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HEALTH HISTORY- PEDIATRIC

NAME: _____DATE: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: HOME: _____WORK: _____CELL: _____
EMAIL: _____
DATE OF BIRTH: _____AGE: _____WEIGHT: _____ HEIGHT: _____

Reason for consultation/goals/issues you'd like to address:

_____
_____
_____
_____
_____
_____

3 DAY DIET RECALL

Record everything that you eat and drink. Be as specific as possible as to size/amount of portion. Indicate how hungry you were and what you were doing while eating (i.e.: watching TV, driving, standing, talking, etc…)

DAY 1

BREAKFAST

_____
_____
_____
_____
_____
_____

MID-MORNING SNACK

_____
_____
_____

LUNCH

_____
_____
_____
_____
_____
_____

AFTERNOON SNACK

_____
_____
_____

DINNER

_____
_____
_____
_____
_____
_____

AFTER DINNER SNACK

_____
_____
_____

DAY 2

BREAKFAST

_____
_____
_____
_____
_____
_____

MID-MORNING SNACK

_____
_____
_____

LUNCH

_____
_____
_____
_____
_____
_____

AFTERNOON SNACK

_____
_____
_____

DINNER

_____
_____
_____
_____
_____
_____

AFTER DINNER SNACK

_____
_____
_____

DAY 3

BREAKFAST

_____
_____
_____
_____
_____
_____

MID-MORNING SNACK

_____
_____
_____

LUNCH

_____
_____
_____
_____
_____
_____

AFTERNOON SNACK

_____
_____
_____

DINNER

_____
_____
_____
_____
_____
_____

AFTER DINNER SNACK

_____
_____
_____

Do you overeat? _____ If so, which foods and how often? _____

Do you have food allergies, restrictions, or sensitivities? _____

Describe your daily energy levels:

Do you get noticeably irritable, light-headed, or weak if you haven't eaten in a while?

Do you crave certain foods? _____ If so, which foods and when? _____

Do you notice an increase in your symptoms with any foods?_____

Do you crave any of the following?

☐ Sugar ☐ Meat ☐ Fat ☐ Chocolate ☐ Fish ☐ Alcohol
☐ Desserts ☐ Milk ☐ Bread ☐ Fried foods ☐ Other _____

Do you take any nutritional supplements or vitamins? _____ If so, which ones? (Please be specific about brands and doses. Attach sheets if necessary)

Which prescription and over the counter medications do you take regularly?

Which oils do you use/consume?

☐ Butter ☐ Peanut Oil ☐ Canola ☐ Margarine ☐ Corn Oil ☐ Sun/Safflower
☐ Olive Oil ☐ Crisco ☐ Mayonnaise ☐ Coconut Oil ☐ Vegetable Oil ☐ Flaxseed Oil
☐ Soybean Oil ☐ Other_____

How is your dental health? _____
Have you ever had a filling removed or replaced? _____ If so, How Many_____ When? _____
Have you ever had any adverse reactions to vaccines or medications? _____
Which ones and when? _____

Please provide vaccines administered and the age they were administered. If you have a vaccine schedule you can attach that.

How many bowel movements do you have a day?

_____

Rank your skin without lotion: ☐ Very Dry ☐ Dry ☐ Normal ☐ Oily ☐ Combination

When did your symptoms begin? _____
How do your symptoms affect your life? _____
What improves your symptoms? _____
What make your symptoms worse? _____

Do you or have you ever participated in self injurious behavior (ie: cutting or burning yourself, punching or hitting yourself, misusing drugs or alcohol, deliberately starving or binge eating)? _____ If yes please describe your behavior._____
_____
_____

Have you ever, or are you currently, experiencing bullying or feeling unsafe? _____ If yes please describe.
_____
_____

Are you struggling with uncertainty regarding your sexuality? _____

Please check off any of the following that pertain to you now or in the past.

