FIVE STONES

Integrative Functional Medicine

GENERAL INFORMATION

Name	*First*	*Middle*	*Last*	
Preferred Name				
Date of Birth				
Age				
Gender	○ Male	○ Female		
Genetic Background	☐ African	☐ European	☐ Native American	☐ Mediterranean
	☐ Asian	☐ Ashkenazi	☐ Middle Eastern	☐ ________________
Mother's Name		Occupation		
Father's Name		Occupation		
	Person completing this questionnaire			
Primary Address	*Number, Street*		*Apt. No.*	
	City	*State*	*Zip*	
Alternate Address	*Number, Street*		*Apt. No.*	
	City	*State*	*Zip*	
Home Phone 1				
Home Phone 2				
Parent's Work Phone				
Parent's Cell Phone				
Fax				
Email				
Emergency Contact	*Name*	*Phone Number*		
	Address		*Apt. No.*	
	City	*State*	*Zip*	
Physician	*Name*	*Phone Number*		
	Fax			
Referred by	○ Website			
	○ Friend or Family Member	○ Other ______________________________		

PHARMACY INFORMATION

Primary Pharmacy

Name	*Phone Number*
Address	
City	*State* *Zip*
E-mail	**Fax***

***** It is extremely important that you list the pharmacy's fax number.***

Compounding/
Supplement Pharmacy

Name	*Phone Number*
Address	
City	*State* *Zip*
E-mail	**Fax***

***** It is extremely important that you list the pharmacy's fax number.***

Pediatric Medical Questionnaire

ALLERGIES

Medication/Supplement/Food	Reaction

COMPLAINTS/CONCERNS

What do you hope to achieve in your visit with us? ______________________

If you had a magic wand and could help your child in three ways, what would they be?

1. ______________________
2. ______________________
3. ______________________

When was the last time you felt your child was well? ______________________

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

Is there anything that makes your child feel worse? ______________________

Is there anything that makes your child feel better? ______________________

Please list current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe	Prior Treatment/Approach	Success: Excellent	Success: Good	Success: Fair
Example: Difficulty Maintaining Attention		*X*		*Elimination Diet*	*X*		

MEDICAL HISTORY

DISEASES/DIAGNOSIS/CONDITIONS *Check appropriate box and provide date of onset*

GASTROINTESTINAL

PAST | CURRENT

- ☐ ☐ Irritable Bowel Syndrome ______
- ☐ ☐ Inflammatory Bowel Disease ______
- ☐ ☐ Crohn's ______
- ☐ ☐ Ulcerative Colitis ______
- ☐ ☐ Gastritis or Peptic Ulcer Disease ______
- ☐ ☐ GERD (reflux) ______
- ☐ ☐ Celiac Disease ______
- ☐ ☐ Other ______

CARDIOVASCULAR

PAST | CURRENT

- ☐ ☐ Heart Disease ______
- ☐ ☐ Elevated Cholesterol ______
- ☐ ☐ Hypertension (high blood pressure) ______
- ☐ ☐ Rheumatic Fever ______
- ☐ ☐ Mitral Valve Prolapse ______
- ☐ ☐ Other ______

METABOLIC/ENDOCRINE

PAST | CURRENT

- ☐ ☐ Type 1 Diabetes ______
- ☐ ☐ Type 2 Diabetes ______
- ☐ ☐ Hypoglycemia ______
- ☐ ☐ Metabolic Syndrome ______ (Insulin Resistance or Pre-Diabetes)
- ☐ ☐ Hypothyroidism (low thyroid) ______
- ☐ ☐ Hyperthyroidism (overactive thyroid) ______
- ☐ ☐ Endocrine Problems ______
- ☐ ☐ Polycystic Ovarian Syndrome (PCOS) ______
- ☐ ☐ Weight Gain ______
- ☐ ☐ Weight Loss ______
- ☐ ☐ Frequent Weight Fluctuations ______
- ☐ ☐ Bulimia ______
- ☐ ☐ Anorexia ______
- ☐ ☐ Binge Eating Disorder ______
- ☐ ☐ Night Eating Syndrome ______
- ☐ ☐ Eating Disorder (non-specific) ______
- ☐ ☐ Other ______

