



Pediatric Patient Questionnaire

1. CONFIDENTIAL PATIENT INFORMATION:

Child's Name: _____ Date of Birth: _____

Parent/Guardian Name(s): _____ Child's SS #: _____

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Height: _____ Weight: _____

How did you hear about us? _____ Who is your primary care physician? _____

2. How did you hear about us?

Current Patient (List who) _____ Professional Referral/Doctor (List who) _____ Google Search _____

Facebook _____ Community Partner (List who) _____ Other (Specify) _____

3. Who is your primary care physician? _____ Date of your last visit: _____

Reason for your last doctor visit: _____

4. Is your child receiving care from any other health professionals?

- Yes
- No

5. If yes, please name them and their specialty:

	Name	Specialty
1		
2		
3		

6. Please list any drugs/medications/vitamins/herbs/other that your child is taking:

	Medication Name	Dosage	Frequency	Reason for Taking
1				
2				
3				

CURRENT HEALTH CONDITIONS

7. What are the primary health conditions for your child?

8. Please describe when your child's issues first began and how they've progressed since:

9. What makes things better?

10. What makes this worse?

19. Did mother drink?

- Yes No

If yes, how many per week?

20. Did mother exercise?

- Yes No

21. If yes, please explain:

22. Was mother ill?

- Yes No

23. If yes, please explain:

24. Any ultrasounds?

- Yes No

25. If yes, please explain:

26. Please explain any notable episodes of mental or physical stress during your pregnancy:

27. Please explain any other concerns or notable remarks about your child's conception or pregnancy:

LABOR & DELIVERY HISTORY

28. Child's birth was:

- Natural vaginal birth Scheduled C-section
 Emergency C-section

At how many week's was your child born?

29. Child's birth was:

- At home At a birthing center At a hospital
 Other

If other, specify:

30. Doctor/Obstetrician's Name:

31. Please check any applicable interventions or complications:

- Breech Induction Pain meds
 Epidural Episiotomy Vacuum extraction
 Forceps Other

If other, specify:

32. Please describe any other concerns or notable remarks about your child's labor and/or delivery.

33. Child's birth weight:

Child's birth height:

APGAR score at birth:

APGAR score after 5
minutes:

GROWTH & DEVELOPMENT HISTORY

34. Is/was your child breastfed?

- Yes No

If yes, how long?

35. Difficulty with breastfeeding?

Yes

No

36. Did they ever use formula?

Yes

No

37. If yes:

At what age:

What type:

38. Did/does your child ever suffer from colic, reflux, or constipation as an infant?

Yes

No

39. If yes, please explain:

40. Did/does your child frequently arch their neck/back, feel stiff, or bang their head?

Yes

No

41. If yes, please explain:

42. At what age did the child:

	Age
Respond to sound	
Follow an object	
Hold their head up	
Vocalize	
Teethe	
Sit alone	
Crawl	
Walk	
Begin cow's milk	
Begin solid foods	

43. Please list any food intolerance or allergies, and when they began:

	Allergy	Onset
1		
2		
3		

44. Please list your child's hospitalization and surgical history, including the year:

	Hospitalization/Surgery	Date
1		
2		
3		

45. Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the current year:

	Major injuries, accidents, falls and/or fractures	Date
1		
2		
3		

46. Have you chosen to vaccinate your child?

- No Yes, on a delayed or selective schedule Yes, on schedule

47. If yes, please list any vaccination reactions:

48. Has your child received any antibiotics?

- Yes No

49. If yes, how many times and list reason

50. Night terrors or difficulty sleeping?

- Yes No

51. If yes, please explain:

52. Behavioral, social or emotional issues?

- Yes No

53. If yes, please explain:

54. How many hours per day does your child typically spend watching a TV, computer, tablet or phone?

55. How would you describe your child's diet?

- Mostly whole, organic foods Pretty average High amount of processed foods

Patient Review of Systems

Below you will find 5 different sections with various conditions, symptoms or states of your system.

Please **CHECK** all boxes currently most associated with your health right **NOW**, or you have had in the PAST.

Your doctor will then use this in conjunction with the additional assessment testing to determine the type of care needed to serve you best.

