AZ GOOD HEALTH CENTER
INTEGRATIVE MEDICAL CARE

INFANT/CHILD/ADOLESCENT INTAKE FORM

Today's Date:			
PATIENT INFORMATION			
Patient's last name:	First:	Middle:	
	Date of Birth:	Age:	Sex:
Patient's address:			
City:	State:	ZIP Code:	
Mother's (or Guardian's) name:			
Lives with patient? ☐ **Yes** ☐ **No**			
Home Telephone: ( ) -	Work Telephone: ( ) -		
Mobile Telephone ( ) -	E-mail Address:		
Street address (if different)			
City:	**State:**	**ZIP Code:**	
Father's (or Guardian's) name:			
Lives with patient? ☐ **Yes** ☐ **No**			
Home Telephone: ( ) -	Work Telephone: ( ) -		
Mobile Telephone ( ) -	E-mail Address:		
Street address (if different)			
City:	**State:**	**ZIP Code:**	
How did you become aware of the AZ Good Health Center or its Practitioners?			
Primary care physician's (or pediatrician) name:	☐ MD ☐ DO ☐ ND ☐ other (specify)		
Address –			
City:	State: Zip		
Phone: ( ) -	Fax: ( ) -		
May we contact? ☐ **Yes** ☐ **No** ☐ **Depends**			

Current Height: Weight: Preferred Language:

Race(s)/Ethnicity(ies)

WHAT ARE YOUR CONCERNS FOR YOUR CHILD?

Is your child in good general health at the present time? ☐ Yes ☐ No	
What are the most important health problems that you wish to address with us:?	1.
	2.
	3.
	4.
	5.
	6.
	7.
	8.
	9.
	10.
Is your child currently under the care of a medical specialist? ☐ Yes ☐ No	
Name, address, telephone:	
Name, address, telephone:	
Name, address, telephone:	
Name, address, telephone:	
Name, address, telephone:	

CURRENT (Prescription) MEDICATIONS … or ☐ currently not taking any medications

Name	Dose (mg, ml, etc)	Frequency (once per day, etc.) or Only As Needed?	Reason for Taking

(Add additional sheets if necessary)

ALLERGIES ….. or ☐ no known allergies

To medications: **Reactions:**

To foods: **Reactions:**

Other: **Reactions:**

SUPPLEMENTS/HERBS/VITAMINS/HOMEOPATHIC REMEDIES (Vitamins, Fish Oil, Minerals, Arnica, Nux Vomica, Melatonin, etc.) **or ☐ currently not taking any**

Name	Dose (mg, ml, etc)	Frequency (once per day, etc.) or Only As Needed?	Reason for Taking

PAST MEDICAL HISTORY

PREGNANCY

Planned: ☐ Yes ☐ No
Full term: ☐ Yes ☐ No
Patient birth order: ☐ First ☐ Second ☐ Third ☐ Other:
Mother smoke? ☐ Yes ☐ No
Mother consume alcohol? ☐ Yes ☐ No
Did mother take medications? ☐ Yes ☐ No Which medications:
Primary language spoken by mother:

☐ Maternal dental fillings (amalgams) placed or removed during pregnancy
☐ Remodeled home, or moved into new house during pregnancy
☐ Mother's workplace chemicals during pregnancy
☐ Maternal diet soda or artificial sweeteners during pregnancy
☐ Maternal smoking, alcohol or recreational drugs during pregnancy

Describe any/all complications:

LABOR/DELIVERY

Describe labor/delivery experience:

Length of labor: Hrs.
☐ vaginal delivery ☐ C-section ☐ induced (Pitocin) ☐ forceps ☐ vacuum ☐ Breech presentation
Complications after birth? ☐ none ☐ oxygen ☐ intubated ☐ resuscitated ☐ surgery:
Birth weight: Birth length: Cried immediately? ☐ Yes ☐ No
Immediate physical contact? (mother/baby) ☐ Yes ☐ No If no, explain:

Positive bonding experience between mother and child at birth? ☐ Yes ☐ No If no, explain:

