Wellness Kids Intake Form

1. Please enter your information.

First Name: ____ Middle Initials: ____ Last Name: ____ Date of Birth: ____

Gender:
○ Female ○ Male

Marital Status:
○ Single ○ Married ○ Domestic Partner ○ Separated ○ Divorced ○ Widowed

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

Mobile Phone: ____ Home Phone: ____ Work Phone: ____

Email: ____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

2. Mother's Name:

____

3. Father's Name:

____

4. What is your main reason for today’s visit?

____

5. Major current health complaints in order of importance to you:

	Complaint	Since when?	Causes
1			
2			

6. Current complaint:

Describe current complaint:

____

0 - Not difficult / 10 - Unbearable
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

7. Current symptoms checklist. Rate intensity of symptoms currently present:

	None	Mild	Moderate	Severe

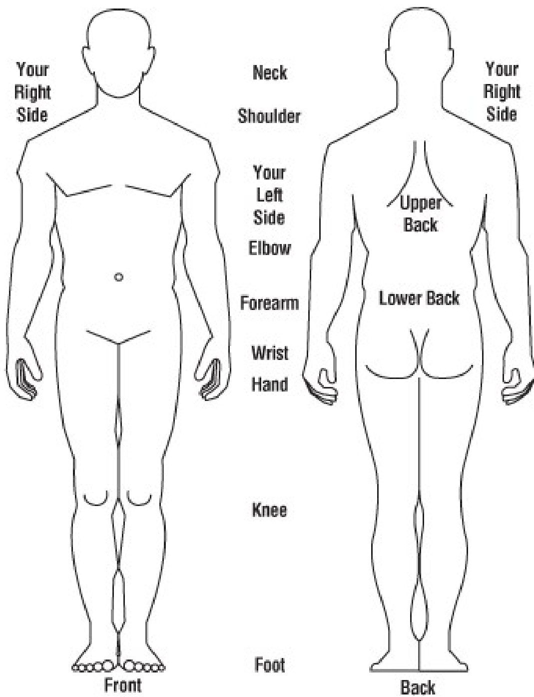
Aggressive Behaviors				
Agitation				
Anorexia				
Appetite Disturbance				
Bingeing / Purging				
Circumstantial Symptoms				
Concomitant Medical Condition				
Conduct Problems				
Delusions				
Depressed Mood				
Dissociative States				
Elevated Mood				
Elimination Disturbance				
Emotional Trauma Perpetrator				
Emotional Trauma Victim				
Emotionality				
Fatigue / Low energy				
Generalized Anxiety				
Grief				
Guilt				
Hallucinations				
Hopelessness				
Hyperactivity				
Irritability				
Laxative / Diuretic abuse				
Loose associations				
Mood swings				
Obsessions / Compulsions				
Oppositional behavior				
Panic attacks				
Paranoid ideation				
Phobias				
Physical trauma perpetrator				
Physical trauma victim				

Poor concentration				
Poor grooming				
Psychomotor retardation				
Self-multilation				
Sexual dysfunction				
Sexual trauma perpetrator				
Sexual trauma victim				
Significant weight gain/loss				
Sleep disturbance				
Social isolation				
Somatic complaints				
Substance abuse				
Worthlessness				
Other				

If "other", please specify

____

8.Please indicate areas of concern:



9. Which medications are you currently taking?

	Medication	Since when?	Adverse effects
1			
2			

10. If you could help your child in 3 ways, what would they be?

11. When was the last time you felt your child was well?

12. Did something trigger your child's change in health?

13. Is there anything that makes your child feel worse?

14. Is there anything that makes your child feel better?

15. Please describe your current health concern and how it began - in order of priority:

	Health Concern	When it began
1		
2		
3		
4		

16. Health history - Musculo-skeletal

- ☐ Headaches
- ☐ Joint stiffness/swelling
- ☐ Broken/fractured bones
- ☐ Back pain
- ☐ Hip pain
- ☐ Leg pain
- ☐ Problems walking
- ☐ Chest, ribs, abdominal pain
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Bone or joint disease
- ☐ Other

If "other", please specify

____

17. Health history - Skin

- ☐ Acne
- ☐ Cosmetic surgery
- ☐ Rashes
- ☐ Allergies
- ☐ Athlete's foot
- ☐ Warts
- ☐ Hives
- ☐ Other

If "other", please specify

____

18. Health history - Reproductive system

- ☐ Hysterectomy
- ☐ Endometriosis
- ☐ Pelvic inflammatory disease
- ☐ PMS
- ☐ Menopause
- ☐ Fertility concerns
- ☐ Prostrate concerns
- ☐ Other

If "other", please specify

____

19. Health history - Circulatory and respiratory

- ☐ Dizziness
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Cold feet or hands
- ☐ Night sweats
- ☐ Swollen ankles
- ☐ Blood clots
- ☐ Stroke
- ☐ Heart condition
- ☐ Allergies
- ☐ Sinus problems
- ☐ Asthma
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Other

If "other", please specify

____

20. Health history - Nervous system

- ☐ Spinal cord injury
- ☐ Chronic fatigue syndrome
- ☐ Numbness/tingling
- ☐ Twitching of face
- ☐ Fatigue
- ☐ Chronic pain
- ☐ Sleep disorders
- ☐ Ulcers
- ☐ Paralysis
- ☐ Herpes/shingles
- ☐ Cerebral palsy
- ☐ Epilepsy
- ☐ Multiple sclerosis
- ☐ Muscular dystrophy
- ☐ Parkinson's disease
- ☐ Other

