**Dr. Vyacheslav Alec Pekler NMD**

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**www.DrHakunaMatata.com**

***Children’s Medical Questionnaire***

**Important Notice:**

Thank you for your interest in becoming a patient with Dr. Alec Pekler . All new patients must complete the following forms and questionnaires. Dr.Pekler will review all of this information *before* meeting with you for the first time. Copies of your medical records, including lab work and diagnostic testing are required **before scheduling an appointment** (a review of past medical records is included in the fees for your initial consultation). Prior to your initial appointment, Dr. Pekler will review all your intake forms and medical records that you have provided. **The initial consultation lasts 1.5 - 2 hours and include the following:**

* Reviewing of past medical history
* Reviewing of the labwork and diagnosis
* Thorough Physical Exam
* 45 - 60 min of Craniosacral Therapy session
* Design of a comprehensive treatment plan

The goal of the visit is to gather necessary details about you and your medical condition so proper testing can be ordered to determine root causes of symptoms and necessary recommendations for care.

* **The cost for the services are listed on the website www.DrHakunaMatata.com**

Dr. Pekler will then review the test results from the lab tests he ordered along with your intake forms

and the information gathered from your initial consultation. You will then be scheduled for a follow up consultation. At this appointment Dr. Pekler will present his *specific* recommendations pertaining to your health. **Expect the report of findings to last about 45-60 minutes or longer, depending on the complication of your case**.

* + **Supplements: Supplements are sold through an online vendor. If patient wishes to use his or her own source, it is their right to do so**

It is important to understand that successful management of any complicated case requires proper testing,

diagnosis, financial commitments and realistic patient expectations.

* **The single most important criteria for effective case management is a comprehensive and detailed health history**.

Please answer the following questions with **as much detail as possible**, because it is vital to know everything about you and your case. Please schedule enough time (about 3-6 hours) to be thorough in completing the questions and intake forms; the more details you provide, the better Dr. Pekler can assess your health. In some cases it may be easier to take the forms in small bites, just answering a few questions each day. Don't be overwhelmed by the forms. Keep in mind these detailed forms are for your benefit, so Dr. Pekler can help you to his fullest.

* **Please fill these forms electronically and submit through the electronic health record portal by uploading them into the system.**

Thank you in advance for your time and effort in completing these forms. The information derived from these forms will provide Dr. Pekler invaluable data allowing for the appropriate course of care.

Some of our patients and staff are very sensitive to chemical odors. Please do not wear any perfume, hair sprays, deodorants or other materials that have a scent when you come to the office. Wear no make up and no nail polish.

**Note:** In this questionnaire “you” is used as if the child were answering questions, avoiding repetition of him/her**.**

|  |  |
| --- | --- |
| **Example: Please follow the example below to a T. I will use it to past into your child’s record.** | |
| **Child Name:**  **Address:**  **-**  **-**  **-**  **Phone: Home,,,,Work....Cell**  **Birth Date:**  **Email.**  **Referred by:**  **Pharmacy Name Phone: & doctors’ ax** | **Parent Name:**  **Address:**  **Home phone:**  **Work:**  **Birth Date:**  **Email.**    **Referred by:**  **Pharmacy Phone: FAX** |

|  |  |  |  |
| --- | --- | --- | --- |
| Male  Female | Eye Color: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Hair Color: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Birth Order. |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Blood Type: | | | Allergy to medication:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Hair Texture: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (lbs) | | | (optional)  SS#: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_ | |
| Mother's Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Father's Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Occupation:\_\_\_\_\_\_\_\_\_\_ | |
| Person(s) filling out this questionnaire:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |

Note that I am interested in so-called minor symptoms as well as in major problems. I know that in many doctor's offices there is some tendency not to mention too many symptoms for fear that the doctor will take you for a hypochondriac. The rules here are different. I am interested in any message you are getting from your body, even though it may be considered irrelevant to "making a diagnosis" or it may seem to you to be of no consequence to your health. Some such symptoms are useful clues in the kind of medical detective work we do. Please include as much information as you can on this form and the chronological history form (feel free to skip any questions you do not wish to answer)

Thank you.

**Insurance Information:**

|  |  |  |
| --- | --- | --- |
| **Insured’s Name** (last, first, middle initial) | **Insured’s Policy/Group Number:** | **Insured’s DOB** (mm/dd/yy)**:** |
|  |  | **Sex:** Male o Female |
| **In Insured’s Address:** | **City, State, Zip Code:** | **Phone Number:** |
|  |  |  |
| **Employer’s Name:** | **Insurance Plan Name:** | **Out of Pocket Maximum Deductible:** |
|  |  |  |
| **Total Annual Deductible:** | **Out of Pocket Maximum:** | **Current Funds Paid:** |
|  |  |  |

**Please rank problems by priority and add strengths (S)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **# =rank, P= past, L= lab, A= acute, S = a Strength** | | | **The boxes below are for future follow up scores.** | | | |
| **⇓** | **Symptom**  **RATING** (0= Absent, 3= mild, 6= Moderate, 9=severe, 12= incapacitating.) | **Date**  **here** |  |  |  |  |
| 0 | Example: Poor appetite | rating |  |  |  |  |
| 1 |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |
| A |  |  |  |  |  |  |
| L |  |  |  |  |  |  |
| L |  |  |  |  |  |  |
| P |  |  |  |  |  |  |
| S |  |  |  |  |  |  |
| S |  |  |  |  |  |  |

What diagnoses or explanations have been given to you?