Infant breast fed? ☐ Yes ☐ No Length of time breast fed:
Vaccination at birth (Hep B): ☐ Yes ☐ No Rhogam injection during pregnancy: ☐ Yes ☐ No
Describe the overall experience for:
Mother:

Father:

Did Mother experience post-partum depression? ☐ Yes ☐ No If yes, describe:

Complications with previous pregnancies? ☐ Yes ☐ No If yes, describe:

POSSIBLE EXPOSURES

- ☐ Childhood vaccinations
- ☐ Insecticide spraying (in the home or in the neighborhood)
- ☐ Frequent (weekly or more) restaurant or fast food meals
- ☐ Tick bites
- ☐ Living near/playing around chemical or waste dumps or smelters
- ☐ Camping
- ☐ Visiting working farms/raches
- ☐ Travel outside the US
- ☐ Mold in the home

CHILDHOOD ILLNESS

Condition	Age(s)	Frequency	Comments
Ear infections			
Upper Respiratory problems/Colds			
Sore throats			
Pneumonias			
Environmental Allergies			
High fever			
Meningitis			

PREVIOUS SURGERIES, HOSPITALIZATIONS, OR SERIOUS ACCIDENTS/INJURIES

Date	Description	Outcome

This Section is for Ages 10+ only:

BOYS: Changes of puberty (voice change, pubic hair) ☐ Yes ☐ No
If yes, please specify: Age of onset
Any history of genital/urologic abnormalities or difficulties? ☐ Yes ☐ No
If yes, please specify: _____
_____

GIRLS: Menstruating? ☐ Yes ☐ No
If yes, please specify:
Age of first menstrual period:
Date of last menstrual period:
Length of cycle: days
Interval between cycles: days
Flow: ☐ Heavy ☐ Moderate ☐ Light
Any recent changes in menstrual flow?
Any history of genital/urologic abnormalities or difficulties? ☐ Yes ☐ No
If yes, please specify: _____
_____
_____

FAMILY HISTORY ☐ **Unknown: Child is adopted/in foster care**
Please list health conditions such as: arthritis, asthma, alcoholism, Alzheimer's, cancer (type and age at diagnosis), depression, developmental problems, diabetes, drug addiction, eating disorders, genetic disorders, glaucoma, heart disease/Heart attack, infertility, learning disability, mental illness, migraines, neurologic illness, obesity, osteoporosis, stroke, seizures, suicide, etc.

Mother	☐ Healthy	☐
Father	☐ Healthy	☐
Siblings (names)		
	☐ Healthy	☐
	☐ Healthy	☐
	☐ Healthy	☐
	☐ Healthy	☐
	☐ Healthy	☐
	☐ Healthy	☐
Maternal grandmother (mother's mother)	☐ Healthy	☐
Maternal grandfather (mother's father)	☐ Healthy	☐
Paternal grandmother (father's mother)	☐ Healthy	☐
Paternal grandfather (father's father)	☐ Healthy	☐

Other family history (i.e. Grandparents' siblings, Maternal or Paternal aunts/uncles or their children)**:**

DEVELOPMENTAL HISTORY

First two (2) years of child's life, what type of baby was he/she (e.g. feeding, sleeping, activity level, etc):

Speech/Language difficulty? ☐ Yes ☐ No If yes, describe: _____

Fine motor difficulty? ☐ Yes ☐ No If yes, describe: _____

Gross motor difficulty? ☐ Yes ☐ No If yes, describe: _____

Social/interaction difficulty? ☐ Yes ☐ No If yes, describe: _____

For ages 4+ only: Does your child wet the bed? ☐ Yes ☐ No If yes, how often? _____

Hand preference: ☐Right ☐Left ☐Mixed ☐Unsure

Last eye examination: _____ Age _____ Year ☐ Other, explain:

Does your child wear glasses/contacts? ☐ Yes ☐ No If yes, describe correctional needs:

Has your child been diagnosed with any of the following:

☐ near sighted	☐ far sighted	☐ astigmatism	☐ amblyopia
☐ strabismus	☐ macular issues	☐ glaucoma	☐ cataracts
☐ nystagmus	☐ blindness	☐ cortical blindness	☐ other, describe:

