Child's Name:___________________________________

New Pediatric Patient Information

Patient Name:__________________________________ **Gender: M or F** **DOB:_____________**

Mother's Name:________________________________ **Father's Name:______________________________**

Street Address:____

City:____ **State:_______** **Zip:_____________________**

Home Phone:____________________ Mother's Cell:___________________ Father's Cell:____________________

Mother's Work Phone:________________________ Father's Work Phone:________________________________

Patient's Primary Care Physician:____ Phone:__________________

Primary Care Physician's Address:____

If known, name of preferred local compounding pharmacy:______________________________________

Any known allergies to medications? If yes, please list and describe adverse reason:__________________________

____

Privacy Constraints:____

No Constraints—Ok to send mail and/or leave messages on answering machine or voice mail?

Emergency Contact Name:____

Relationship to Patient:____________________________________ Phone number(s):______________________

Address:____

Insurance Information:

While we do not participate with insurance and fees are due in full at the time of your visit, we will provide a duplicate copy for your encounter form ready to send to your insurance.

Policy Holder's Name:________________________ Relationship to patient:_______________ DOB:_______

Insurance Company:_________________________ ID #:_______________________ Group # ___________

Policy Holder's Employer:____

Child's Name:________________________________

MODERN HEALTH CLINIC , PLLC

2000 S. Tompson Str. Ste. D
Flagstaff, AZ 86001

Pediatric Patient Consent Form

To Whom It May Concern:

We ask that both parents sign this document and return it to MODRERN HEALTH CLINIC Your signatures will document your understanding and consent of the principles and practices of MODRERN HEALTH CLINIC

In asking MHC for help in optimizing the options for my child, ____________________________ (name), I understand that my child's symptoms may relate to other underlying medical issues. Evaluation and treatment of these medical issues may impact behavior and cognition. These symptoms are indicated on the questionnaire and other documents introduced at the initial visit. I am not seeking a cure for a disease/ condition such as Autism, ADHD, Allergies, Asthma and other related problems, but rather an approach focusing on my child as an individual and his/her potential medical problems.

I understand that no environmental cause has proven to be linked to Autistic Spectrum Disorder (ASD) or Attention Deficit Hyperactivity Disorder (ADHD) or related problems in children or adults. However, due to the possible causative links, I desire to have the biochemical, immunological, and toxicological aspects of my child's problems investigated and treated.

I desire that my child be evaluated with diagnostic steps aimed at some or all of the following factors:

- Necessary dietary changes
- Vitamin, mineral, amino acid supplementation
- Detoxification, immune, antimicrobial, and enzyme therapy
- Other necessary medications and adjunctive interventions

I understand that many elements of this approach may be described as unproven or off-label. I understand that many of the above factors may be considered unproven or experimental by third party payers.

My signature below confirms my consent to the diagnostic approach embodied in this document and acknowledges that I have had ample opportunity to voice concerns or ask questions. Any specific measures taken have been or will be carried out by me or under my supervision as a parent.

To the extent that some of the approaches embodied in this document have already been undertaken in my child's care, I acknowledge that my understanding of the approaches at the time of first considering each of these steps was essentially no different than at the time of signing this document. At no time in the course of my child's care did any of the practitioners at Born Clinic lack my complete informed consent.

___________________________________	___________________________________
(Parent)	(Date)
___________________________________	___________________________________
(Parent)	(Date)

Child's Name:___________________________________

PRENATAL HISTORY	
Maternal age at delivery: __________years	**Number of dental amalgams (mom)________**
Illnesses during pregnancy:	
Vaccines during pregnancy:	
Other complications during pregnancy:	
Complications during labor and delivery:	
Mode of delivery: C-section or vaginal (circle one) If C-section, explain why:	
If vaginal delivery, did you have forceps/vacuum?	
Medications(s) during labor and delivery?	
Full term/premature? (Circle one)	**How many weeks at delivery?________ weeks**
Complications after delivery?	
Medications given to child during hospital stay?	