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

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

What other doctors, clinics or hospitals have you consulted, and when?

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

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Who referred you or how did you hear about me

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

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If the referring person is a health professional who should receive reports, please give his or her full address:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_

Telephone Number: \_\_\_\_\_\_\_ - \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_

**Personal Descriptive Information:**

|  |
| --- |
| With whom do you live? (Include children, parents, relatives, friends...please include ages )  {Example: Wendy, age 7, sister}  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Who are the main people who look after you?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| What pets live with you - indoor or outdoors only?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| When and where have you lived or traveled outside of the United States?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Major life changes recent or soon for you or your family?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Have you experienced any major losses or invasive experiences in life?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Past Medical and Surgical History:**

|  |  |  |
| --- | --- | --- |
| **ILLNESSES** | **WHEN** | **COMMENTS** |
| Ear Infections |  |  |
| Chicken Pox |  |  |
| Mononucleosis |  |  |
| Measles |  |  |
| German Measles |  |  |
| Mumps |  |  |
| Hepatitis |  |  |
| **INJURIES** | **WHEN** | **COMMENTS** |
| Head Injury |  |  |
| Neck Injury |  |  |
| Back Injury |  |  |
| Broken … |  |  |
| Broken … |  |  |
| **DIAGNOSTIC STUDIES** | **WHEN** | **COMMENTS** |
| Chest X-ray |  |  |
| EKG |  |  |
| Hearing test |  |  |
| Vision test |  |  |
| CAT scan of brain |  |  |
| CAT scan of abdomen |  |  |
| CAT scan of spine |  |  |
| Liver scan |  |  |
| Bone scan |  |  |
| Neck X-ray |  |  |
| **OPERATIONS** | **WHEN** | **COMMENTS** |
| Tonsillectomy |  |  |
| Tonsil/Adnoid |  |  |
| P.E. Tubes in Ears |  |  |
| Appendectomy |  |  |
| Circumcision |  |  |
| Hernia |  |  |

**Immunizations**

Please indicate the exact date or approximate age at which you have had the following immunizations and if an adverse reaction took place following the immunization.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Test** | **Date** | **Age** | **Reaction?** | **Test** | **Date** | **Age** | **Reaction?** |
| DPT **1**  (Diphtheria-Pertussis-Tetanus) |  |  |  | HBV 1  (Hepatitis-b vaccine) |  |  |  |
| DPT **2**  (Diphtheria-Pertussis-Tetanus) |  |  |  | HBV 2  (Hepatitis-b vaccine) |  |  |  |
| DPT **3**  (Diphtheria-Pertussis-Tetanus) |  |  |  | HBV 3  (Hepatitis-b vaccine) |  |  |  |
| DPT **4**  (Diphtheria-Pertussis-Tetanus) |  |  |  | HBV **4**  (Hepatitis-b vaccine) |  |  |  |
| DPT **5**  (Diphtheria-Pertussis-Tetanus) |  |  |  | Varivax Vaccine  (Chicken Pox) |  |  |  |
| dT  (Adult Diphtheria-Tetanus) |  |  |  | Tine Test |  |  |  |
| DT  (Pediatric Diphtheria- Tetanus) |  |  |  | Other |  |  |  |
| Hib **1**  (H Influenzae) |  |  |  |  |  |  |  |
| Hib **2**  (H Influenzae) |  |  |  |  |  |  |  |
| Hib **3**  (H Influenzae) |  |  |  |  |  |  |  |
| Hib **4**  (H Influenzae) |  |  |  |  |  |  |  |
| OPV **1**  (Oral Polio) |  |  |  |  |  |  |  |
| OPV **2**  (Oral Polio) |  |  |  |  |  |  |  |
| OPV **3**  (Oral Polio) |  |  |  |  |  |  |  |
| OPV **4**  (Oral Polio) |  |  |  |  |  |  |  |
| OPV **5**  (Oral Polio) |  |  |  |  |  |  |  |
| Polio Vaccine Injection **1** |  |  |  |  |  |  |  |
| Polio Vaccine Injection **2** |  |  |  |  |  |  |  |
| MMR **1**  (Measles-Mumps-Rubella) |  |  |  |  |  |  |  |
| MMR **2**  (Measles-Mumps-Rubella) |  |  |  |  |  |  |  |

**Medications:**

How many times have you taken:

Birth to 2 –5 6-13 Since age

1 year years years 13

Antibiotics: \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_

Steroids: \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_

What medications are you taking now? Include non-prescription drugs

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication Name** | **Date started** | **Date stopped\*** | **Dosage** | **# per day** |
|  |  |  |  |  |
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\* If you are still taking the medication leave this space blank.

