**Pediatric Intake Form**

**Child’s Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Today’s Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of birth (MM/DD/YY)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_

**Referred by:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who is filling out this form (name and relation)?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**With whom does the child live?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Telephone number**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_May we leave a message at this number? Y N

**Emergency contact**: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you hear about Martin Wellness**?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list all other health care providers they see:** (include name, title and phone number)

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Have they had previous naturopathic care? Y N**

**Major Health Concerns in order of importance**:

|  |
| --- |
| 1. |
| 2. |
| 3. |
| 4. |

**How would you describe your child’s general health (Circle)? Excellent Good Fair Poor**

**Please indicate any serious conditions, illnesses or injuries, and any hospitalizations (along with approximate dates).**

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

**Do they have any allergies (to foods, medicines, environmental, etc.)? Please explain:**

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

**Please list all current medications and date started:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Prescription Drugs | Over-the-counter Drugs | Supplements (mineral, vitamin etc) | Herbal Medicines | Homeopathic Medicines |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Are you currently following a special diet/have any dietary restrictions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How many times have they been treated with Antibiotics? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please indicate which immunizations they have had (Ontario vaccine schedule dates appear next to each immunization):**

□ DPT (Diphtheria, pertussis, tetanus) – 2,4,6 & 18 months

□ Rotavirus – 2 & 4 months

□Haemophilus Influenza B – 2,4,6, 8 months

□Pneumococcal Conjugate - 2, 4, & 12 months

□ Meningicoccal Conjugate – 12 months (ACYW version – grade 7)

□ Chicken Pox – 15 months, 4-6 years

□ Tetanus booster (14-18 years) When?\_\_\_\_\_\_

□ MMR (measles, mumps, rubella) – 1 year, 4 – 6 years

□ Seasonal Influenza – Every year

□ Polio – 4 – 6 years

□ Hepatitis B – Grade 7

□ HPV – Grade 8

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your child experience any adverse reactions to the vaccines? Y N

**Personal & Family medical history:**

Indicate if a close relative (Parent or Sibling) or the Child has had any of the following:

|  |  |  |  |
| --- | --- | --- | --- |
| Condition | Who? | Condition | Who? |
| Allergies |  | Depression |  |
| Asthma |  | Anxiety |  |
| Heart Disease |  | Drug Addiction |  |
| High Blood Pressure |  | Alcohol Addiction |  |
| Autoimmune |  | Kidney Disease |  |
| Cancer |  | Diabetes |  |
| Seizures |  | Other |  |

**Prenatal health**

**What was the health of the parents at conception?**

Mother □ Poor □ Fair □ Good □ Excellent □ Unknown

Father □ Poor □ Fair □ Good □ Excellent □ Unknown

**What was the health of the mother during the pregnancy?**

□ Poor □ Fair □ Good □ Excellent □ Unknown

**What was the mother’s age at child’s birth?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How was the mother’s diet during pregnancy?**

□ Poor □ Fair □ Good □ Excellent □ Unknown

**Did the mother receive prenatal medical care?** □ Y □ N □ Unknown

|  |  |  |  |
| --- | --- | --- | --- |
| **Did the mother experience any of the following during the pregnancy:** □ Bleeding  | □ High blood pressure  | □ Nausea  | □ Vomiting  |
| □ Diabetes  | □Thyroid problems  | □ Physical or emotional trauma  |

**Did the mother use any of the following during the pregnancy?**

□ Tobacco □ Alcohol □ Recreational drugs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Prescription medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Over-the-counter medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Birth History**

**Term length:** □ Full □ Premature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ wks □ Late: \_\_\_\_\_\_\_\_\_\_\_\_ wks

**Length of labour:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Weight at birth** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any complications?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Was the birth:** □ Vaginal □ C-section □ Induced □ Forceps □ Anesthesia used

