Print Form

Date of Service: **Place of Service:**

Location of Service:

Preliminary Questionnaire For Prospective New Pediatric Patient

Our practice asks that you fill out this brief questionnaire before we schedule an appointment with our office. The purpose of this questionnaire is to determine if there is a good fit between your needs and our practice, and to determine starting points from which to give you more detailed intake materials to fill out.

If after reviewing your responses on this form we determine our practice is likely to be able to help the child you describe here, we will provide you with possible appointment times and also send you a lengthier/more involved historical questionnaire to complete before that appointment. Otherwise, we will provide you with referrals, if possible, to other practitioners.

Please understand that neither the completion of this brief questionnaire nor the practitioner reviewing it prior to the child's face-to-face appointment will establish a practitioner-patient relationship. **If the child has severe or potentially life-threatening physical or emotional situations arise while waiting for an appointment in this practice, you should take the child to a hospital emergency department or at least immediately communicate with their primary care physician.** Please do not contact our office as we will not be able to provide any advice or care until your first in-person appointment.

Demographics:

Pt's First Name:		Middle Name:		Last Name:	
Birth Date:		Age:		Sex:	
Patient's Residence, Street No:		Street Name:		City	
State:		Zip		Country:	
Legal guardian #1 First name:		Middle Name:		Last Name:	
Birth Date:		Cell phone:		Home phone:	
Preferred email:		Relationship:			
Legal guardian #2 First name:		Middle Name:		Last Name:	
Birth Date:		Cell phone:		Home phone:	
Relationship:					

Referred by:

- ☐ Family/Friends
- ☐ Other Physician/Therapist
- ☐ Support group, including online group
- ☐ Website
- ☐ Newspaper article/interview
- ☐ Magazine article/interview
- ☐ Internet search
- ☐ Internet article/interview
- ☐ Radio or TV interview/presentation
- ☐ Conference/webinar presentation
- ☐ Other

1) Concisely, what do you hope to achieve overall from your treatment in this practice?

2) Chief Complaints/Concerns

a) Please list and briefly describe your child's top 3-5 concerns/symptoms/challenges in order of priority.

1)

2)

3)

4)

5)

b) Are there any specific types of treatments that you hope to incorporate in your child's treatment:

c) Please list and briefly describe any previous integrative/holistic approaches that you already used to help your child (i.e. herbal therapies, homeopathy, etc.)

3) Height (ft and in): ☐ ☐

Present Weight (lbs): ☐

4) Readiness assessment - Rate by choosing on a scale from 5 (very willing) to 1 (not willing)

a) In order to achieve your health goals for your child, how willing are you to:

i) Improve/change your child's diet and water intake? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

ii) Give nutritional supplements to your child 2-3 times per day? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

iii) Support your child's lifestyle changes (i.e. sleep, exercise, relaxation)? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

iv) Do lab testing (collecting urine &/or stool & going for a blood draw?) ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

b) How supportive are those closest to you in assisting/helping you make changes? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

c) Would anyone close to you be an obstacle to you as your child gets well? ☐ Yes ☐ No

d) How certain/confident are you in your ability to make changes in your child's diet, water consumption, exercise, supplements, lifestyle? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

e) If you are not very confident in your ability to make necessary changes or to get the help you need to make changes, what obstacles do you foresee?

5) Do you speak English? ☐ Y ☐ N

If the patient or family does not speak English, you will be required to bring a medical translator to all appointments.

If not, will you have an interpreter available for all consultation and phone calls? ☐

6) If the patient is a minor or has a legal guardian, with whom does the patient live? ☐

7) If parents of the minor are not married, who has legal custody? ☐

8) Do both parents of the patient have legal medical-decision-making authority? ☐ Yes ☐ No

If no, explain:

9) Are both parents supportive of alternative/integrative medical treatments? ☐ Yes ☐ No

If no, explain:

10) Are both parents willing to either attend the first appointment or one to attend & the other participate by Skype-video call for at least 15-20 minutes during the initial visit? ☐ Yes ☐ No

11) Does your child have a known or suspected genetic or chromosomal disorder, such as Downs syndrome? If so, please indicate the condition. (Do not include genetic SNPs such as CBS, MTHFR, or COMT variants).

12) Has your child been diagnosed with a neurological condition other than a seizure disorder? If so, please specify the condition(s).

13) Has your child had any of the following recently (in the last 2 months) or in the past (>2mo.)?

Indicate "R" for recent, "P" for past or check both if both apply.

Thoughts of harming yourself	☐ No ☐ R ☐ P
Suicide attempts	☐ No ☐ R ☐ P
Thoughts of harming others	☐ No ☐ R ☐ P
Self-injurious behaviors (cutting, head-banging, etc.)	☐ No ☐ R ☐ P
Destructive behavior towards things or environments	☐ No ☐ R ☐ P
Aggressive behavior toward people or animals	☐ No ☐ R ☐ P
Alcohol abuse or dependence	☐ No ☐ R ☐ P
Recreational drug use	☐ No ☐ R ☐ P
Psychosis	☐ No ☐ R ☐ P
Periods of mania	☐ No ☐ R ☐ P
Eating disorder (purging, laxatives, etc.)	☐ No ☐ R ☐ P

If you mark "Recent" or "Past" to any of the questions in section 11, please comment further below. Include dates that your child experienced symptoms and treatments. Please also indicate you child is currently under the care of a psychologist or psychiatrist. Feel free to provide additional information.

If you believe your child has PANS/PANDAS, please explain in detail why?