Integrative Medicine – Pediatric Medical Questionnaire

Date of Initial Visit: _____ **MRN:** _____
(For office use only)

First Name: _____ **Middle Name:** _____ **Last Name:** _____

Mother's Name: _____ **Father's Name:** _____

What sex was your child assigned at birth? _____ **How would your child like to be addressed?** _____

What is your child's current gender identity? _____ **Preferred Pronouns?** _____

Date of your child's birth: _____

Guardian's Email Address: _____

Would you like to be added to the Integrative Medicine newsletter? Yes: ☐ No: ☐

Child's Primary Care Physician: _____ **Referred By:** _____

What do you hope to achieve in your child's visit? _____

When was the last time you believe your child felt well? _____

Did something trigger your child's change in health? _____

What do you feel your child's strengths are at this time? _____

Allergies

Does your child have any allergies or reactions to food, medication, or environmental factors? Yes: ☐ No: ☐

List any allergies or reactions your child experiences.

	Food / Medication / Environmental Factor	Reaction
1.		
2.		
3.		
4.		
5.		

Name: _____ **Date of Birth:** _____

List current medications your child is currently taking along with date started, dose and frequency.

	Medication	Date Started	Dose	Frequency
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

List all vitamins, minerals, and other nutritional supplements that your child is currently taking along with date started, dose and frequency (indicate mg or IU or form such as calcium carbonate vs calcium lactate when possible).

	Vitamin / Mineral / Supplement	Date Started	Dose	Frequency
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

Name: _____ **Date of Birth:** _____

Medical Health Timeline

Birth – 5 years

Full term / premature Vaginal delivery / C section Required induction? Yes: ☐ No: ☐

Weight at birth:_____

Bottle Fed: What kind of formula?_____ Breast Fed: How long?_____

Any challenges during pregnancy or birth? _____

Circle all that apply to your child:

- **Illness:** Infections, allergies, asthma, eczema, headaches, digestive issues, sinus infections, UTI, toxic exposures, cancer, diabetes, neurologic issues, anxiety/depression
- **Injuries:** Fractures, sprains, dislocations, head injury, concussion, back/neck injury
- **Surgeries:** Appendectomy, tonsillectomy, orthopedic surgery, cholecystectomy
- **Emotional Events:** Drug/alcohol use in the house, mental illness of parent or sibling, divorce of child's parents, abuse (physical, sexual, emotional), significant losses, bullying, significant moves

Other Details:

_____

_____

_____

_____

6 years – 12 years

- **Illness:** Infections, allergies, asthma, eczema, headaches, digestive issues, sinus infections, UTI, toxic exposures, cancer, diabetes, neurologic issues, anxiety/depression
- **Injuries:** Fractures, sprains, dislocations, head injury, concussion, back/neck injury
- **Surgeries:** Appendectomy, tonsillectomy, orthopedic surgery, cholecystectomy
- **Emotional Events:** Drug/alcohol use in the house, mental illness of parent or sibling, divorce of child's parents, abuse (physical, sexual, emotional), significant losses, bullying, significant moves, menstruation, pregnancy

Other Details:

_____

_____

_____

_____

Name: _____ **Date of Birth:** _____

13 years – 17 years

- **Illness:** Infections, allergies, asthma, eczema, headaches, digestive issues, sinus infections, UTI, toxic exposures, cancer, diabetes, neurologic issues, anxiety/depression
- **Injuries:** Fractures, sprains, dislocations, head injury, concussion, back/neck injury
- **Surgeries:** Appendectomy, tonsillectomy, orthopedic surgery, cholecystectomy
- **Emotional Events:** Drug/alcohol use in the house, mental illness of parent or sibling, divorce of child's parents, abuse (physical, sexual, emotional), significant losses, bullying, significant moves, menstruation, pregnancy

Other Details:

_____

_____

_____

Early Childhood Illness

How often has your child had earaches or other infections in the first two years: _____

How often has your child had antibiotic in the first two years: _____

Does your child's behavior change when on antibiotics? If yes, please explain: _____

_____

Immunizations

Is your child up-to-date with immunizations? Yes: ☐ No: ☐

Attach or bring a copy of your child's immunization record.

Growth

Has your child progressed normally on the growth chart? Yes: ☐ No: ☐

Attach or bring a copy of your child's growth chart.

Developmental Problems

Has your child had normal development (motor, speech, social): If no, describe: _____

_____

If your child has developmental problems, at what age did they start? _____

Sleep/Relaxation

Does your child have? Sleep Apnea ☐ Trouble Falling Asleep ☐ Trouble Staying Asleep ☐

How many hours of sleep does your child get per night? _____

What time does your child typically fall asleep? _____

Does your child experience sleepiness during the day? Yes: ☐ No: ☐ Does your child take naps? Yes: ☐ No: ☐

Does your child awaken refreshed? Yes: ☐ No: ☐

Name: _____ **Date of Birth:** _____

Digestion/Nutrition

Does your child follow a special diet? Vegan Vegetarian Mediterranean Anti-Inflammatory Paleo Ketogenic

Other: _____

Does your child develop any symptoms after eating certain foods? _____

How much water does your child drink per day? _____ How much caffeine does your child consume per day? _____

Does your child use artificial sweeteners? Yes: ☐ No: ☐ If yes, which ones? _____

Bowel movements: How often: _____ Color: _____ Consistency: _____

Has your child's weight been stable? Yes: ☐ No: ☐

Food allergy (ex: peanuts, eggs, etc): _____

Environmental History

Is there anything in your child's environment that you feel might be harmful (e.g. dampness, mold, chemicals, tobacco smoke, well water, insects, pets, or carpeting)?

