



For Office Use Only:

| | |
|--|------------------------------|
| <input type="checkbox"/> Bloomington Natural Care Center | Date: _____ |
| <input type="checkbox"/> Burnsville Natural Care Center | |
| <input type="checkbox"/> Woodwinds Natural Care Center | |
| <input type="checkbox"/> Edith Davis Teaching Clinic | |
| <input type="checkbox"/> University Health Service | |
| | Account Number: _____ |

Child's Name: _____
(Last, First, Middle Initial)

Mother's Name: _____
(Last, First, Middle Initial)

Address: _____

Phone: _____ Occupation: _____

Father's Name: _____
(Last, First, Middle Initial)

Address: _____

Phone: _____ Occupation: _____

Sibling's Name: _____ Age: _____ Sex: _____

Sibling's Name: _____ Age: _____ Sex: _____

Sibling's Name: _____ Age: _____ Sex: _____

Sibling's Name: _____ Age: _____ Sex: _____

Primary Healthcare Provider and/or Clinic: _____

Address: _____

Phone: _____

Your answers to the following questions will help us learn more about your child's health. Please take a few minutes to complete this questionnaire; you may skip any questions you are uncomfortable answering.

1. What is your child's chief complaint today? _____

Check all that apply.

1Neck / Back / Joint pain

2Headaches

3Depression / Anxiety

4Respiratory Problems (e.g., asthma, allergies, sinus congestion)

5Digestive Problems (e.g., poor appetite, heartburn, constipation, diarrhea)

6Urinary Problems (e.g., difficult or painful urination, kidney stones)

- 7Fatigue or low energy
- 8Female reproductive health
- 9Male reproductive health
- 10.....Stress management
- 11.....General wellness
- 12Other: _____

2. Health History

Please list any health problems your child currently has or has had. Answer to the best of your knowledge.

- Cancer (malignant or metastatic):

- Diabetes (Type I or II):

- Infectious Diseases (e.g. hepatitis, HIV):

- Heart, Lungs and Circulation (e.g. asthma, heart murmur):

- Digestive System (e.g. poor appetite, heartburn, constipation, diarrhea):

- Psychosocial Health (e.g. depression, anxiety, violence toward self or others):

- Skeleton and joints (e.g. arthritis, back or neck pain):

- Genitourinary System (e.g. difficult or painful urination, kidney stones, sexually transmitted diseases, painful menses):

- Nervous System (e.g. headache, dizziness):

- Eyes, ears, nose, and throat (e.g. loss of vision or hearing, ear infections, severe dental problems):

- Skin (e.g. rashes, sores, moles that have changed):

- Chronic Immune System deficiencies (e.g. colds, sinusitis, bronchitis):

- Other:

Family health History

Do/did any members of your immediate family (mother, father, sister, brother) have any serious health conditions?

- No
- Yes → Please describe your relation to this individual and their condition

3.

PREGNANCY

Please check any areas that applied to the patient's mother during her pregnancy:

- | | | |
|--|--|--|
| <input type="checkbox"/> Complications | <input type="checkbox"/> Vitamins/Minerals | <input type="checkbox"/> Toxic Exposures |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Any diagnosed illnesses | <input type="checkbox"/> Allergic Reactions |
| <input type="checkbox"/> Recreational drugs | <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Mental Trauma |
| <input type="checkbox"/> Smoking | <input type="checkbox"/> Immunization | <input type="checkbox"/> Physical Injury |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Prenatal Classes |
| <input type="checkbox"/> Caffeine: Cola | <input type="checkbox"/> Premature Contractions | <input type="checkbox"/> Chiropractic Care |
| <input type="checkbox"/> Caffeine: Coffee | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Prenatal Care |
| <input type="checkbox"/> Caffeine: Tea | <input type="checkbox"/> Other Pain | <input type="checkbox"/> Carried to Full Term |
| <input type="checkbox"/> Caffeine: Chocolate | <input type="checkbox"/> Excessive Weight Loss | <input type="checkbox"/> Attitude – Mostly Happy |
| <input type="checkbox"/> Caffeine: Other | <input type="checkbox"/> Excessive Weight Gain | <input type="checkbox"/> Attitude – Mostly Depressed |

4.