If "other", please specify

____

21. Health history - Digestive

- ☐ Nervous stomach
- ☐ Indigestion
- ☐ Constipation
- ☐ Intestinal gas
- ☐ Bloating
- ☐ Diarrhea
- ☐ Diverticulitis
- ☐ Crohn's disease
- ☐ Colitis
- ☐ Irritable bowel
- ☐ Food allergies
- ☐ Other

If "other", please specify

____

22. Health history - Other

- ☐ Migraine
- ☐ Cancer
- ☐ Loss of appetite
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Hearing impaired
- ☐ Visually impaired
- ☐ Bladder infection
- ☐ Eating disorder
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Infectious disease
- ☐ Other

If "other", please specify

____

23. Your vaccination history:

	Yes	No
Chicken pox		
Diphteria		
Measles		
Mumps		
Rubella/German Measles		
Tetanus		
Whooping Cough		

24. Any other vaccinations?

____

____

____

____

25. Any adverse effects from any of these vaccinations?

____

____

____

____

26. Do you consume the following? Check "yes" for those applicable and include frequency:

	Yes	Frequency
Artificial sweeteners		
Soy products		
MSG		
Dairy		
Eggs		
Nuts / seeds		
Alcohol		
Fast foods		
Sweets / desserts		
Fried foods		
Coffee / black tea		
Soda / diet soda		
Fruit juice or fruit drinks		
Bread / pasta (refined)		
Whole grains		
Red meat		
Poultry		
Pork		
Seafood		
Beans		
Legumes		
Vegetables		
Whole fruits		
Water		
Other(s)		

If "other(s)", please specify

____

27. What influences your food choices? Check all that apply:

- ☐ Taste
- ☐ Nutrition
- ☐ Price
- ☐ Convenience
- ☐ Family members
- ☐ Friends
- ☐ Partner
- ☐ Other

If "other", please specify

____

28. Describe your childhood mealtime environment (peaceful, nurturing, rushed, chaotic, hostile, lonely, irregular, etc.):

____
____
____
____

29. How would you describe your bowel movement?

- ☐ Strained
- ☐ Loose
- ☐ Soft
- ☐ Hard
- ☐ Very thin
- ☐ Diarrhea
- ☐ Explosive
- ☐ Constipated
- ☐ Undigested food
- ☐ Blood in stool
- ☐ Mucus in stoll
- ☐ Regular
- ☐ Other

If "other", please specify

____

30. As a child, did you experience dificulty with any of the following? You may use the boxes to further specify the behaviors. Check all that apply:

- ☐ Animal cruelty ____________
- ☐ Assaults to others ____________
- ☐ Bizarre behavior ____________
- ☐ Breaking things ____________
- ☐ Controlling bladder ____________
- ☐ Disobedience ____________
- ☐ Feeding self ____________
- ☐ Fire-setting ____________
- ☐ Frequently daydreams ____________
- ☐ Frequently tearful ____________
- ☐ Hyperactivity ____________
- ☐ Lack of attachment ____________
- ☐ Often sad ____________
- ☐ Unable to play cooperatively ____________
- ☐ Poor concentration ____________
- ☐ Riding bicycle ____________
- ☐ Riding tricycle ____________
- ☐ Self-injurious threats ____________
- ☐ Speaking sentences ____________
- ☐ Speaking words ____________
- ☐ Tolerating separation ____________
- ☐ Other(s) ____________

If "other(s)", please specify

____

31. About your family feel free to add extra pertinent information in the box down below:

	Age if alive	Age at death
Mother		
Father		
Brothers		
Sisters		
Children		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		

Additional info

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32. Average number of hours your child sleeps at night?

____

33. Does your child have trouble falling asleep?

____

34. Does your child feel rested upon sleeping?

____

35. Does your child feel rested upon awakening?

____

36. Does your child snore?

____

37. Who are the main people that care for your child?

____

38. Has your child travelled to foreign countries? And if so, which ones, and when?

____

39. Dental History?

- ☐ Silver Mercury
- ☐ Gold Fillings
- ☐ Root Canals
- ☐ Implants
- ☐ Tooth Pain
- ☐ Bleeding Gums
- ☐ Gingivitis
- ☐ Problems with Chewing?

40. Environmental History

- ☐ Mold in bathroom
- ☐ Damp cellar
- ☐ Pest extermination
- ☐ Mold visible on exterior of house
- ☐ Forced hot air heat
- ☐ had water in basement
- ☐ Heavily wooded or damp surroundings
- ☐ Mold in cellar, crawl space. or basement
- ☐ Moldy, musty school/daycare
- ☐ Tobacco smoke
- ☐ Well water
- ☐ Carpet in bedroom
- ☐ Carpet in most parts of house
- ☐ Feather or down bedding

41. Supplements now or in the recent past:

	Name of supplement	Dosage	Duration	Benefits	Side effects
1					
2					

42. Other allergies or sensitivities (foods, pollen, animals, chemicals):

____

____

____

____

43. Do you follow a specific diet?

- ○ No
- ○ Vegetarian
- ○ Vegan
- ○ Low Fat
- ○ Low Carb
- ○ High Fiber
- ○ Other

If "other", please specify

____

44. Nutrition and Dietary habits

How many meals do you typically eat per day? ______________

Do you snack? ______________

How many times a week do you eat breakfast? ______________

How many times a week do you cook meals at home? ______________

How many times a week do you eat out at restaurants? ______________

How many times a week do you grocery shop? ______________

Do you normally eat alone or with friends/family? ______________

Where do you grocery shop? ______________

What is your weekly budget? ______________

Do you read food labels? ______________

List your favorite 3 meals: ______________

List your favorite restaurants and the type of food they serve: ______________

45. Feel free to use the space below to inform me with any extra information pertinent to your health:

____
____
____
____

46. Were you referred to us by anyone (physician, friend, etc)? Is yes, who? If no, how did you hear about us?

____
____
____
____