56. Section 1

- | | | |
|---|--|---|
| <input type="checkbox"/> High Energy | <input type="checkbox"/> Mentally Alert | <input type="checkbox"/> Few Symptoms |
| <input type="checkbox"/> Excellent Health | <input type="checkbox"/> Resistant to Infections | <input type="checkbox"/> Positive Mental Attitude |
| <input type="checkbox"/> Active | <input type="checkbox"/> Vibrant | <input type="checkbox"/> Not Applicable |

57. Section 2

- | | | |
|--|---|---|
| <input type="checkbox"/> Poor Attention | <input type="checkbox"/> Spaciness | <input type="checkbox"/> Impulsive |
| <input type="checkbox"/> Easily Distracted | <input type="checkbox"/> Constipation | <input type="checkbox"/> Low Pain Threshold |
| <input type="checkbox"/> Disorganized | <input type="checkbox"/> Difficulty Walking | <input type="checkbox"/> Poor Concentration |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Irritable | <input type="checkbox"/> Lacking Motivation |
| <input type="checkbox"/> Worry | <input type="checkbox"/> Low Energy | <input type="checkbox"/> Not Applicable |

58. Section 3

- | | | |
|---|--|---|
| <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Poor Expression of Emotions | <input type="checkbox"/> Poor Immune System |
| <input type="checkbox"/> Cold Feet | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Accelerated Aging |
| <input type="checkbox"/> Tight Muscles | <input type="checkbox"/> Racing Mind | <input type="checkbox"/> Heart Palpitations |
| <input type="checkbox"/> Teeth Grinding | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Restless Sleep |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Not Applicable | |

59. Section 4

- | | | |
|---|---|---|
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Bed Wetting/Bladder Issues | <input type="checkbox"/> Sleepwalking |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Food Sensitivities |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Headaches | <input type="checkbox"/> Panic Attacks |
| <input type="checkbox"/> PMS | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Not Applicable | | |

60. Section 5

- | | | |
|---|---|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> ALS | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Epstein-Barr Syndrome | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Depression | <input type="checkbox"/> Autoimmune Disease |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Not Applicable | |

The TRUTH: The Disease Process *90-95% of disease is due to STRESS (not genetics) *Pre-birth brain controlled the development of EVERY SYSTEM *Post-birth brain controls and coordinates EVERY FUNCTION in your body *The longer the dysfunction, the more severe the disease (earliest correction is BEST) *The brain should be able to "fix" any issue IF it can communicate properly *STRESS affects the brain's ability to communicate properly *Poor brain function equals poor body function leading to symptoms and disease
 By signing below, I am agreeing that I have read the information presented above.

Signature

Stress Scale

Below is a list of stressors that adults can experience during their life, and will impact their health. Beside each stress, you will see a number listed. That is called a "Life Change Unit". Please write the value listed in "Life Change Units" for each of the stressors you have experienced in the past, or are experiencing currently. The **total sum** of life change units will help the doctors and team to have a rough estimate on how greatly your stressors are affecting your life.

61.	Life Event - Life Change Unit	My Score
	Death of parent - 100	
	Unplanned pregnancy/abortion - 100	
	Getting married - 95	
	Divorce of parents - 90	
	Acquiring a deformity - 80	
	Fathering a child - 70	
	Jail sentence of parent for over one year - 70	
	Marital separation of parents - 69	
	Death of a brother or sister - 68	
	Change in acceptance by peers - 67	
	Unplanned pregnancy of sister - 64	
	Discovery of being an adopted child - 63	
	Marriage of parent to stepparent - 63	
	Death of a close friend - 63	
	Having a visible congenital deformity - 62	
	Serious Illness requiring hospitalization - 58	
	Failure of a grade in school - 56	
	Not making an extracurricular activity - 55	
	Breaking up with boyfriend or girlfriend - 53	
	Hospitalization - 55	

Jail sentence of parent for over 30 days - 53	
Beginning to date - 51	
Suspension from school - 50	
Becoming involved with drugs or alcohol - 50	
Birth of a brother or sister - 50	
Increase in arguments between parents - 47	
Loss of job by parent - 46	
Outstanding personal achievement - 46	
Change in parent's financial status - 45	
Accepted at college of choice - 43	
Being a senior in high school - 42	
Hospitalization of a sibling - 41	
Increased absence of parent from home - 38	
Brother or sister leaving home - 37	
Addition of third adult to family - 34	
Becoming a full-fledged member of a church - 31	
Decrease in arguments between parents - 27	
Decrease in arguments with parents - 26	
Mother or father beginning work - 26	

What is your total score?

What does that score mean?

Score of 300+: At risk of illness

Score of 150-299: Risk of illness is moderate (reduced by 30% from the above risk)

Score of 150 or less: Only a slight risk of illness

62. Anything else you wish to share about your family or child?

63. Please answer below if you DO or DO NOT allow your child's image (photographs and/or videos) or likeness to be used in Media publications including, but not limited to: Social Media Posts, Videos, Email Blasts, Educational Brochures, Newsletters, Handouts, Magazines, General Publications, Website and/or Affiliates.

Yes, I DO consent

No, I DO NOT consent

ACKNOWLEDGEMENT & CONSENT

Signature

Date