Has your child received any vision therapy? ☐ Yes ☐ No If yes, describe:
Any hearing complications? (operations, infections, tubes) ☐ Yes ☐ No If yes, describe:

How would you describe your child's speech/language development: ☐ Normal ☐ Delayed ☐ Advanced
Comments:

FAMILY DYNAMICS

Please list ALL family members or non-family members residing within the home (siblings, cousins, grandparents, etc):

Name	Relationship	Age
Name	Relationship	Age
Name	Relationship	Age
Name	Relationship	Age
Name	Relationship	Age
Name	Relationship	Age
Name	Relationship	Age
Name	Relationship	Age
Name	Relationship	Age
Name	Relationship	Age

Is your child adopted? : ☐ Yes ☐ No If yes, age at adoption: Date of adoption:
If adopted, was the prior foster care? ☐ Yes ☐ No If yes, term:
Describe dynamics of child's initial interaction with family members within the home (positive/negative):

Is family involved with community groups or activities? ☐Yes ☐No
If yes, describe:

Are parental caretakers biological? ☐ Yes ☐ No
Any history of separation/ divorce? ☐ Yes ☐ No
If yes, was separation/divorce: ☐ Agreeable ☐ Disagreeable ☐ On-going
Age of patient during separation/divorce: _____ Year of separation/divorce:
Is biological mother remarried? ☐ Yes ☐ No If yes, year remarried:
Is biological father remarried? ☐ Yes ☐ No If yes, year remarried:
Is either biological parent deceased? ☐ Yes ☐ No If yes please explain:
Please describe any involvement of non-custodial parent with the patient:

Is your current marital situation stable, positive, and nurturing? Describe:

Mother's level of education: Father's level of education:
What, if any, stressors are currently affecting the family unit:

EDUCATION

For ages 5+ only:
Current grade level School name:

Past/Present special educational services ☐Yes ☐No
Describe your child's learning experience thus far (include difficulties/success stories):

Has your child been evaluated/tested for remedial instruction and or placement: ☐Yes ☐No
If yes, at what age, grade:

NUTRITION

Describe your child's diet: (Check all that apply)
Infants: ☐Breastfed ☐ Formula (type):_____ ☐Baby food/puree ☐ Rice cereal/oatmeal

Ages 1+ :
☐ Mixed food diet (animal and vegetable sources)
☐ Vegetarian
☐ Vegan
☐ Organic
☐ Non-GMO
☐ Salt restriction
☐ Fat restriction
☐ Starch/carbohydrate restriction
☐ Other (describe) _____
_____

Specific food restrictions ☐dairy ☐wheat ☐all gluten ☐eggs ☐soy ☐corn ☐ other (describe):_____
_____
_____
_____

Food cravings? ☐ Yes ☐ No If yes, which foods?

MEDICAL SYMPTOM QUESTIONAIRE FOR CHILDREN

For Infants and children, ages 0-13

The MEDICAL SYMPTOM QUESTIONAIRE identifies symptoms that help to identify the underlying causes of illness and helps track your child's progress over time. Rate each of the following symptoms based upon your child's health profile for the past 30 days.

POINTSCALE

0 = Never or almost never has the symptom
1 = Occasionally has it, effect is not severe
2 = Occasionally has, effect is severe
3 = Frequently has it, effect is not severe
4 = Frequently has it, effect is severe

DIGESTIVE TRACT
_____ Nausea
_____ Vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching
_____ Passing gas (flatulence)
_____ Heartburn
_____ Tummy ache
_____ Poor appetite
_____ Refusal to eat
_____ Total

EARS
_____ Reddening of ears
_____ Itchy ears
_____ Earaches/ear infections (circle which)
_____ Drainage from ears
_____ Hearing loss
_____ Frequent pulling on ears
_____ Total

MIND/EMOTIONS
_____ Inattentiveness, poor concentration
_____ Mood swings
_____ Fear
_____ Anger
_____ Irritability
_____ Aggressiveness (hitting, kicking, biting)
_____ Crying or weepiness
_____ Tantrums
_____ Total

