



New Patient Health Questionnaire

Thank you for taking the time to fill out this new patient health questionnaire. This questionnaire is an important part of your child's initial consultation. Accurate completion of this form will ensure more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will assist your doctor in formulating the most appropriate treatment plan.

Personal Information			
Patient's Name: _____	Date of Birth: _____	Male	Female
Requesting appointment with:			
<input type="checkbox"/> Dr. Elisa Song (not available)	<input type="checkbox"/> Dr. Donna Ruiz	<input type="checkbox"/> Dr. Suruchi Chandra	<input type="checkbox"/> No preference
Form Completed by (include relation to patient):			
Name/Address of Primary Care Physician:			
Name/Address of Additional Therapists/Specialists Working With Your Child (if any):			
Name/Address of Additional Therapists/Specialists Working With Your Child (if any):			
Name/Address of Additional Therapists/Specialists Working With Your Child (if any):			

Please check appropriate box(es):

- | | | | |
|---|------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> African American | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Mediterranean | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Native American | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Northern European | <input type="checkbox"/> Other _____ |

Diagnosis

Please describe your child's main medical diagnoses or problem(s) that you would like addressed today:

Dates of diagnosis and diagnosing practitioner (please include address and telephone number):

What factors or events, if any, do you believe may have triggered your child's problem/illness?

What are your goals of treatment for your child?

Please describe your child, in as much detail as possible (personality, likes and dislikes, temperament, etc.). Tell me their story (you may use the additional sheet at the end of this document if necessary)...

Current Symptoms or Health Concerns

- | | | |
|---|---|--|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Allergies | <input type="checkbox"/> Attention Problems |
| <input type="checkbox"/> Behavioral Difficulties | <input type="checkbox"/> Constipation | <input type="checkbox"/> Developmental Delay |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Eczema | <input type="checkbox"/> Energy Problems |
| <input type="checkbox"/> Environmental Issues | <input type="checkbox"/> Frequent Infections | <input type="checkbox"/> Medications/Therapies |
| <input type="checkbox"/> Nutrition | <input type="checkbox"/> Obsessions/Compulsions | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Sensory Issues | <input type="checkbox"/> Sleep Issues | <input type="checkbox"/> Tics |
| <input type="checkbox"/> Vaccinations | | |
| <input type="checkbox"/> Other Neurologic Issues (please describe): | | |
| <input type="checkbox"/> Other (please describe): | | |

Current Therapies

Please describe your child's current therapies:

- | | | | |
|---|---|---------------------------------------|---|
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Auditory training | <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Craniosacral |
| <input type="checkbox"/> Energy therapy | <input type="checkbox"/> Homeopathy | <input type="checkbox"/> Lovaas- ABA | <input type="checkbox"/> Naturopathy |
| <input type="checkbox"/> Neural Therapy | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Osteopathy | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Sensory Diet | <input type="checkbox"/> Speech Therapy | | |
| <input type="checkbox"/> Other (please describe): | | | |

Please list all therapies tried and stopped (use additional sheet at the end of this document if necessary):

Therapy tried	Reason Stopped

Past Medical History

Please list any other medical problems that your child has had :

- | | | |
|---|--|--|
| <input type="checkbox"/> Colic | <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Pneumonia/Bronchitis |
| <input type="checkbox"/> Throat Infections | <input type="checkbox"/> Recurrent colds | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Persistent Diaper Rashes | <input type="checkbox"/> Thrush | <input type="checkbox"/> Behavior problems |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Dental amalgam fillings |
| <input type="checkbox"/> Other (please describe): | | |

Please list any medications or supplements that your child has taken in the past, including antibiotics and steroids, and dates of use:

Please list any hospitalizations, emergency room visits, or surgeries. Please give dates, locations, diagnoses, lengths of hospital stays, and surgeries:



Medication/Supplement History

Please list all current medications, vitamins, nutritional supplements, herbs, homeopathic remedies, etc. (use additional sheet at the end of this document if necessary):

Supplement/Medication	Dose	Frequency	How long?

Please list all medications/supplements stopped secondary to not working or negative response. If there was a negative response, please describe. (use additional sheet at the end of this document if necessary):

Supplement/Medication	Reason Stopped

Vaccine History

Please provide a copy of your child's immunization record. Please describe any reactions that your child has had to vaccinations:

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Birth History	
Prenatal/Pregnancy History	
Maternal age at delivery:	
Fertility treatments?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please list which ones):
Illnesses during pregnancy:	
Medications during pregnancy (including rhogam, antibiotics, vaccines, herbs, nutritional supplements, others):	
Stressors during pregnancy:	
Dental amalgams before or during pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other complications during pregnancy:	
Birth History	
Mode of delivery:	<input type="checkbox"/> Vaginal delivery <input type="checkbox"/> C-section (If c-section, please explain why):
If vaginal, was labor induced or augmented with any pitocin or other medications: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, which medication?):	
Forceps or vacuum used?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gestation:	<input type="checkbox"/> Premature <input type="checkbox"/> Full-term
Birth weight:	Apgar scores (if known):
Please describe any other complications after delivery:	
Postpartum History	
Did your child have jaundice?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, describe what treatments were needed):
Did you or your child receive antibiotics after delivery?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, why?):
Did your child receive any vaccines after delivery?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, which ones):
Did you or your child receive any other medications after delivery?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, why?):
Did you suffer from postpartum blues/depression?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please describe any medication or treatments that you required:	

Developmental History

List the age when the following skills were mastered and any problems associated with them:

Has your child's development been normal? Yes No If no, please describe the developmental problem(s), and at what age the problem(s) began to appear:

First words (mama, dada, etc.):

Phrases or sentences:

Sitting unsupported:

Crawling:

Pulling to stand:

Walking unsupported:

Climbing:

Running:

Walking up/down stairs unassisted:

Jumping:

Hopping on one foot:

Pedaling a tricycle:

Riding 2-wheel bicycle:

Feeding self with spoon:

Put on clothing:

Potty-trained:

Sleep History

Please describe the pattern and quality of your child's sleep? (i.e., does your child sleep soundly, or toss and turn, have nightmares? Does your child wake up refreshed?)

