

PERSONAL INFORMATION					
Date:					
Child's Name: First:		Last:		Middle Initial:	
Parent(s) Name(s):					
Address: Street:			City:		
State:		Zip:		Phone: (    )	
Work Phone: (    )			Cell: (    )		
EMAIL:			Fax: (    )		
Child's Date of Birth: Month:		Day:	Year:	Child's Sex (Circle One): M/F	
Health Insurance:			ID Number:		
Referred By:					
Siblings: Name:		Sex: (Circle One)		Birth Date	
		Male/Female	Month:	Day:	Year:
		Male/Female	Month:	Day:	Year:
		Male/Female	Month:	Day:	Year:
Parent's Occupation(s):					
Note: Please email a baby picture and a recent picture to <a href="mailto:info@healthfromwithin.net">info@healthfromwithin.net</a> for your child's records. If email format is not possible; please bring a copy or original that can be kept in the file.					
Diagnoses or explanation given to you about your child (Date of diagnoses: ___/___/___):					



MEDICAL HISTORY				
PRIMARY DOCTOR(S)				
Name:	Degree:MD/DO	Phone Numbers:	City, State	Last Visit
SPECIALISTS				
Name:	Specialty:	Phone Numbers:	City, State	Last Visit
NUTRITIONIST				
Name:	Phone Numbers:		City, State	Last Visit
NATUROPATH(S) and/ or HOMEOPATH(S)				
Name:	Phone Numbers:		City, State	Last Visit
THERAPIST(S)				
Name:	Type:	Phone Numbers:	City, State	Last Visit
OTHER				
Name:	Phone Numbers:		City, State	Last Visit

PRENATAL HISTORY	
Maternal age at delivery: _____ years	# of Dental Amalgams (mom) _____
Illnesses during pregnancy:	
Medication during pregnancy:	
Vaccines during pregnancy:	
Other complications during pregnancy:	
Complications during labor and delivery:	
Mode of deliver: C-section/vaginal? (Circle one) If C-section, explain why:	
If vaginal delivery, did you have forceps/vacuum?	
Medication(s) during labor and delivery?	
Full term/premature? (Circle one)	How many weeks? _____ weeks
Complications after delivery?	
Medications given to child during hospital stay?	

**DIETARY/NUTRITIONAL HISTORY**

Breast fed? Yes/No (Circle one) If yes, for how long: \_\_\_\_\_

Bottle fed? Brand of formula? \_\_\_\_\_ Begun at what age? \_\_\_\_\_ For how long? \_\_\_\_\_

Foods? Begun at what age? \_\_\_\_\_ First foods? \_\_\_\_\_

Whole milk? Yes/No (Circle one) If yes, begun at what age? \_\_\_\_\_

Known allergies to food? (Please list):  
 \_\_\_\_\_

Suspected sensitivities to foods? (Please list):  
 \_\_\_\_\_  
 \_\_\_\_\_

Food cravings? (Please list):  
 \_\_\_\_\_

**Foods my child eats: (Place X in appropriate column)**

Food	Daily	3-5 times/ week	1-3 times/ week	Never or almost never	Used to eat a lot but no longer does
Cookies:					
Candy:					
Sweet foods:					
Caffeine (soda, tea, etc.):					
Chocolate:					
Milk: Whole:					
2 %:					
1 %:					
Skim:					
Cheese:					
Ice Cream:					
Salty Foods:					
Meat:					
Pasta:					
Bread: White:					
Wheat:					

