Initial Patient Assessment

Visit Date________________________

Name____

Date of Birth________________________ Age_________

Gender ___male ___female

Reason for Consultation

____

____

____

Referred by ____

Allergies

Medications/environmental/food Reaction

______________________________ ____________________

______________________________ ____________________

______________________________ ____________________

Medical History of Patient

Birth history: vaginal delivery __C-section ___full term ___preterm___
Birth weight ______
Complications during pregnancy or delivery?_________________________
Breast fed _____ Formula fed_____

Any history of colic? __________________________________
Walked at what age? __________ First words at what age? ___________

Please check all that apply and provide approximate date of onset

Gastrointestinal

___Irritable Bowel Syndrome ____________________
___GERD (reflux) ____________________________
___Crohn's __________________________________
___Celiac Disease ____________________________
___Other ____________________________________

Metabolic/Endocrine

___Type 1 Diabetes____________________________
___Type 2 Diabetes____________________________
___Metabolic Syndrome (Insulin Resistance or Pre-Diabetes) _________________
___PCOS ____________________________________
___Weight Gain _______________________________
___Weight Loss _______________________________
___Hypothyroidism _____________________________
___Hyperthyroidism ____________________________
___Other ____________________________________

Cardiovascular

___Arrhythmia _________________________________
___Murmur
___Mitral Valve Prolapse ________________________
___Hypertension _______________________________
___Elevated Cholesterol _________________________
___Other ____________________________________

Genital and Urinary System

___Frequent Urinary Tract Infections____
___Sexually Transmitted Infections____
___Frequent Yeast Infections____
___Kidney Stones____
___Other____

Musculoskeletal System

__Fibromyalgia____
__Fractures____
__Injuries____
__Other____

Inflammatory/ Autoimmune

___Celiac Disease____
___Grave's Disease____
___Hashimoto's Thyroiditis____
___Lupus____
___Crohn's Disease____
___Ulcerative colitis____
___Other

Infectious Disease

___Varicella (chicken pox) ____
___Frequent Tonsil Infections____
___Lyme Disease____
___Other____

Respiratory Disease

___Asthma____
___Sinusitis____
___Pneumonia____
___Sleep Apnea____
___Other____

Skin Disorders

___Acne____
___Eczema____
___Psoriasis____
___Other____

Neurologic / Psychologic/ Psychiatric Disorders

___Headache____
___Migraine____
___Seizure Disorder____
___ADD/ADHD____
___Depresssion____
___Anxiety____
___Bipolar Disorder____
___Autism____
___Schizophrenia____
___Anorexia Nervosa____
___Bulimia Nervosa____
___Binge Eating Disorder____
___Eating Disorder (non- specified) ____
___Developmental Delays ____
___Other____

Hospitalizations or Surgeries

____
____

Menstrual/Gynecologic History

Age at First Menstrual Period_______
Last Menstrual Period_____________ Prior Menstrual Period____________
Length of Menses___________ Menses Frequency_________________
Irregular Menses? ____
Pain during Menses? (If so, please provide treatment)____________________________________
Use of contraception? ________________________ What type? ___________________________
Last gynecologic exam_________________________
Last PAP test______________________________ Normal ____ Abnormal____
Have you ever been pregnant?____

Medications

Please provide all current medications including vitamins, herbs and other supplements. Please provide dosage and frequency.

1) ____
2) ____
3) ____
4) ____
5) ____

Family History

Please specify illness and provide family member these apply to (sibling, parent, etc.)

Heart Disease ____
Respiratory
Disease____
Neurologic Disorders____
Autoimmune Disorders____
Gastrointestinal Disorders____
Cancer____
Obesity____
Psychiatric Disorders____
Endocrine Disorders (diabetes, thyroid disease) ___________________________

Psychosocial

Are you happy? Yes_____ No_____
Are you stressed? If so, by what? ____
Have you ever thought about hurting yourself or other people? _________________
If yes, please explain____
Have you ever sought counseling? _______________________________________
Are you currently in therapy? ____
Average number of hours you sleep per night_______________________________
Any difficulty falling asleep?____
Any difficulty staying asleep?____

Symptom Review

General

____Fatigue
_____Daytime sleepiness
_____Cold Intolerance
_____Heat Intolerance
_____Cold Hands and Feet
_____Dizziness
_____Weakness

Head, Eyes, Ears, Nose and Throat

____Hearing Loss
____Ear Pain
____Eye pain
____Vision problems
____Headache/Migraine
____Sore throat
____Sinus pain/ pressure

Cardiovascular

____Chest pain
____Palpitations

Respiratory

____Shortness of Breath
____Cough
____Wheezing

Gastrointestinal

____Abdominal Pain
____Bloating
____Diarrhea
____Constipation
____Heartburn
____Food Intolerance
____Vomiting

Genito- Urinary
__Painful urination
__Urinary Urgency
__Vaginal Discharge
__Breast Pain
__Testicular pain
__Urethral Discharge
__Pain During Menses
__Genital lesions/rashes

Skin
__Acne
__Rashes
__Itching

Musculoskeletal
__Joint pain
__Joint swelling
__Muscular pain
__Leg pain
__Arm pain

Neurologic
__Headache
__seizure
__unsteadiness while walking
__word finding difficulty
__weakness
__numbness

Psychiatric
__anxiety
__depression
__hearing voices
__obsessive or compulsive thoughts or behaviors