**Vitamin, Minerals and Other Nutritional Supplements:** List all vitamins, mineral and other nutritional supplements. Indicate the mg or IU's and the form (eg. calcium carbonate vs calcium lactate), when possible.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Vitamin/Mineral/Supplement Name** | **Date started** | **Date stopped\*** | **Dosage** | **# per day** |
|  |  |  |  |  |
|  |  |  |  |  |
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|  |  |  |  |  |

\* If you are still taking the supplement leave this space blank.

**Mother’s Pregnancy**

|  |  |  |
| --- | --- | --- |
| Question | Yes | Comment |
| When your mother was pregnant with you did she: |  |  |
| Have a complicated pregnancy? |  |  |
| Have a normal labor and delivery? |  |  |
| Smoke tobacco? |  |  |
| Drink alcohol? |  |  |
| Take estrogen? |  |  |
| Have a C-section? |  |  |
| Were you a full term baby? |  |  |
| A preemie? |  |  |
| Breast fed? |  |  |
| Bottle fed? |  |  |

**Developmental History:**

Please note the age at which the following skills were mastered:

Sitting up \_\_\_\_\_ Pulled to stand \_\_\_\_\_ Walked \_\_\_\_\_

Spoke clearly ­\_\_\_\_\_ Bowel trained ­\_\_\_\_\_ Dry at night \_\_\_\_\_

Rode two wheel bicycle \_\_\_\_\_

….. or not sure but everything seemed on schedule \_\_\_\_\_

….. or information not available \_\_\_\_\_

**Present or Recent Diet:** Place a check mark next to the food/drink that applies to your diet.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Usual Breakfast** | **√** | **Usual Lunch** | **√** | **Usual Dinner** | **√** |
| None |  | None |  | None |  |
| Eggs |  | Meat sandwich |  | Red meat |  |
| Bacon/Sausage |  | Fish sandwich |  | Poultry |  |
| Milk |  | Lettuce |  | Fish |  |
| Coffee |  | Tomato |  | Green vegetables |  |
| Tea |  | Mayo |  | Beans (legumes) |  |
| Toast |  | Leftovers |  | Carrots |  |
| Bagel |  | Yogurt |  | Yellow vegetables |  |
| Donut |  | Soup |  | Salad |  |
| Sweet roll |  | Salad |  | Salad dressing |  |
| Juice |  | Salad dressing |  | Potato |  |
| Fruit |  | Coffee |  | Pasta |  |
| Cereal |  | Tea |  | Rice |  |
| Oat bran |  | Milk |  | Brown rice |  |
| Wheat bran |  | Soda |  | Butter |  |
| Yogurt |  | Juice |  | Margarine |  |
| Sugar |  | Sugar |  | Coffee |  |
| Sweetener |  | Sweetener |  | Tea |  |
| Butter |  | Butter |  | Sugar |  |
| Margarine |  | Margarine |  | Sweetener |  |
| Other: (List below) |  | Eat in work cafeteria |  | Soda |  |
|  |  | Eat in restaurant |  | Juice |  |
|  |  | Other: (List below) |  | Milk |  |
|  |  |  |  | Other: (List below) |  |
|  |  |  |  |  |  |

**Snacks:** What snacks do you eat or drink between:

Breakfast and lunch? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lunch and dinner? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

After dinner? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How much of the following do you consume each day?**

|  |  |  |
| --- | --- | --- |
|  | **Daily or Weekly** | |
| Slices of white bread (rolls/bagels) |  |  |
| Cups of caffeine containing coffee |  |  |
| Cup of caffeine containing tea |  |  |
| Cups of hot chocolate |  |  |
| Cups of decaffeinated coffee or tea |  |  |
| Diet sodas |  |  |
| Sodas with caffeine |  |  |
| Sodas without caffeine |  |  |
| Candy |  |  |
| Chocolate |  |  |
| Cheese |  |  |
| Sardines |  |  |
| Carrots |  |  |
| Salty foods |  |  |
| Ice cream |  |  |

Is there any food that you had to avoid because it gave you symptoms - such as milk/gas or diarrhea? (please name the food and symptom.

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

Is there anything special about your diet that I should know about?

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

Has there ever been a food that you craved or really "pigged out" on over a period of time? (Please indicate what and when). \*Food craving is an indicator that you may be allergic to that food.