LABOR AND DELIVERY

- | | |
|--|---|
| <input type="checkbox"/> Greater than 12 Hours | <input type="checkbox"/> Caesarian |
| <input type="checkbox"/> Complications | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Fetal Monitor Used | <input type="checkbox"/> Home Birth |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Premature Delivery |
| <input type="checkbox"/> Forceps | <input type="checkbox"/> Vacuum Extraction |
| Other _____ | |

5. PERINATAL HISTORY – *If known please indicate*

The duration of the pregnancy was _____ weeks.
 The apgar score at birth was _____
 The apgar score at five minutes was _____
 The length at birth was _____
 The birth weight was _____

Please check any problems the patient had at birth:

- | | |
|---|-----------------------------------|
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Nursing |
| <input type="checkbox"/> Coloring | <input type="checkbox"/> Sleeping |
| <input type="checkbox"/> Crying | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Choking | |
| <input type="checkbox"/> Other _____ (Please Explain) | |

Please check if any item(s) applied to the patient at birth:

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Medication | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Artificial Feeding | <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> Vitamin K | <input type="checkbox"/> Circumcision |
| <input type="checkbox"/> Other _____ (Please Explain) | |

Please list your child's allergies: _____

Please list any surgeries your child has had in the past, and their date: _____

Please list any traumas or injuries: _____

Please list current medications: _____

6. NUTRITION

Please check if the patient has received any of the following items:

- | | |
|---|---|
| <input type="checkbox"/> Breast Milk | <input type="checkbox"/> Sweets |
| <input type="checkbox"/> Commercial Formula | <input type="checkbox"/> Juice: Fruit |
| <input type="checkbox"/> Cow's Milk | <input type="checkbox"/> Juice: Vegetable |
| <input type="checkbox"/> Goat's Milk | <input type="checkbox"/> Vitamins |
| <input type="checkbox"/> Solid Foods | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Other _____ | (Please Explain) |

7. IMMUNIZATION

Please list any immunizations the patient has received along with the date it was received and any reactions observed: _____

Note foreign travel: _____

8. Please identify your race, as defined by the federal government. (Please check one)

- 1Asian or Pacific Islander
- 2Black/African American
- 3Hispanic
- 4American Indian or Alaskan Native
- 5White
- 6Other _____

Any of the following problems for mother during the pregnancy?

| | | | |
|--|--|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Sugar | <input type="checkbox"/> Excess Sugar Use | <input type="checkbox"/> Emotional Trauma |
| <input type="checkbox"/> Spotting, Bleeding, Hemorrhage | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Excess Alcohol Use | <input type="checkbox"/> Physical Trauma |
| <input type="checkbox"/> Morning Sickness (1 st trim) | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Recreational Drug Use | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Morning Sickness (2 nd , 3 rd trim) | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Abortions/Miscarriages | _____ |
| <input type="checkbox"/> Vaginal Infections | <input type="checkbox"/> Preeclampsia, Eclampsia | <input type="checkbox"/> Kidney and/or Bladder Infections | |

DEVELOPMENTAL HISTORY (if patient is less than 3 years old)

Any of the following problems during infancy?

| | | | |
|---|--|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Colic |
| <input type="checkbox"/> "Blue Baby" | <input type="checkbox"/> Feeding Difficulties | <input type="checkbox"/> Rashes | <input type="checkbox"/> Injuries |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Fever | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other _____ |

Was child breastfed? No Yes; for how long? _____ Any problems? _____

Was child put on formula? No Yes; what kind? _____ Any problems? _____

Age at which solid foods introduced _____ Food introduced _____

Please indicate if there were any problems with the following and age when activity first started:

AGE

Holding head up while on stomach _____

Rolling from front to back and back to front _____

Sitting with and without support _____

Crawling _____

Teething _____

Talking (first word, combination of words, sentences) _____

Walking with and without support _____

Toilet training _____

Any particular habits (thumb sucking, nail biting, head banging, rocking) _____

Were there any nightmares, terrors, or sleepwalking? _____

DENTAL HISTORY

Last Dental Exam: _____

Describe any dental work done: _____

What is the oral hygiene practice of the child? _____

Is your child's toothpaste fluoridated? No Yes

Does your child have bleeding gums? No Yes

VISION HISTORY

Last Vision Exam: _____

Describe any vision problems: _____

FAMILY HISTORY (Indicate maternal with "M" and paternal with "P")

| | | | |
|--|--|---|---------------------------------------|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Allergies/Hay fever | <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Mental Illness | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Thyroid (hyper/hypo) | |

OVERALL HEALTH

Digestion

| | |
|---|--|
| <input type="checkbox"/> Weak appetite | <input type="checkbox"/> Bloating |
| <input type="checkbox"/> Strong appetite | <input type="checkbox"/> Gas |
| <input type="checkbox"/> Body/breath odor | <input type="checkbox"/> Number of bowel movements a day |
| <input type="checkbox"/> Excess gas | Color _____ |
| <input type="checkbox"/> Abdominal pains | <input type="checkbox"/> Formed |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Soft |
| <input type="checkbox"/> Canker sores | |

Other comments: _____

Sleep

| | |
|----------------------------------|--|
| <input type="checkbox"/> Light | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Deep | <input type="checkbox"/> Nightsweats |
| <input type="checkbox"/> Lacking | <input type="checkbox"/> Difficulty falling asleep |
| <input type="checkbox"/> Excess | <input type="checkbox"/> Nightmares |

Position: _____

Other comments: _____

Immune System

| | |
|---|---|
| <input type="checkbox"/> Good | <input type="checkbox"/> Sore throats |
| <input type="checkbox"/> Poor | <input type="checkbox"/> High fevers |
| <input type="checkbox"/> Frequent colds/flu | <input type="checkbox"/> Chronic coughs |

Other comments: _____

Mental Emotional Disposition

How does your child express the following emotions?

Anger _____

Sadness _____

Anxiety _____

Happiness _____

Fear _____

What fears does your child have _____

List major experiences of grief/loss in your child's life and how your child has coped with them: _____

Name: _____ Dates: _____

Food Plan Instructions:

- Please record, in honesty, what you eat for a few days. It will benefit you more to be real and not ideal!
- Include condiments, drinks, snacks, supplements (vitamins/minerals/herbs/homeopathic remedies).
- Include any comments, symptoms (emotional/mental/physical), energy levels, etc at the end of each column for each day.
- Be specific in your recordings by including what type of food is eaten ("white bread" or "whole wheat bread"), the quantity (cups, tsp, oz, etc), how it was prepared (baked, boiled, deep fried, etc) and the time of day it was eaten.

| | Breakfast | Snack | Lunch | Snack | Dinner | Snack |
|-------|-----------|-------|-------|-------|--------|-------|
| Day 1 | | | | | | |
| Day 2 | | | | | | |
| Day 3 | | | | | | |

How many meals do you generally eat each day? One Two Three More than three

How often do you skip meals? Never Once or twice a month Once a week More than once a week

Where do you usually buy your food? _____

Who cooks the food you eat? _____

List the foods you exclude from your diet and why: _____

List any foods you crave, regardless of their nutritional value: _____

List any foods to which you are allergic to or have a bad reaction to and how you react: _____

Are you thirsty? No Yes Amount of plain water you drink each day _____

What type of water do you drink? Distilled water Filtered Spring Well Deionized Tap

At what temperature do you prefer to drink liquids? Hot Cold Room temp