CANCER

PAST | CURRENT

- ☐ ☐ ______

GENITAL AND URINARY SYSTEMS

PAST | CURRENT

- ☐ ☐ Kidney Stones ______
- ☐ ☐ Urinary Tract Infections ______
- ☐ ☐ Yeast Infections ______
- ☐ ☐ Other ______

MUSCULOSKELETAL/PAIN

PAST | CURRENT

- ☐ ☐ Arthritis ______
- ☐ ☐ Fibromyalgia ______
- ☐ ☐ Chronic Pain ______
- ☐ ☐ Other ______

INFLAMMATORY/AUTOIMMUNE

PAST | CURRENT

- ☐ ☐ Chronic Fatigue Syndrome ______
- ☐ ☐ Autoimmune Disease ______
- ☐ ☐ Rheumatoid Arthritis ______
- ☐ ☐ Lupus SLE ______
- ☐ ☐ Immune Deficiency Disease ______
- ☐ ☐ Severe Infectious Disease ______
- ☐ ☐ Poor Immune Function ______ (frequent infections)
- ☐ ☐ Food Allergies ______
- ☐ ☐ Environmental Allergies ______
- ☐ ☐ Multiple Chemical Sensitivities ______
- ☐ ☐ Latex Allergy ______
- ☐ ☐ Other ______

RESPIRATORY DISEASES

PAST | CURRENT

- ☐ ☐ Frequent Ear Infections ______
- ☐ ☐ Frequent Upper Respiratory Infections ______
- ☐ ☐ Asthma ______
- ☐ ☐ Chronic Sinusitis ______
- ☐ ☐ Bronchitis ______
- ☐ ☐ Sleep Apnea ______
- ☐ ☐ Other ______

SKIN DISEASES

PAST | CURRENT

- ☐ ☐ Eczema ______
- ☐ ☐ Psoriasis ______
- ☐ ☐ Acne ______
- ☐ ☐ Other ______

MEDICAL HISTORY (CONTINUED)

NEUROLOGIC/MOOD

PAST | CURRENT

- ☐ ☐ Depression ____________
- ☐ ☐ Anxiety ____________
- ☐ ☐ Bipolar Disorder ____________
- ☐ ☐ Schizophrenia ____________
- ☐ ☐ Headaches ____________
- ☐ ☐ Migraines ____________
- ☐ ☐ ADD/ADHD ____________
- ☐ ☐ Sensory Integrative Disorder ____________
- ☐ ☐ Autism ____________
- ☐ ☐ Mild Cognitive Impairment ____________
- ☐ ☐ Multiple Sclerosis ____________
- ☐ ☐ ALS ____________
- ☐ ☐ Seizures ____________
- ☐ ☐ Other Neurological Problems ____________

PREVIOUS EVALUATIONS

Check box if yes and provide date

- ☐ Full Physical Exam ____________
- ☐ Psychological Evaluations ____________
- ☐ Wechsler Preschool & Primary Scale of Intelligence ____________
- ☐ Speech and Language Evaluations ____________
- ☐ Genetic Evaluation ____________
- ☐ Neurological Evaluations ____________
- ☐ Gastroenterology Evaluations ____________
- ☐ Celiac/Gluten Testing ____________
- ☐ Allergy Evaluation ____________
- ☐ Nutritional Evaluation ____________
- ☐ Auditory Evaluation ____________
- ☐ Vision Evaluation ____________
- ☐ Osteopathic ____________
- ☐ Acupuncture ____________
- ☐ Physical Therapy ____________
- ☐ Occupational Therapy ____________
- ☐ Sensory Integration Therapy ____________
- ☐ Language Classes ____________
- ☐ Sign Language ____________
- ☐ Homeopathic ____________
- ☐ Naturopathic ____________
- ☐ Craniosacral ____________
- ☐ Chiropractic ____________
- ☐ MRI ____________
- ☐ CT Scan ____________
- ☐ Upper Endoscopy ____________
- ☐ Upper GI Series ____________
- ☐ Ultrasound ____________