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

**Past and Present Symptoms**

Please check the best description of your symptoms (mild, moderate or severe) and indicate the time frame (occasional, frequent or always): **Please do not put any page breaks or line breaks in this table. If you wish to elaborate**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **General** | **MILD** | **MOD** | | **SEV** | | **OCC** | | | **FREQ** | | | **ALWAYS** | | |
| Cold all over |  |  | |  | |  | | |  | | |  | | |
| Cold hands & feet |  |  | |  | |  | | |  | | |  | | |
| Cold intolerance |  |  | |  | |  | | |  | | |  | | |
| Chills |  |  | |  | |  | | |  | | |  | | |
| Flushing |  |  | |  | |  | | |  | | |  | | |
| Heat intolerance |  |  | |  | |  | | |  | | |  | | |
| Fever |  |  | |  | |  | | |  | | |  | | |
| Fatigue |  |  | |  | |  | | |  | | |  | | |
| Malaise |  |  | |  | |  | | |  | | |  | | |
| Difficulty falling asleep |  |  | |  | |  | | |  | | |  | | |
| Night waking |  |  | |  | |  | | |  | | |  | | |
| Nightmares |  |  | |  | |  | | |  | | |  | | |
| No dream recall |  |  | |  | |  | | |  | | |  | | |
| **General, Cont'd.** | **MILD** | **MOD** | | **SEV** | | **OCC** | | | **FREQ** | | | **ALWAYS** | | |
| Early waking |  |  | |  | |  | | |  | | |  | | |
| Daytime sleepiness |  |  | |  | |  | | |  | | |  | | |
| Headache |  |  | |  | |  | | |  | | |  | | |
| Migraine |  |  | |  | |  | | |  | | |  | | |
| Distorted Vision |  |  | |  | |  | | |  | | |  | | |
| Distorted Hearing |  |  | |  | |  | | |  | | |  | | |
| Distorted Taste |  |  | |  | |  | | |  | | |  | | |
| Distorted sense of smell |  |  | |  | |  | | |  | | |  | | |
| Distorted feeling of self |  |  | |  | |  | | |  | | |  | | |
| Visual Hallucinations |  |  | |  | |  | | |  | | |  | | |
| Auditory Hallucinations |  |  | |  | |  | | |  | | |  | | |
| Breath holding |  |  | |  | |  | | |  | | |  | | |
| Head banging |  |  | |  | |  | | |  | | |  | | |
| Rocking |  |  | |  | |  | | |  | | |  | | |
| **EYES & EARS:** |  |  | |  | |  | | |  | | |  | | |
| Conjunctivitis |  |  | |  | |  | | |  | | |  | | |
| Eye pain |  |  | |  | |  | | |  | | |  | | |
| Eye crusting |  |  | |  | |  | | |  | | |  | | |
| Lid margin redness |  |  | |  | |  | | |  | | |  | | |
| Ear fullness |  |  | |  | |  | | |  | | |  | | |
| Ear pain |  |  | |  | |  | | |  | | |  | | |
| Ear ringing |  |  | |  | |  | | |  | | |  | | |
| Ear noises |  |  | |  | |  | | |  | | |  | | |
| Hearing loss |  |  | |  | |  | | |  | | |  | | |
| Sensitive to loud noises |  |  | |  | |  | | |  | | |  | | |
| **MUSCULAR:** | **MILD** | **MOD** | | **SEV** | | **OCC** | | | **FREQ** | | | **ALWAYS** | | |
| Calf cramps |  |  | |  | |  | | |  | | |  | | |
| Foot cramps |  |  | |  | |  | | |  | | |  | | |
| Constant movement |  |  | |  | |  | | |  | | |  | | |
| Muscle twitches: Around eyes |  |  | |  | |  | | |  | | |  | | |
| Muscle Arms or Legs |  |  | |  | |  | | |  | | |  | | |
| Muscle spasms |  |  | |  | |  | | |  | | |  | | |
| Chest tightness |  |  | |  | |  | | |  | | |  | | |
| Tendonitis |  |  | |  | |  | | |  | | |  | | |
| Tension headache |  |  | |  | |  | | |  | | |  | | |
| Difficulty swallowing |  |  | |  | |  | | |  | | |  | | |
| Tics |  |  | |  | |  | | |  | | |  | | |
| Muscle weakness |  |  | |  | |  | | |  | | |  | | |
| Neck muscle spasm |  |  | |  | |  | | |  | | |  | | |
| Back muscle spasm |  |  | |  | |  | | |  | | |  | | |
| Shoulder muscle spasm |  |  | |  | |  | | |  | | |  | | |
| Muscle pain |  |  | |  | |  | | |  | | |  | | |
| Muscle stiffness |  |  | |  | |  | | |  | | |  | | |
| Muscle tremor |  |  | |  | |  | | |  | | |  | | |
| Joint pain |  |  | |  | |  | | |  | | |  | | |
| **MOOD/NERVES:** | **MILD** | **MOD** | | **SEV** | | **OCC** | | | **FREQ** | | | **ALWAYS** | | |
| Anxiety |  |  | |  | |  | | |  | | |  | | |
| Irritability |  |  | |  | |  | | |  | | |  | | |
| Depression |  |  | |  | |  | | |  | | |  | | |
| Panic attacks |  |  | |  | |  | | |  | | |  | | |
| Hyperactivity |  |  | |  | |  | | |  | | |  | | |
| Phobias |  |  | |  | |  | | |  | | |  | | |
| Fearfulness |  |  | |  | |  | | |  | | |  | | |
| Paranoia |  |  | |  | |  | | |  | | |  | | |
| Sighing |  |  | |  | |  | | |  | | |  | | |
| Suicidal thoughts |  |  | |  | |  | | |  | | |  | | |
| Light headedness |  |  | |  | |  | | |  | | |  | | |
| Dizzy (spins) |  |  | |  | |  | | |  | | |  | | |
| Fainting |  |  | |  | |  | | |  | | |  | | |
| Seizures |  |  | |  | |  | | |  | | |  | | |
| Difficulty: Concentrating |  |  | |  | |  | | |  | | |  | | |
| Difficulty With balance |  |  | |  | |  | | |  | | |  | | |
| Difficulty With thinking |  |  | |  | |  | | |  | | |  | | |
| Difficulty With judgement |  |  | |  | |  | | |  | | |  | | |
| Difficulty With speech |  |  | |  | |  | | |  | | |  | | |
| Difficulty memory |  |  | |  | |  | | |  | | |  | | |
| Learning problem |  |  | |  | |  | | |  | | |  | | |
| Numbness |  |  | |  | |  | | |  | | |  | | |