**Did the child experience any of the following at or shortly after birth?**

□ Jaundice □ Rashes □ Seizures □ Birth injuries □ Birth defects □ Other

**Was your child breast fed? Y N For how long:\_\_\_\_\_\_**

**Was your child formula fed? Y N For how long: \_\_\_\_\_**

**Describe a typical day’s diet:**

Breakfast\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lunch \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dinner\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Snacks \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Beverages (and total quantity)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health and Development**

**How was your child’s health in the first year?** □ Poor □ Fair □ Good □ Excellent □ Unknown

**At what age did your child first:**

Sit up \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Crawl \_\_\_\_\_\_\_\_\_\_\_\_\_ Walk \_\_\_\_\_\_\_\_\_\_\_\_\_ Talk \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Describe your child’s sleep pattern:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**How would you describe your child’s temperament?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How would you describe your child’s behaviour and performance at school?**

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

**Environment**

**Is the child in:** □ school □ daycare □ home care □ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What are your child’s favorite activities?**

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

**Does the child exercise regularly?** □ Y □ N **How much, how often?**

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

**How much screen time (TV, Tablet/Computer) does your child get?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hours/d

**How often does your child read (not for school), or how often does someone read to your child?**

□ Daily □ Several times a week □ Weekly □ Less than weekly

**Does anyone in the child’s household smoke?** □ Y □ N

**Are there animals in the home?** □ Y □ N

**How is the child’s home heated?**

□ Natural Gas □ Oil □ Electric □Wood □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you know of any toxins or other hazards the child is regularly exposed to (home, other’s work, hobbies, etc.)? Please describe.**

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

**Is there anything that you feel is important that has not been covered?**

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

**SYSTEMS REVIEW**

Below is a list of symptoms which may or may not seem relevant to your current health concerns. Please answer completely as a detailed health history is necessary to develop a personalized health plan. The relevant issues brought up by this questionnaire will be discussed during your appointment. **Please check (√) “C" if you currently have the symptom or "P" if you have had it in the past 6 months.**

|  |  |  |
| --- | --- | --- |
| **Skin** | **C** | **P** |
| Rashes |  |  |
| Hives |  |  |
| Acne |  |  |
| Boils |  |  |
| Eczema |  |  |
| Psoriasis |  |  |
| Dry Skin |  |  |
| Itching |  |  |
| Lumps |  |  |
| Night Sweats |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Head** | **C** | **P** |
| Tension headaches |  |  |
| Migraines |  |  |
| Head Injury |  |  |
| Dizziness |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Eye** | **C** | **P** |
| Impaired Vision |  |  |
| Use Contacts/glasses |  |  |
| Eye Pain |  |  |
| Tearing |  |  |
| Dryness |  |  |
| Double vision |  |  |
| Glaucoma |  |  |
| Cataracts |  |  |
| Blurring |  |  |
| Light Sensitivity |  |  |
| Itching |  |  |
| Redness |  |  |
| Discharge |  |  |
| Blind spot |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Ears** | **C** | **P** |
| Impaired hearing |  |  |
| Earache  |  |  |
| Discharge |  |  |
| Infections |  |  |
| Excessive Wax |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Nose & Sinuses** | **C** | **P** |
| Frequent colds |  |  |
| Nose bleeds |  |  |
| Stuffiness |  |  |
| Hay Fever |  |  |
| Infections |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Mouth & Throat** | **C** | **P** |
| Hoarseness |  |  |
| Gum problems |  |  |
| Sores |  |  |
| Dryness |  |  |
| Sore throat |  |  |
| Loss of taste |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Neck** | **C** | **P** |
| Lumps |  |  |
| Swollen glands |  |  |
| Goiter |  |  |
| Pain or Stiff |  |  |
| other |  |  |