(Please mark Present conditions with a P next to it):

- ☐ Acne
- ☐ ADD/ ADHD
- ☐ Anemia
- ☐ Anorexia/Bulimia
- ☐ Anxiety or nervousness
- ☐ Arthritis (Rheumatoid or Osteo)
- ☐ Asthma
- ☐ Autism
- ☐ Autoimmune Disease _____
- ☐ Bladder infections (Cystitis)
- ☐ Bloating, gas or indigestion
- ☐ Blood Sugar problems
- ☐ Bronchitis
- ☐ Cancer
- ☐ Colds or flu (frequent)
- ☐ Cold Sores
- ☐ Chronic fatigue
- ☐ Constipation
- ☐ Dandruff
- ☐ Depression
- ☐ Diabetes I (insulin dependent)
- ☐ Diabetes II
- ☐ Difficulty losing weight
- ☐ Difficulty gaining weight
- ☐ Dizziness
- ☐ Ear Infections (current or past)
- ☐ Emotional problems (instability or sensitivity)
- ☐ Fainting
- ☐ Gall bladder problems
- ☐ Gout
- ☐ Hair loss or poor hair growth
- ☐ Hair: excessive growth, area _____
- ☐ Headaches
- ☐ Heart disease or problems
- ☐ Hemorrhoids
- ☐ Herpes simplex or type II
- ☐ Hiatal Hernia
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV
- ☐ Hot flashes
- ☐ Hypoglycemia
- ☐ Insomnia
- ☐ Intestinal problems
- ☐ Kidney stones
- ☐ Liver problems
- ☐ Loose stools
- ☐ Learning Disabilities_____
- ☐ Memory loss or confusion
- ☐ Nails, poor growth
- ☐ OCD
- ☐ ODD
- ☐ PANDAS
- ☐ Panic attacks
- ☐ Parasites
- ☐ Recurrent Strep infections
- ☐ Reflux / Heartburn
- ☐ Respiratory problems
- ☐ Ringing in ears
- ☐ Seizures
- ☐ Severe mood swings
- ☐ Skin conditions
- ☐ Stroke
- ☐ Suicidal tendencies
- ☐ Thyroid condition
- ☐ Tics
- ☐ Ulcers
- ☐ Yeast Infections (candidiasis)

Pediatrician: _____ Telephone number:_____

Birth: Vaginal _____ Cesarean Section _____ IVF or Assisted Fertility: _____

Please describe any pregnancy or delivery complications: _____
_____

Please describe any medications taken during pregnancy or medications taken for fertility: _____
_____

Injuries or falls: _____

Serious medical events: (ie: surgeries, loss of consciousness, drug side effects)
_____

Please list any hospitalizations with dates and events:

_____
_____
_____
_____

Females Only:

Date Menstrual Cycle first began: _____
Date of last Menstrual Cycle: _____
Duration of Menstrual Cycle: _____
Heavy Periods ☐ yes ☐ no
Painful Periods ☐ yes ☐ no
Irregular Periods ☐ yes ☐ no Please describe the irregularity: _____
Birth Control Pills ☐ yes ☐ no

Have you had a sudden loss or gain in weight? _____ How much loss/gain? _____ Period of time: _____
Do you have any concerns about your weight being either underweight or overweight? _____

Please describe your concerns.

_____
_____
_____

Please list any disease, illness, or ailments in your immediate family (i.e., mother-breast cancer, father-type II diabetic, grandfather-heart disease).

_____
_____
_____
_____
_____
_____

Do you exercise? _____ If so, what kind? _____
How often: Since when? _____

Please rate the following:

Daily energy level:	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Energy level after exercise:	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Daily stress level:	☐ Very High	☐ High	☐ Moderate	☐ Low

Do you have a support system of family and friends? _____
General enjoyment of life: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How many hours do you sleep? _____ Do you sleep throughout the night? _____
Do you wake up without an alarm? _____ Do you wake up feeling rested? _____
Do you fall asleep within 15 minutes? _____ How many nights a week do you sleep through the night? _____

Please describe any health concerns you think are important:

_____
_____
_____
_____

By signing below, I acknowledge that any dietary or supplemental suggestions made by this office are entirely nutritional in nature, and are not intended as the diagnosis, cure or treatment for any disease or ailment. I also acknowledge that my physician is my primary health care provider and is responsible for supervising all changes in diet and nutrient intake that I make. I understand that insurance is not accepted for this service, there are no diagnostic codes or forms available for this procedure, and no insurance claim forms will be filled out for this service. I further understand that there are no refunds for this service.

Date: _____

Name: _____

Signature: _____

Guardian's Name: (if minor child) _____

Guardian's Signature: (if minor child) _____