INJURIES

Check box if yes and provide date

- ☐ Back Injury ____________
- ☐ Neck Injury ____________
- ☐ Head Injury ____________
- ☐ Broken Bones ____________
- ☐ Other ____________

SURGERIES

Check box if yes and provide date

- ☐ Appendectomy ____________
- ☐ Circumcision ____________
- ☐ Hernia ____________
- ☐ Tonsils ____________
- ☐ Adenoids ____________
- ☐ Dental Surgery ____________
- ☐ Tubes in Ears ____________
- ☐ Other ____________

BLOOD TYPE: ○ A ○ B ○ AB ○ 0 ○ Rh+ ○ Unknown

HOSPITALIZATIONS ☐ None

Date	Reason

IMMUNIZATIONS

Is your child up to date with immunizations? ○ Yes ○ No

Do you feel immunizations have had an impact on your child's health? ○ Yes ○ No

If relevant, attach a copy of your child's immunization record or see addendum.

PSYCHOSOCIAL

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

STRESS/COPING

Have you ever sought counseling for your child? ○ Yes ○ No

Is your child or family currently in therapy? ○ Yes ○ No Describe:______________________________

Does your child have a favorite toy or object? ○ Yes ○ No

Does your child practice stress release methods? ○ Yes ○ No If yes, then check all that apply:

☐ Yoga ☐ Meditation ☐ Imagery ☐ Breathing ☐ Tai Chi ☐ Prayer ☐ Other: ________________

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

SLEEP/REST

Average number of hours your child sleeps per night: ○ >12 ○ 10-12 ○ 8-10 ○ < 8

Does your child have trouble falling asleep? ○ Yes ○ No

Does your child feel rested upon awakening? ○ Yes ○ No

Does your child snore? ○ Yes ○ No

ROLES/RELATIONSHIP

List Family Members:

Family Member and Relationship	Age	Gender

Who are the main people who care for your child?______________________________

Their employment/occupation:______________________________

Resources for emotional support?

Check all that apply: ☐ Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other: ____________

GYNECOLOGIC HISTORY *(for females only)*

MENSTRUAL HISTORY

Age at first period:______ Menses Frequency:______ Length:______ Pain: ○ Yes ○ No Clotting: ○ Yes ○ No

Has your period ever skipped?______ For how long?______

Last Menstrual Period:__________

Does your child use contraception? ○ Yes ○ No ☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner Vasectomy

Use of hormonal contraception such as: ☐ Birth Control Pills ☐ Patch ☐ Nuva Ring How long?______

GI HISTORY

Has your child traveled to foreign countries? ○ Yes ○ No   Where? ______________________________

Wilderness Camping? ○ Yes ○ No   Where? ______________________________

Ever had severe: ○ Gastroenteritis ○ Diarrhea

DENTAL HISTORY

☐ Silver Mercury Fillings   How many? __________

☐ Gold Fillings ☐ Root Canals ☐ Implants ☐ Tooth Pain ☐ Bleeding Gums

☐ Gingivitis ☐ Problems with Chewing

Do you floss regularly? ○ Yes ○ No

PATIENT BIRTH HISTORY

MOTHER'S PAST PREGNANCIES

Number of: Pregnancies: __________ Live births: __________ Miscarriages: __________

