

If yes, how many cups per day? _____

Drink cola or other sodas? Y / N / P

If yes, how many cans per day? _____

Been religious or spiritual? Y / N / P

If yes or past, please explain: _____

How does your condition affect your daily life?

What do you think is happening?

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

What do you enjoy most in your life?

How much change are you willing to make at this time to improve your health?

Minimal

Some

Complete