<b>Other:</b>			
<p>Check (X) the most appropriate description below of your child's diet:</p> <p><input type="checkbox"/> Mostly baby foods</p> <p><input type="checkbox"/> Mostly carbohydrates (bread, pasta, etc.)</p> <p><input type="checkbox"/> Mostly dairy (milk, cheese, etc.)</p> <p><input type="checkbox"/> Mostly vegetarian (vegetables, fruits, grains, etc.)</p> <p><input type="checkbox"/> Other, describe:</p>			
Please describe your child's stool pattern (Examples: daily, foul, large, mushy, etc.):			
Please list the foods and beverages normally consumed by your child for three typical days:			
<b>DAY 1</b>			
Breakfast:			
Morning snack(s):			
Lunch:			
Afternoon snack(s):			
Dinner:			
Other:			
<b>DAY 2</b>			
Breakfast:			
Morning snack(s):			
Lunch:			
Afternoon snack(s):			
Dinner:			
Other:			
<b>DAY 3</b>			
Breakfast:			
Morning snack(s):			
Lunch:			
Afternoon snack(s):			
Dinner:			
Other:			



**MEDICAL HISTORY (Continued)**

Major surgeries - Please describe and give dates:

**SURGERY**

Major injuries - Please describe and give dates:

**INJURY**

**MEDICATIONS**

Please list any current /past medications being taken.

**SUPPLEMENTS**

Please list any current/past supplements being taken.

**THERAPIES AND DIETS**

Please list any current/past Therapies/Diets



## MUSCULOSKELETAL HISTORY

**Chief Complaint** (Circle all that apply)

Neck (pain/stiffness)      Leg/Foot/Toes (numbness/tingling/pain)      Headaches/Migraines  
 Back (pain/stiffness)      Arm/Hand /Finger (numbness/tingling/pain)

When did these symptoms begin? \_\_\_\_\_ Have they ever occurred before:  Yes  No  
 Was this due to an accident/Trauma?  Yes  No  
 If Yes, explain.(ex. fall, auto, sports,)

\_\_\_\_\_

**Symptoms:** When symptoms are their worst, explain how it feels (or describe what your child does when the symptoms come on).

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Severity**       Mild                               Moderate                               Severe

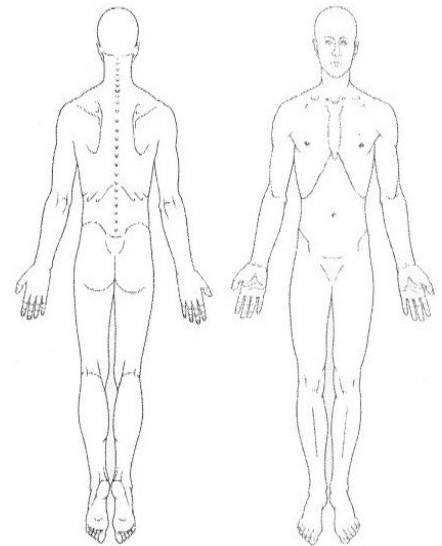
Does pain travel or radiate? If so, Where? \_\_\_\_\_  
 \_\_\_\_\_

**Quality:** (mark all that apply)

- Burning                       Diffuse                       Dull/Aching                       Localized
- Sharp                       Shooting                       Stabbing                       Tingling
- Radiating                       Other \_\_\_\_\_

Is there anything that makes this better or worse? \_\_\_\_\_  
 \_\_\_\_\_

**Please mark on the diagram below the area of discomfort.**



Timing:

- Worse AM    Worse PM    Worse W/ Activity    Worse Sleeping  
 Occasional (0-25%)    Intermittent (25-50%)    Frequent (50-75%)    Constant (75-100%)

How often do you find yourself/your child suffering from this problem? \_\_\_\_\_

How long does the problem last? (all the details of timing) \_\_\_\_\_

What solutions have you attempted to solve this problem? \_\_\_\_\_

**Daily Activities: Effects of Current Condition on Performance**

Changing Positions	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do )	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do )	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climbing Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do )	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Household Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do )	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting Objects	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do )	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Reading/Concentration	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do )	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Self Care – Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do )	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do )	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting Still	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do )	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Standing Still	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do )	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do )	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

Please List any effects that this may have on any Recreational Activities or Therapies: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