MOTHER'S PREGNANCY

Check box if yes and provide description if applicable

☐ Difficulty getting pregnant (more than 6 months) ____
☐ Infertility drugs used Specify: ______________
☐ In vitro fertilization ______________
☐ Drink alcohol ______________
☐ Drink coffee ______________
☐ Smoke tobacco ______________
☐ Take Progesterone ______________
☐ Take prenatal vitamins ______________
☐ Take antibiotics ☐ During Labor? ______________
☐ Take other drugs Specify: ______________
☐ Excessive vomiting, nausea (more than 3 weeks) ____
☐ Have a viral infection ______________
☐ Have a yeast infection ______________
☐ Have amalgam fillings put in teeth ______________
☐ Have amalgam fillings removed from teeth ________
☐ Number of fillings in teeth when pregnant ________
☐ Have bleeding? If so which months? ______________
☐ Have birth problems ______________
☐ Group B strep infection ______________
☐ Have c-section because of ______________
☐ Use induction for labor (such as Pitocin) ________
☐ Have anesthesia, if so list type ______________
☐ Use oxygen during labor ______________
☐ Have an x-ray ______________
☐ Have Rhogam, if so how many shots ________
How many when pregnant? ______________
☐ Gestational Diabetes ______________
☐ High blood pressure (pre-eclampsia) ________
☐ High blood pressure/toxemia ______________
☐ Have chemical exposure ______________
☐ Father have chemical exposure ______________
☐ Move to a newly built house ______________
☐ House painted indoors ______________
☐ House painted outdoors ______________
☐ House exterminated for insects ______________

PREGNANCY

Total weight gain during pregnancy: ________lb   Total weight loss during pregnancy: ________ lb

Please describe diet during pregnancy: ______________________________

Please describe labor: ______________________________

PATIENT BIRTH HISTORY (CONTINUED)

PERINATAL

Pregnancy duration: *(Please indicate at what week was your baby born)*

○ 24 ○ 25 ○ 26 ○ 27 ○ 28 ○ 29 ○ 30 ○ 31 ○ 32 ○ 33 ○ 34 ○ 35
○ 36 ○ 37 ○ 38 ○ 39 ○ 40 (full term) ○ 41 ○ 42 ○ 43 ○ 44 Weeks

Very active before birth? ○ Yes ○ No

Hospital/Birthing Center? ○ Yes ○ No

Needed Newborn Special Care? ○ Yes ○ No

Appeared healthy? ○ Yes ○ No

Easily consoled during first month? ○ Yes ○ No

Antibiotics first month? ○ Yes ○ No

Experienced no complications first month of life? ○ Yes ○ No

BIRTH WEIGHT AND APGAR

Weight at birth: _________ lbs Apgar score at 1 minute: _________ Apgar score at 5 minutes: _________

EARLY CHILDHOOD ILLNESSES

Number of earaches in the first two years: _________

Number of other infections in the first two years: _________

Number of times you had antibiotics in the first two years of life: _________

Number of courses of prophylactic antibiotics in first 2 years of life: _________

First antibiotic at _________ months.

First illness at _________ months.

DESCRIPTION OF DEVELOPMENTAL PROBLEMS

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

○ 0-1months ○ 2-6 months ○ 7-15 months ○ 16-24 months ○ After 24 months

Is this impression shared among parents and others caring for the child? ○ Yes ○ No

Does this impression, as to the timing of onset, differ among parents and others caring for the child? ○ Yes ○ No

Is the impression, as to the timing of onset, weak? ○ Yes ○ No

Or is the impression strong? ○ Yes ○ No

MEDICATIONS

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

PREVIOUS MEDICATIONS: *Last 10 years*

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Supplication and Brand	Dose	Frequency	Start Date (month/year)	Reason For Use

Have medications or supplements ever caused your child unusual side effects or problems? ○ Yes ○ No
Describe: ____

Has your child had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ○ Yes ○ No

Has your child had prolonged or regular use of Tylenol? ○ Yes ○ No

Has your child had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.) ○ Yes ○ No

Frequent antibiotics > 3 times/year ○ Yes ○ No

Long term antibiotics ○ Yes ○ No

Use of steroids (prednisone, nasal allergy inhalers) in the past ○ Yes ○ No

Use of oral contraceptives ○ Yes ○ No

FAMILY HISTORY

Check family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Sondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Diseases (such as Lupus)												
Irritable Bowel Syndrome												
Celiac Disease (Wheat Sensitivity)												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson’s												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												