| Blinking |  |  | |  | |  | | |  | | |  | | |
| Yawning |  |  | |  | |  | | |  | | |  | | |
| Tingling |  |  | |  | |  | | |  | | |  | | |
| Electrical zaps |  |  | |  | |  | | |  | | |  | | |
| **EATING ETC.** |  |  | |  | |  | | |  | | |  | | |
| Can't loose weight |  |  | |  | |  | | |  | | |  | | |
| Can't gain weight |  |  | |  | |  | | |  | | |  | | |
| Poor appetite |  |  | |  | |  | | |  | | |  | | |
| Carbohydrate Craving |  |  | |  | |  | | |  | | |  | | |
| Carbohydrate Intolerance |  |  | |  | |  | | |  | | |  | | |
| Binging |  |  | |  | |  | | |  | | |  | | |
| Bulimia |  |  | |  | |  | | |  | | |  | | |
| Salt craving |  |  | |  | |  | | |  | | |  | | |
| Alcohol craving |  |  | |  | |  | | |  | | |  | | |
| Bread craving |  |  | |  | |  | | |  | | |  | | |
| Chocolate craving |  |  | |  | |  | | |  | | |  | | |
| Diet soda craving |  |  | |  | |  | | |  | | |  | | |
| Juice craving |  |  | |  | |  | | |  | | |  | | |
| **DIGESTION:** | **MILD** | **MOD** | | **SEV** | | **OCC** | | | **FREQ** | | | **ALWAYS** | | |
| Thrush |  |  | |  | |  | | |  | | |  | | |
| Bad teeth |  |  | |  | |  | | |  | | |  | | |
| Grinding teeth |  |  | |  | |  | | |  | | |  | | |
| Gums bleed |  |  | |  | |  | | |  | | |  | | |
| Periodontal dis |  |  | |  | |  | | |  | | |  | | |
| Dry mouth |  |  | |  | |  | | |  | | |  | | |
| Geographic tongue map-like rash on tongue, indicating food allergy. |  |  | |  | |  | | |  | | |  | | |
| Sore tongue |  |  | |  | |  | | |  | | |  | | |
| Canker sores |  |  | |  | |  | | |  | | |  | | |
| Cold sores |  | |  |  | | |  | | |  | | |  | | |
| Cracking at corner of lips |  | |  |  | | |  | | |  | | |  | | |
| Sore throat |  | |  |  | | |  | | |  | | |  | | |
| Swollen lymph nodes |  | |  |  | | |  | | |  | | |  | | |
| Intolerance Lactose |  | |  |  | | |  | | |  | | |  | | |
| Intolerance All milk products |  | |  |  | | |  | | |  | | |  | | |
| Intolerance Gluten(wheat) |  | |  |  | | |  | | |  | | |  | | |
| Intolerance Fattyfoods |  | |  |  | | |  | | |  | | |  | | |
| IntoleranceCorn |  | |  |  | | |  | | |  | | |  | | |
| Intolerance Yeast |  | |  |  | | |  | | |  | | |  | | |
| Intolerance Eggs |  | |  |  | | |  | | |  | | |  | | |
| Foods "repeat" |  | |  |  | | |  | | |  | | |  | | |
| Spitting up |  | |  |  | | |  | | |  | | |  | | |
| Nausea |  | |  |  | | |  | | |  | | |  | | |
| Vomiting |  | |  |  | | |  | | |  | | |  | | |
| Upper abdomen pain |  | |  |  | | |  | | |  | | |  | | |
| Lower abdomen pain |  | |  |  | | |  | | |  | | |  | | |
| Bloating Lower abdomen |  | |  |  | | |  | | |  | | |  | | |
| Bloating Whole abdomen |  | |  |  | | |  | | |  | | |  | | |
| Burping |  | |  |  | | |  | | |  | | |  | | |
| Farting |  | |  |  | | |  | | |  | | |  | | |
| Diarrhea |  | |  |  | | |  | | |  | | |  | | |
| Undigested food in stools |  | |  |  | | |  | | |  | | |  | | |
| Mucous in stools |  | |  |  | | |  | | |  | | |  | | |
| Blood in stools |  | |  |  | | |  | | |  | | |  | | |
| Hemorrhoids |  | |  | |  | | |  | | |  | | |  | | |
| Anal spasms |  | |  | |  | | |  | | |  | | |  | | |
| Fissures |  | |  | |  | | |  | | |  | | |  | | |
| Colic |  | |  | |  | | |  | | |  | | |  | | |
| Strong stool odor |  | |  | |  | | |  | | |  | | |  | | |
| Constipation |  | |  | |  | | |  | | |  | | |  | | |
| **SKIN:** | **MILD** | | **MOD** | | **SEV** | | | **OCC** | | | **FREQ** | | | **ALWAYS** | | |
| Psoriasis |  | |  | |  | | |  | | |  | | |  | | |
| Eczema |  | |  | |  | | |  | | |  | | |  | | |
| Hives |  | |  | |  | | |  | | |  | | |  | | |
| Rash |  | |  | |  | | |  | | |  | | |  | | |
| Cradle cap |  | |  | |  | | |  | | |  | | |  | | |
| Seborrhea on face |  | |  | |  | | |  | | |  | | |  | | |
| Bumps upper arms |  | |  | |  | | |  | | |  | | |  | | |
| Acne on back |  | |  | |  | | |  | | |  | | |  | | |
| Acne on chest |  | |  | |  | | |  | | |  | | |  | | |
| Acne on face |  | |  | |  | | |  | | |  | | |  | | |
| Acne on shoulders |  | |  | |  | | |  | | |  | | |  | | |
| Cellulite |  | |  | |  | | |  | | |  | | |  | | |
| Easy bruising |  | |  | |  | | |  | | |  | | |  | | |
| Dark circles under eyes |  | |  | |  | | |  | | |  | | |  | | |
| Lackluster skin |  | |  | |  | | |  | | |  | | |  | | |
| Patchy dullness |  | |  | |  | | |  | | |  | | |  | | |
| Thick calluses |  | |  | |  | | |  | | |  | | |  | | |
| Oily skin |  | |  | |  | | |  | | |  | | |  | | |
| Red face |  | |  | |  | | |  | | |  | | |  | | |
| Pale skin |  | |  | |  | | |  | | |  | | |  | | |
| Ears get red |  | |  | |  | | |  | | |  | | |  | | |
| Strong body odor |  | |  | |  | | |  | | |  | | |  | | |
| Bugs love to bite you and |  | |  | |  | | |  | | |  | | |  | | |
| Sensitive to bites |  | |  | |  | | |  | | |  | | |  | | |
| Poison Ivy too? |  | |  | |  | | |  | | |  | | |  | | |
| Leg pains |  | |  | |  | | |  | | |  | | |  | | |
| Foot pains |  | |  | |  | | |  | | |  | | |  | | |
| Back pains |  | |  | |  | | |  | | |  | | |  | | |