What time does your child typically fall asleep at night?

What time does your child typically wake up?

How many hours of sleep does your child get every day?

Does your child fall asleep easily? Yes No If no, please explain:

Does your child stay asleep through the night? Yes No If no, please explain:

Allergies/Sensitivities

Please list any medications or supplements that your child has had a reaction to. Describe the reaction:

Please list any other sensitivities that you child has, or that you suspect your child may have:

- | | | | | |
|---|--|---|---|------------------------------------|
| <input type="checkbox"/> Perfumes/cosmetics | <input type="checkbox"/> Cleaning products | <input type="checkbox"/> Soaps | <input type="checkbox"/> Detergents | <input type="checkbox"/> Gasoline |
| <input type="checkbox"/> Dust | <input type="checkbox"/> Mold | <input type="checkbox"/> Pollens/Grasses | <input type="checkbox"/> Animals (dander) | <input type="checkbox"/> Chemicals |
| <input type="checkbox"/> Other (please describe): | | <input type="checkbox"/> Foods, which ones? | | |

Environmental History

Water: City Well Purification system? Yes No If yes, please describe:

Type of Heat: Electric Gas Oil Other If other, please describe:

Live near: Power lines Woods Industrial Areas Water

If you live near water, list type: River Ocean Swamp Other If other, please describe:

Child's bedding: Down Synthetic Mattress/pillow cover? Yes No

Flooring: Carpet Area rug Wood Other If other, please describe:

Does your home have a lot of: Dust Mold

Is your child exposed to cigarette smoke? Yes No

Travel history:

Please list any other exposures your child may have had in the past and present:

Digestive History

How often does your child have a bowel movement?

What is your child's stool like (check all that apply)?

- Well-formed Mucousy Loose, falls apart Watery
 Small, hard pieces Greasy, floats Bloody Thin and long, ribbons
 Foul-smelling Painful Lots of undigested food particles
 Other (please describe):

Does your child have heartburn or reflux? Yes No (If yes, please list any treatments):

Does your child have frequent gas or belly bloating? Yes No (If yes, please describe):

Does your child have any abdominal pain? Yes No (If yes, please describe):

Diet History

Was your child breastfed? Yes No If yes, for how long? _____

Was your child bottle-fed? Yes No Brand of formula? _____

Begun at what age? _____ For how long? _____

At what age were solids introduced? _____ First foods:

Do you have any concerns about your child's current diet? Yes No
If yes, what concerns?

Please describe your child's current diet:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> No restrictions | <input type="checkbox"/> Gluten Free | <input type="checkbox"/> Casein Free | <input type="checkbox"/> Yeast Free |
| <input type="checkbox"/> Salicylate Free | <input type="checkbox"/> Low Phenolics | <input type="checkbox"/> Organic | <input type="checkbox"/> High Protein/Low Carb |
| <input type="checkbox"/> IgG Reactive Foods Avoidance | | <input type="checkbox"/> Specific Carbohydrate Diet | |
| <input type="checkbox"/> Other (please describe): | | | |

Please describe your child's typical breakfast:

Please describe your child's typical lunch:

Please describe your child's typical dinner:

Please describe your child's typical snacks:

What does your child drink throughout the day?

Does your child eat refined sugar? Yes No (If yes, what kind and how often):

Does your child eat fast food? Yes No (If yes, what kind and how often):

Does your child eat food with artificial colors/flavorings or preservations? Yes No (If yes, how often):

Does your child eat artificial sweeteners? Yes No (If yes, what kind and how often):

Does your child drink soda? Yes No (If yes, what kind and how often):



Please list all diets tried and stopped (use additional sheet at the end of this document if necessary):	
Diet tried	Reason Stopped

School History	
School Name:	
Address:	
Grade:	
Teacher:	
Phone:	Fax:
Does your child have an Individualized Education Plan (IEP)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your child receive any special services at school? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list:	
Do you have any concerns regarding your child's school progress (academics, social, teacher, peer relationships)?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe:

Social History

Who lives in the home with your child?

Please list any pets in the house:

Please list any caregivers beside parents:

Please describe family relationships:

Please describe any recent stressful events (life changes, losses, births, deaths, divorce, remarriage, moves, illness, financial problems, arguments with family/friend, etc.):

How does your child interact with other children?

How does your child interact with adults?

What makes your child:

Happy?

Sad?

Angry?

Stressed?



Please send copies of any evaluations, consultations, laboratory tests, vaccinations, and any other information you feel is important for us to review.

Please use this space to describe anything else you would like us to know about your child. List any other history, pertinent thoughts, or question that you would like to address:



Additional Space

Please use this area when additional space was needed elsewhere in the questionnaire.