Child's Name:___________________________________

MEDICAL HISTORY		
Major surgeries – Please describe and give dates:		
SURGERY	**DATE(S)**	**RESULTS**
Major injuries – Please describe and give dates:		
INJURY	**DATE(S)**	**RESULTS**
Illnesses – Please list appropriate dates and any complications		
ILLNESS	**DATE(S)**	**COMPLICATIONS**
Ear infections:		
Sinus infections:		
Bronchitis:		
Pneumonia:		
Thrush:		
Chicken Pox:		
Seizures:		
Mono:		
Other (please list):		
Please describe your child's STOOL pattern (Examples: daily, foul, large, mush, etc.):		

Child's Name:___________________________________

SIGNS AND SYMPTOMS

Please check (√) any signs/symptoms your child may demonstrate and note duration and details if appropriate:

No.	Description	Mild	Moderate	Severe	Duration	Unique Details
1	Stimming (repetitive actions or movements)					
2	Rocking					
3	Head banging					
4	Self-mutilation					
5	Nail biting					
6	Hand/arm biting					
7	Nail/skin picking				`	
8	Aggressiveness (hitting, kicking, biting others)					
9	Mood swings					
10	Irritability/tantrums					
11	Fears/anxieties					
12	Hyperactivity					
13	Inability to concentrate/focus					
14	Always fidgety in his/her seat					
15	Impulsive					
16	Breath holding					
17	Dizziness					
18	Seizures					
19	Poor coordination					
20	Poor balance					
21	Problems with buttons, ties, snaps or zippers					
22	Processing problems—visual, motor, language, etc.					
23	Problems with social interactions					
24	Sensitive to crowds					
25	Trouble remembering					
26	Low self-esteem					
27	Fatigue					
28	Cold hands/feet					
29	Cold intolerance					
30	Heat intolerance					
31	Recurrent/chronic fever					
32	Flushing					
33	Difficulty falling to sleep					
34	Night waking					
35	Nightmares					
36	Difficulty waking					
37	Bed wetting/soiling					

Child's Name:___________________________________

SIGNS AND SYMPTOMS CONTINUED						
No.	**Description**	**Mild**	**Moderate**	**Severe**	**Duration**	**Unique Details**
38	Daytime wetting/soiling					
39	Numbness/tingling in hands/feet					
40	Headache					
41	Blinking					
42	Tics					
43	Eye discharge					
44	Dark circles/puffiness under eyes					
45	Night blindness in child/family					
46	Congestion					
47	Dripping nose					
48	Sensitivity to bright lights					
49	Earaches					
50	Ringing in ears					
51	Sensitive to sounds/noise					
52	Bad breath					
53	Nose bleeds					
54	Acute sense of smell					
55	Sore throats					
56	Hoarseness					
57	Cough					
58	Wheezing					
59	Geographic tongue					
60	Swollen gums					
61	Canker sores					
62	Dry lips/mouth					
63	Diarrhea					
64	Constipation					
65	Bloating					
66	Passing gas					
67	Belching					
68	Stomach ache					
69	Refusal to eat					
70	Sensitive to texture of food					
71	Difficulty swallowing					
72	Food craving					
73	Grinding teeth					
74	Mucous/blood in stools					
75	Undigested food in stools					
76	Anal itching					
77	Calf cramps					
78	Other muscle cramps/spasms					
79	Tremors					
80	Weakness					

Child's Name:___________________________________

SIGNS AND SYMPTOMS CONTINUED						
No.	**Description**	**Mild**	**Moderate**	**Severe**	**Duration**	**Unique Details**
81	Stiffness					
82	Eczema					
83	Psoriasis					
84	Hives					
85	Acne					
86	Seborrhea (cradle cap)					
87	Other rashes					
88	Easy bruising					
89	Itchy scalp					
90	Dry skin					
91	Oily skin					
92	Pale skin					
93	Sensitivity to insect bites					
94	Sensitivity to texture of clothes					
95	Cracking/peeling hands					
96	Cracking/peeling feet					
97	Strong body odor					
98	Strong urine odor					
99	Strong stool odor					
100	Soft nails					
101	Thickening of nails					
102	Ridges/pitting of nails					
103	White spots/lines on nails					
104	Brittle nails					
105	Any OCD (obsessive compulsive) behaviors					
106	Strategies to put pressure on abdomen					
107	Masturbation					
108	Thrush					
109	Low tone					
110	Staring episodes					
111	Reflux					
112	Persistent colic					
113	Toe walking					
114	Positive behavioral/cognitive reaction:					
	with illness					
	with fever					
	with antibiotics					
	when not eating					
115	Regression (repeated or one time—please specify)					
	with/after illness					
	with fever					