| Muscle pains |  | |  | |  | | |  | | |  | | |  | | |
| Tender lymph nodes |  | |  | |  | | |  | | |  | | |  | | |
| **ITCHING OF:** |  | |  | |  | | |  | | |  | | |  | | |
| Scalp |  | |  | |  | | |  | | |  | | |  | | |
| Ear canals |  | |  | |  | | |  | | |  | | |  | | |
| Eyes |  | |  | |  | | |  | | |  | | |  | | |
| Nose |  | |  | |  | | |  | | |  | | |  | | |
| Roof of mouth |  | |  | |  | | |  | | |  | | |  | | |
| Throat |  | |  | |  | | |  | | |  | | |  | | |
| Nipples |  | |  | |  | | |  | | |  | | |  | | |
| Arms |  | |  | |  | | |  | | |  | | |  | | |
| Hands |  | |  | |  | | |  | | |  | | |  | | |
| Legs |  | |  | |  | | |  | | |  | | |  | | |
| Feet |  | |  | |  | | |  | | |  | | |  | | |
| Vagina |  | |  | |  | | |  | | |  | | |  | | |
| Penis |  | |  | |  | | |  | | |  | | |  | | |
| Anus |  | |  | |  | | |  | | |  | | |  | | |
| Skin in general |  | |  | |  | | |  | | |  | | |  | | |
| **DRYNESS OF:** |  | |  | |  | | |  | | |  | | |  | | |
| Dry Hair |  | |  | |  | | |  | | |  | | |  | | |
| Unmanageable Hair? |  | |  | |  | | |  | | |  | | |  | | |
| Dry Scalp |  | |  | |  | | |  | | |  | | |  | | |
| Dandruff? |  | |  | |  | | |  | | |  | | |  | | |
| Dry Hands |  | |  | |  | | |  | | |  | | |  | | |
| Cracking finger |  | |  | |  | | |  | | |  | | |  | | |
| Peeling hands |  | |  | |  | | |  | | |  | | |  | | |
| Peeling Feet |  | |  | |  | | |  | | |  | | |  | | |
| Cracking Feet? |  | |  | |  | | |  | | |  | | |  | | |
| Lower legs dry |  | |  | |  | | |  | | |  | | |  | | |
| Skin in general Dry |  | |  | |  | | |  | | |  | | |  | | |
| Eyes Dry |  | |  | |  | | |  | | |  | | |  | | |
| **NAILS** | **MILD** | | **MOD** | | **SEV** | | | **OCC** | | | **FREQ** | | | **ALWAYS** | | |
| Bitten |  | |  | |  | | |  | | |  | | |  | | |
| Frayed |  | |  | |  | | |  | | |  | | |  | | |
| Soft |  | |  | |  | | |  | | |  | | |  | | |
| Brittle |  | |  | |  | | |  | | |  | | |  | | |
| White spots/lines |  | |  | |  | | |  | | |  | | |  | | |
| of:  Thickening Finger nails |  | |  | |  | | |  | | |  | | |  | | |
| Thickening Toenails |  | |  | |  | | |  | | |  | | |  | | |
| Fungus – fingernails |  | |  | |  | | |  | | |  | | |  | | |
| Fungus - toenails |  | |  | |  | | |  | | |  | | |  | | |
| Nails Curve up |  | |  | |  | | |  | | |  | | |  | | |
| Nail Ridges |  | |  | |  | | |  | | |  | | |  | | |
| Nail Pitting |  | |  | |  | | |  | | |  | | |  | | |
| Ragged cuticles |  | |  | |  | | |  | | |  | | |  | | |
| **RESPIRATORY:** |  | |  | |  | | |  | | |  | | |  | | |
| Loss of sense of |  | |  | |  | | |  | | |  | | |  | | |
| Smell |  | |  | |  | | |  | | |  | | |  | | |
| Taste |  | |  | |  | | |  | | |  | | |  | | |
| Acute sense/smell |  | |  | |  | | |  | | |  | | |  | | |
| Nasal stuffiness |  | |  | |  | | |  | | |  | | |  | | |
| Sinus fullness |  | |  | |  | | |  | | |  | | |  | | |
| Sinus infection |  | |  | |  | | |  | | |  | | |  | | |
| Post nasal drip |  | |  | |  | | |  | | |  | | |  | | |
| Bad odor in nose |  | |  | |  | | |  | | |  | | |  | | |
| Bad breath |  | |  | |  | | |  | | |  | | |  | | |
| Nose bleeds |  | |  | |  | | |  | | |  | | |  | | |
| Hay fever |  | |  | |  | | |  | | |  | | |  | | |
| Spring |  | |  | |  | | |  | | |  | | |  | | |
| Summer |  | |  | |  | | |  | | |  | | |  | | |
| Fall |  | |  | |  | | |  | | |  | | |  | | |
| Change of season |  | |  | |  | | |  | | |  | | |  | | |
| Winter stuffiness |  | |  | |  | | |  | | |  | | |  | | |
| Sore throat |  | |  | |  | | |  | | |  | | |  | | |
| Hoarseness |  | |  | |  | | |  | | |  | | |  | | |
| Cough - dry |  | |  | |  | | |  | | |  | | |  | | |
| Cough - productive |  | |  | |  | | |  | | |  | | |  | | |
| Wheezing |  | |  | |  | | |  | | |  | | |  | | |
| **CARDIOVASCULAR:** | **MILD** | | **MOD** | | **SEV** | | | **OCC** | | | **FREQ** | | | **ALWAYS** | | |
| High blood pressure |  | |  | |  | | |  | | |  | | |  | | |
| Palpitations |  | |  | |  | | |  | | |  | | |  | | |
| Heart pounding |  | |  | |  | | |  | | |  | | |  | | |
| Rapid pulse |  | |  | |  | | |  | | |  | | |  | | |
| Irregular pulse |  | |  | |  | | |  | | |  | | |  | | |
| Faints easily |  | |  | |  | | |  | | |  | | |  | | |
| Chest pains |  | |  | |  | | |  | | |  | | |  | | |
| Mitral valve prolapse |  | |  | |  | | |  | | |  | | |  | | |
| Heart murmur |  | |  | |  | | |  | | |  | | |  | | |
| Varicose veins |  | |  | |  | | |  | | |  | | |  | | |
| Phlebitis |  | |  | |  | | |  | | |  | | |  | | |
| **URINARY:** |  | |  | |  | | |  | | |  | | |  | | |
| Urgency |  | |  | |  | | |  | | |  | | |  | | |
| Leaking |  | |  | |  | | |  | | |  | | |  | | |
| Pain |  | |  | |  | | |  | | |  | | |  | | |
| Hesitancy |  | |  | |  | | |  | | |  | | |  | | |
| Bed wetting |  | |  | |  | | |  | | |  | | |  | | |
| Kidney stone |  | |  | |  | | |  | | |  | | |  | | |
| Infection |  | |  | |  | | |  | | |  | | |  | | |
| Bleeding |  | |  | |  | | |  | | |  | | |  | | |