HEAD
_____ Headaches
_____ Difficulty falling asleep
_____ Wakes up during the night
_____ Total

EYES
_____ Dark circles under eyes
_____ Bags under eyes
_____ Swollen eyelids
_____ Total

NOSE
_____ Runny nose
_____ Stuffy nose
_____ Sneezing
_____ Allergic salute (rubs nose often)
_____ **Total**

MOUTH/THROAT
_____ Swollen or red lips
_____ Gagging, frequent clearing of throat
_____ Sore throat, hoarseness
_____Swollen, sore, or discolored tongue
_____ Swollen or sore gums or lips
_____Canker sores
_____ Total

LUNGS
_____ Coughing
_____ Sneezing
_____ Difficulty breathing
_____ Wheezing
_____ **Total**

ENERGY
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness
_____ Sleeping problems
_____ Total

SKIN
_____ Easy bruising
_____ Hives
_____ Rash
_____ Dry or flaky skin
_____ Flushing
_____ Cold hands or feet
_____ Eczema
_____ **Total**

JOINTS, MUSCLES
_____ Coordination problems
_____ Pain in muscles, e.g. legs aches
_____ Pain in joints, e.g. knees ache
_____ **Total**

OTHER
_____ Frequent urination
_____ Itching of anus or genitals
_____ Bed-wetting
_____ Wetting or soiling of clothes
_____ **Total**

GRAND TOTAL _____

Key to Questionnaire: Add individual scores and total each group. Add each group score and give a grand total.
Optimal is less than 10 • Mild Toxicity: 10-50 • Moderate Toxicity: 50-100 • Severe Toxicity: over 100

Medical Symptoms Questionnaire
For Adolescents 14+

Rate each of the following symptoms based upon your typical health profile for the p*ast 30 days*
Record numbers in the yellow column, front and back.

Point Scale
0 -*Never* or *almost never* have the symptom
1 -*Occasionally* have it, effect is *not severe*
2 -*Occasionally* have it, effect is *severe*
3 -*Frequently* have it, effect is *not severe*
4 -*Frequently* have it, effect is *severe*

HEAD	Headaches		
	Faintness		
	Dizziness		
	Insomnia	Total	
EYES	Watery or itchy eyes		
	Swollen, reddened or sticky eyelids		
	Bags or dark circles under eyes		
	Blurred or tunnel vision		
	(does not include near or far-sightedness)	Total	
EARS	Itchy ears		
	Earaches, ear infections		
	Drainage from ear		
	Ringing in ears, hearing loss	Total	
NOSE	Stuffy nose		
	Sinus problems		
	Hay fever		
	Sneezing attacks		
	Excessive mucus formation	Total	
MOUTH/THROAT	Chronic coughing		
	Gagging, frequent need to clear throat		
	Sore throat, hoarseness, loss of voice		
	Swollen or discolored tongue, gums, lips		
	Canker sores	Total	
SKIN	Acne		
	Hives, rashes, dry skin		
	Hair loss		
	Flushing, hot flashes		
	Excessive sweating	Total	
HEART	Irregular or skipped heartbeat		
	Rapid or pounding heartbeat		
	Chest pain	Total	
TOTAL THIS PAGE			

LUNGS	Chest congestion		
	Asthma, bronchitis		
	Shortness of breath		
	Difficulty breathing	Total	
DIGESTION	Nausea, vomiting		
	Diarrhea		
	Constipation		
	Bloated feeling		
	Belching, passing gas		
	Heartburn		
	Intestinal/stomach pain	Total	
JOINTS/MUSCLE	Pain or aches in joints		
	Arthritis		
	Stiffness or limitation of movement		
	Pain or aches in muscles		
	Feeling of weakness or tiredness	Total	
WEIGHT	Binge eating/drinking		
	Craving certain foods		
	Excessive weight		
	Compulsive eating		
	Water retention		
	Underweight	Total	
ENERGY/ACTIVITY	Fatigue, sluggishness		
	Apathy, lethargy		
	Hyperactivity		
	Restlessness	Total	
MIND	Poor memory		
	Confusion, poor comprehension		
	Poor concentration		
	Poor physical coordination		
	Difficulty in making decisions		
	Stuttering or stammering		
	Slurred speech		
	Learning disabilities	Total	
EMOTIONS	Mood swings		
	Anxiety, fear, nervousness		
	Anger, irritability, aggressiveness		
	Depression	Total	
OTHER	Frequent illness		
	Frequent or urgent urination		
	Genital itch or discharge	Total	
TOTAL THIS PAGE			
GRAND TOTAL		TOTAL	