NUTRITION HISTORY

Has your child ever had a nutrition consultation? ○ Yes ○ No

Have you made any changes in your child's diet because of health problems? ○ Yes ○ No Describe ____________

Does your child follow a special diet or nutritional program? ○ Yes ○ No

Check all that apply:

☐ Yeast Free ☐ Feingold ☐ Weight Management ☐ Diabetic ☐ Dairy Free ☐ Wheat Free ☐ Ketogenic

☐ Specific Carbohydrate ☐ Gluten Free/Casein Free ☐ Gluten Restricted ☐ Vegetarian ☐ Vegan ☐ Low Oxalate

☐ Food Allergy (Peanuts, Eggs, etc.): ______________________________

Height (feet/inches)___________ Current Weight ___________

Longest Weight Fluctuations ○ Yes ○ No

Does your child avoid any particular foods? ○ Yes ○ No If yes, types and reason: ____________________

____

If your child could eat only a few foods daily, what would they be? ____________________

____

Who does the shopping in your household? ______________________________

Who does the cooking in your household? ______________________________

How many meals does your child eat out per week? ○ 0-1 ○ 1-3 ○ 3-5 ○ >5 meals per week

Check all the factors that apply to your child's current lifestyle and eating habits:

☐ Fast eater
☐ Erratic eating pattern
☐ Eat too much
☐ Dislike healthy food
☐ Time constraints
☐ Eat more than 50% meals away from home
☐ Poor snack choices
☐ Sensory issues with food
☐ Picky eater
☐ Limited variety of foods <5/day
☐ Prefers cold food
☐ Prefers hot food
☐ Every meal is a struggle

☐ Most family meals together
☐ Use food as a bribe or reward
☐ Erratic mealtimes
☐ Most meals eaten at the table
☐ High juice intake
☐ Low fruit/vegetable intake
☐ High sugar/sweet intake
☐ Drinks soda or diet soda
☐ Cow's Milk 1 2 3+
☐ Caffeine intake
☐ TV or videos with meals
☐ Challenges with food served outside the home (Ex. childcare, friend's home)

BREASTFED HISTORY

Breastfed? ○ Yes ○ No How long? ________ Problems latching on? ○ Yes ○ No

Sucking quality? ○ Very Good ○ Good ○ Poor Exclusively breastfed for ________ months

BOTTLE FED HISTORY

Bottle fed? ○ Yes ○ No Type of formula: ○ Soy ○ Cow's Milk ○ Low Allergy

Introduction of cow's milk at ________ months. Introduction of solid foods at _________ months.

First foods introduced at ________ months. Introduction of wheat or other grain at ________ months.

Choke/Gas/Vomit on milk? ○ Yes ○ No Refused to chew solids? ○ Yes ○ No

List mother's known food allergies or sensitivities: ______________________________

Please describe any other eating concerns that you have regarding your child: ____________________

____

ACTIVITY

List type and amount of activity daily.

Type	Amount Daily

How much time does your child spend watching tv? _______________

How much time does your child spend on the computer or playing video games? _______________

ENVIRONMENTAL HISTORY

Please check appropriate box

PAST	CURRENT	EXPOSURES
☐	☐	Mold in bathroom
☐	☐	Damp cellar
☐	☐	Pest extermination - Inside
☐	☐	Pest extermination - Outside
☐	☐	Forced hot air heat
☐	☐	Had water in basement
☐	☐	Mold visible on exterior of house
☐	☐	Heavily wooded or damp surroundings
☐	☐	Mold in cellar, crawl space, or basement
☐	☐	Moldy, musty school/daycare
☐	☐	Tobacco smoke
☐	☐	Well water
☐	☐	Carpet in bedroom
☐	☐	Carpet in most parts of house
☐	☐	Feather or down bedding