**Environmental History:** Do you have or use any of the following at/near home or work?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Exposure:** | **Home** | **Work** | **Exposure** | **Home** | **Work** |
| Spring water |  |  | Foam rubber pillows |  |  |
| Well water |  |  | Feather/down  Comforter |  |  |
| Water purifier |  |  | Coat/jacket |  |  |
| Damp cellar |  |  | Stuffed upholstery |  |  |
| Wooded area |  |  | Animals |  |  |
| Swamp |  |  | Polyester blend in:  Sheets |  |  |
| Power lines |  |  | Pillow case |  |  |
| Microwave transmitter |  |  | Pajamas |  |  |
| Smoke stacks |  |  | Shirts |  |  |
| Dump |  |  | Skirts |  |  |
| Gas stove |  |  | Pants |  |  |
| Gas furnace |  |  | Exterminator |  |  |
| Gas hot water heater |  |  | Moth balls |  |  |
| Gas dryer |  |  | Mold on:  Shower curtain |  |  |
| Wood stove |  |  | Basement walls |  |  |
| Coal stove |  |  | First story walls |  |  |
| Kero space heater |  |  | Second story walls |  |  |
| Forced hot air heat |  |  | Garage under living space |  |  |
| Electric blankets |  |  | Urea formaldehyde insulation |  |  |
| Feather pillows |  |  | Other: |  |  |