|  |  |  |
| --- | --- | --- |
| **Respiratory** | **C** | **P** |
| Cough |  |  |
| Sputum/phlegm |  |  |
| Spit up blood |  |  |
| Wheeze |  |  |
| Asthma |  |  |
| Bronchitis |  |  |
| Pneumonia |  |  |
| Pleurisy |  |  |
| Emphysema |  |  |
| Pain w Breathing |  |  |
| Short of breath |  |  |
| Positive tuberculin test |  |  |
| Last TB test |  |  |
| Lest chest x-ray |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Cardiovascular** | **C** | **P** |
| Angina |  |  |
| Murmurs |  |  |
| Chest pain |  |  |
| Swollen ankles |  |  |
| Palpitations, fluttering |  |  |
| Last ECG |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Breasts** | **C** | **P** |
| Lumps |  |  |
| Tenderness |  |  |
| Nipple discharge |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Gastrointestinal** | **C** | **P** |
| Vomiting |  |  |
| Heartburn |  |  |
| Change in appetite |  |  |
| Nausea |  |  |
| # of Bowel movements/day:  |
| Vomiting blood |  |  |
| Belching |  |  |
| Passing gas |  |  |
| Abdominal Pain |  |  |
| Indigestion |  |  |
| Diarrhea |  |  |
| Constipation |  |  |
| Blood in stools |  |  |
| Hemorrhoids |  |  |
| Black tarry stool |  |  |
| Jaundice |  |  |
| Liver disease |  |  |
| Gallbladder disease  |  |  |
| Food allergy |  |  |
| Hiatus hernia |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Blood/Lymph** | **C** | **P** |
| Anemia |  |  |
| Easy bleed/bruise |  |  |
| Past infusions |  |  |
| Lymph node swelling |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Urinary** | **C** | **P** |
| Pain on urination |  |  |
| Increased frequency |  |  |
| Frequency at night |  |  |
| Urgency |  |  |
| Leakage |  |  |
| Frequent UTI |  |  |
| Blood in urine |  |  |
| Reduced urine flow |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Musculoskeletal** | **C** | **P** |
| Broken bones |  |  |
| Muscle cramps/spasms |  |  |
| Weakness |  |  |
| Joint swelling |  |  |
| Backache |  |  |
| Joint pain |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Peripheral vascular** | **C** | **P** |
| Deep leg pain |  |  |
| Cold hands/feet |  |  |
| Varicose veins |  |  |
| Leg cramps |  |  |
| Numbness |  |  |
| Ulcers |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Neurologic** | **C** | **P** |
| Fainting |  |  |
| Seizure/convulsions |  |  |
| Paralysis |  |  |
| Muscle weakness |  |  |
| Loss of memory |  |  |
| Involuntary movements |  |  |
| Loss of balance |  |  |
| Speech problems |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Endocrine** | **C** | **P** |
| Heat/cold intolerance |  |  |
| Thyroid trouble |  |  |
| Excess thirst |  |  |
| Excess hunger |  |  |
| Excess sweating |  |  |
| diabetes |  |  |
| Low blood sugar |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Emotional** | **C** | **P** |
| Depression |  |  |
| Extreme anger |  |  |
| Mood swings |  |  |
| Anxiety |  |  |
| Nervousness |  |  |
| Tension |  |  |
| Phobias |  |  |
| Insomnia |  |  |
| Sexual difficulties |  |  |
| Drug abuse |  |  |
| Psychiatric care |  |  |
| Psychological counselling |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Male Reproductive** | **C** | **P** |
| Hernia |  |  |
| Testicular mass |  |  |
| Testicular pain |  |  |
| Impotence |  |  |
| Premature ejaculation |  |  |
| STI |  |  |
| Sores |  |  |
| Sexually active |  |  |
| Circle sexual preference: Heterosexual Homosexual Bisexual |
| Other |

|  |  |  |
| --- | --- | --- |
| **Female Reproductive** | **C** | **P** |
| Bleeding between periods |  |  |
| Irregular cycle |  |  |
| PMS |  |  |
| Heavy flow |  |  |
| Painful menses |  |  |
| Vaginal discharge |  |  |
| Vaginal itching |  |  |
| Sexually active |  |  |
| Age of first menses: |
| Last menstrual period: |
| #of days period lasts: |
| Length of cycle: |
| #of pregnancies: |
| #of live births: |
| #of miscarriages: |
| # of abortions: |
| Circle preference: Heterosexual Homosexual Bisexual |
| Other |  |  |