DIET DIARY
For Ages 1+

Please complete your diet diary every day for 3 days, and bring this record to your initial appointment.

1. Note the time you wake up.
2. List & describe in detail **all foods, snacks and drinks**. Note the time of each meal or snack. List everything, including condiments (ketchup, mustard, pickles, etc)
3. Keep track of how much water you drink, and list amount in ounces.

DAY 1 **Date:**_____

TIME	DAY EVENT	FOOD & DRINK INTAKE (include type, amount, brand)
	WAKE-UP	
	BREAKFAST	
	MID-AM SNACK	
	LUNCH	
	MID-PM SNACK	
	DINNER	
	PM SNACK	

Day 2 **Date:_____**

TIME	DAY EVENT	FOOD & DRINK INTAKE (include type, amount, brand)
	WAKE-UP	
	BREAKFAST	
	MID-AM SNACK	
	LUNCH	
	MID-PM SNACK	
	DINNER	
	PM SNACK	

Day 3 **Date:**_____

TIME	DAY EVENT	FOOD & DRINK INTAKE (include type, amount, brand)
	WAKE-UP	
	BREAKFAST	
	MID-AM SNACK	
	LUNCH	
	MID-PM SNACK	
	DINNER	
	PM SNACK	

Patient's Name: _____ **AZ Good Health Center**

How Healthy Is Your Child's Diet?
For Ages 1+

Circle or Check your answers after careful thought

1. How many times does your child eat dried beans or peas (legumes, lentils, chickpeas, kidney beans, green peas, etc.) in a normal week?
   ☐ A. 0 ☐ B. 1 to 2 ☐ C. 3 to 4 ☐ D. 5 to 6 ☐ E. 7 or More

2. How many times does your child eat red meat in a normal week?
   ☐ A. 6 or More ☐ B. 4 to 5 ☐ C. 1 to 3 ☐ D. Less than Once a Week ☐ E. 0

3. How many times does your child eat in a fast food restaurant in a normal week?
   ☐ A. 6 or More ☐ B. 4 to 5 ☐ C. 1 to 3 ☐ D. Less than Once a Week ☐ E. 0

4. In a typical day, what does your child drink most often?
   ☐ A. Soda (Regular or Diet) ☐ B. Caffeinated Coffee /Tea ☐ C. Decaffeinated Coffee/Tea
   ☐ D. Milk or Fruit Juice ☐ E. Herbal Tea or Water

5. How many cans or bottles of soda does your child drink in a normal day?
   ☐ A. 6 or More ☐ B. 4 to 5 ☐ C. 2 to 3 ☐ D. 1 ☐ E. Less than 1 ☐ F. 0

6. How often do you eat fish in a typical week?
   ☐ A. Never ☐ B. Once ☐ C. Twice ☐ D. 3 to 5 Times

7. In a typical week, how often does your child eat whole grains (100% whole grain bread, whole oats, brown rice, quinoa, whole rye crackers)?
   ☐ A. Never ☐ B. 1 - 2 x Week ☐ C. 3 - 4 x Week ☐ D. 5 - 6 x Week
   ☐ E. 1 or More x Day

8. How often does your child eat sweets such as cookies, cakes, or ice cream?
   ☐ A. 1 or More x Day ☐ B. Every other Day ☐ C. Twice a Week ☐ D. Once a Week
   ☐ E. 2 – 3 Times x Month ☐ F. Rarely