**Environmental Carpet:** Do you have .. .(check appropriate selections)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **BEDROOM** | **√** | **LIVING ROOM** | **√** | **FAMILY ROOM** | **√** |
| None |  | None |  | None |  |
| Area Rugs |  | Area Rugs |  | Area Rugs |  |
| Wall to Wall |  | Wall to Wall |  | Wall to Wall |  |
| Wool |  | Wool |  | Wool |  |
| Synthetic Pad |  | Synthetic Pad |  | Synthetic Pad |  |
| Glued Down |  | Glued Down |  | Glued Down |  |
| How Old Is Carpeting |  | How Old Is Carpeting |  | How Old Is Carpeting |  |
|  |  | On slab |  | On slab |  |
|  |  | Ever damp |  | Ever damp |  |
|  |  | Moldy |  | Moldy |  |

Did you live in an area with soft water? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you live in an area with hard water? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
|  | **Are you bothered by:** | **√** |
|  | Gasoline fumes |  |
|  | Diesel exhaust |  |
|  | Soaps |  |
|  | Detergents |  |
|  | Chlorinated water |  |
|  | Moth balls |  |
|  | Asphalt/tar |  |
|  | Hair spray |  |
|  | Cosmetics |  |
|  | Perfume |  |
|  | Dust |  |
|  | Fabric stores |  |
|  | New car smell |  |
|  | Air conditioners |  |
|  | Newsprint |  |
|  | Tobacco smoke |  |
|  | Cats |  |
|  | Dogs |  |
|  | Mold |  |
|  | Tree pollen |  |
|  | Grass pollen |  |
|  | Ragweed pollen |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **How well have things been going for you?** | **Very Well** | **Fair** | **Poor** | **Very Poor** | **Does not apply** |
| At school |  |  |  |  |  |
| With friends |  |  |  |  |  |
| With your parents |  |  |  |  |  |
| With your teachers |  |  |  |  |  |
| With your brothers/sisters |  |  |  |  |  |
| With sports |  |  |  |  |  |
| With music |  |  |  |  |  |

Have you ever had psychotherapy or counseling?

Never \_\_\_\_\_ Now \_\_\_\_\_ From \_\_\_\_\_\_\_\_\_ Until \_\_\_\_\_\_\_\_\_\_ What kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is filling out this questionnaire?

Yourself \_\_\_\_\_\_\_\_ Parent \_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_

When were your parents married? \_\_\_\_\_ Never \_\_\_\_\_

When were they separated \_\_\_\_\_ Never \_\_\_\_\_

When were they divorced \_\_\_\_\_ Never \_\_\_\_\_

When were they remarried \_\_\_\_\_ Never \_\_\_\_\_

Custody arrangements\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If adopted, at what age: \_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Mother: | Father: | Mother's Mother: | Mother's Father: | Father's Mother: | Father's Father: | Sibling: | Sibling: |
| Spouse: | Significant Other: | Child: | Child: | Mother's Brothers: | Mother's Sisters: | Father's Brothers: | Father's Sisters: |

Any other family history I should know about? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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