_____

_____

Stress/Coping

Has your child experienced any major life changes that may have impacted his/her health? Yes: ☐ No: ☐

_____

Has your child ever experienced any major losses? Yes: ☐ No: ☐

_____

Has your child ever been abused, a victim of a crime, or experienced a significant trauma? Yes: ☐ No: ☐

_____

Have you ever sought counseling for your child? Yes: ☐ No: ☐

_____

Activity

How active is your child on a daily basis? _____

What types of activities does your child enjoy? _____

How much time does your child spend watching TV or using electronic devices? _____

Name: _____ **Date of Birth:** _____

Review of Systems Checklist

Please indicate if your child has had any of the below symptoms in the past 7 days

Constitutional/General		
Fever	Yes	No
Difficulty Managing Weight	Yes	No
Food Cravings	Yes	No
Poor Appetite	Yes	No
Binge Eating/Drinking	Yes	No
Fatigue	Yes	No
Restlessness	Yes	No
General Weakness	Yes	No
Low Stamina	Yes	No
Skin/Nails		
Rash	Yes	No
Acne	Yes	No
Vitiligo	Yes	No
Rosacea	Yes	No
Eczema	Yes	No
Psoriasis	Yes	No
Itching	Yes	No
Hives	Yes	No
Thin/Cracking/Peeling Nails	Yes	No
Nail Fungus	Yes	No
Discolored Nails	Yes	No
Nails with Ridges	Yes	No
Nails with Pits	Yes	No
Cardiovascular		
Chest Pain	Yes	No
Hypertension	Yes	No
Palpitations	Yes	No
Rapid Heart Rate	Yes	No
Slow Heart Rate	Yes	No
Leg or Foot Swelling	Yes	No
Respiratory		
Cough	Yes	No
Cough Up Blood	Yes	No
Wheezing/Asthma	Yes	No
COPD	Yes	No
Difficulty Breathing	Yes	No
Shortness of Breath	Yes	No
Allergy/Immune		
Hepatitis	Yes	No
HIV+	Yes	No
Food Allergies	Yes	No
Environmental Allergies	Yes	No
Frequent Infections	Yes	No

Eyes		
Watering	Yes	No
Itching	Yes	No
Dryness	Yes	No
Redness	Yes	No
Drainage	Yes	No
Bags Under Eyes	Yes	No
Dark Circles	Yes	No
Eyelid Irritation	Yes	No
Change in Vision	Yes	No
Light Sensitivity	Yes	No
Head/Eyes/Ears/Nose/Throat		
Hearing Loss	Yes	No
Ringing in Ears	Yes	No
Ear Pain	Yes	No
Sore Throat	Yes	No
Hoarse Voice	Yes	No
Clearing Throat Often	Yes	No
Canker Sores	Yes	No
Dental Cavities	Yes	No
Gums Sore/Swollen	Yes	No
Tongue Sore	Yes	No
Nasal/Sinus Congestion	Yes	No
Bad Breath	Yes	No
TMJ	Yes	No
Grinding Teeth	Yes	No
Headaches/Migraines	Yes	No
Blurred Vision	Yes	No
Glasses or Contacts	Yes	No
Neurologic		
Seizures	Yes	No
Stroke	Yes	No
Headache	Yes	No
Dizziness	Yes	No
Fainting	Yes	No
Difficulty with Balance	Yes	No
Slurred Speech	Yes	No
Numbness/Tingling	Yes	No
Tremor	Yes	No
Memory Loss	Yes	No
Vertigo: spinning, movement sensations	Yes	No

Gastrointestinal/Abdominal		
Reflux	Yes	No
Ulcer	Yes	No
Belching	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Cramping	Yes	No
Abdominal Pain	Yes	No
Poor Appetite	Yes	No
Poor Thirst	Yes	No
Burning Sensation	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Excess Gas	Yes	No
Bloating	Yes	No
Hemorrhoids	Yes	No
Rectal Pain	Yes	No
Mucus in Stool	Yes	No
Blood in Stool	Yes	No
Black Stool	Yes	No
Stool Incontinence	Yes	No
Genitourinary		
Frequency	Yes	No
Pain with Urination	Yes	No
Up at Night to Urinate	Yes	No
Incontinence	Yes	No
Blood in Urine	Yes	No
Genital Discharge	Yes	No
Genital Itching	Yes	No
Low Libido	Yes	No
Erectile Dysfunction	Yes	No
Musculoskeletal		
Joint Pain	Yes	No
Joint Stiffness	Yes	No
Muscle Pain	Yes	No
Muscle Stiffness	Yes	No
Neck Pain	Yes	No
Back Pain	Yes	No
Muscle Cramps	Yes	No
Muscle Twitching	Yes	No

Name: _____ **Date of Birth:** _____

Review of Systems Checklist Continued

Please indicate if your child has had any of the below symptoms in the past 7 days

Endocrine/Hematology		
Goiter	Yes	No
Hypothyroid	Yes	No
Blood Clots (DVT)	Yes	No
Easy Bruising	Yes	No
Easy Bleeding	Yes	No
Easily Over Heated	Yes	No
Cold Intolerant	Yes	No
Breast Abnormality	Yes	No
Irregular Periods	Yes	No
Heavy Periods	Yes	No
PMS Symptoms	Yes	No
Frequent Thirst	Yes	No
Sweating/Night Sweats	Yes	No
Hot Flashes	Yes	No
Hair Loss	Yes	No

Psychiatric		
Anxiety	Yes	No
Depression	Yes	No
Hallucinations	Yes	No
Mood Disorder	Yes	No