Child's Name:____________________________________

SIGNS AND SYMPTOMS CONTINUED						
No.	**Description**	**Mild**	**Moderate**	**Severe**	**Duration**	**Unique Details**
115	Regression *continued* (repeated or one time—please specify)					
	with antibiotics					
	when not eating					
	with anesthesia					

THERAPIES AND DIETS

Please indicate therapies and diets you have used and/or are using.

Now	Past	Therapies	Very Good	Good	None	Bad	Very Bad	Bad then good	Comments
		Acupuncture							
		Auditory training							
		Craniosacral							
		Energy Therapy (specifiy)							
		Homeopathy							
		HBOT							
		Lovaas (ABA)							
		Naturopathy							
		Neural Therapy							
		Occupational Therapy							
		Osteopathy							
		Physical Therapy							
		Sensory Diet							
		Speech Therapy							
		Other:							
		DIETS:							
		Gluten Free (GF)							
		Casein Free (CF)							
		Yeast Free							
		High Protein/Low Carb							
		Salicylate Free							
		Low Phenolics							
		IgG reactive food avoidance							
		Specific Carbohydrate Diet (SCD)							
		Body Ecology Diet (BED)							
		Gut and Psychology Syndrome							
		Other:							

Child's Name:___________________________________

MEDICATIONS OR SUPPLEMENTS

Please write medications or supplements taken now or in the past and make the appropriate reaction.

Now	Past	Medication or Supplement	Very good	Good	None	Bad	Very bad	Bad then good	Comments

TESTS PERFORMED

Please list diagnostic test(s) your child has had recently or in the past.

Date		Test	Very good	Good	None	Bad	Very bad	Bad then good	Comments

Child's Name:___________________________________

DIETARY/NUTRITIONAL HISTORY

Breast fed? Yes/No (Circle one) If yes, for how long:_________________________

Bottle fed? Brand of formula?____________ Begun at what age?_______________ For how long?_____________

Foods? Begun at what age?_________ First foods:____

Whole milk? Yes/No (Circle one) If yes, begun at what age?____

Known allergies to food? (Please list):____

____

Suspected sensitivities to foods: (Please list):____

____

Food cravings? (Please list):____

____

Foods my child eats: (Place ☑ in appropriate column)

Food	Daily	3-5 times per week	1-3 times per week	Never or almost never	Used to eat a lot but no longer does.
Cookies:					
Candy:					
Sweet foods:					
Caffeine (soda, tea, etc.):					
Chocolate:					
Milk: Whole:					
2%					
1%					
Skim:					
Cheese:					
Ice cream:					
Salty foods:					
Meat:					
Pasta:					
Bread: White:					
Wheat:					

Check the most appropriate description below of your child's diet:

___Most baby foods
___Mostly dairy
___Mostly vegetarian
___Mostly carbs
___Other, describe:

Child's Name:___________________________________

ENVIRONMENTAL HISTORY	
Do you, your child, or any family members practice any relaxation management techniques? Please describe:	
CIRCLE THE APPROPRIATE ANSWERS TO THE FOLLOWING QUESTIONS:	
Location of home: City/Suburban/Wooded/Farm	**Other (describe):**
Water: City/Well Purification system: Yes/No If yes, please describe:	
Do you live near: Power lines/Woods/Industrial areas/Water?	
If you live near water, list type: Swamp/River/Ocean/Other. If other, please describe:	
Does your home have a lot of: Dust/Mold/Down or Feather items (pillows, upholstery, stuffed animals)? If so, please give details:	
Any tick exposure? Yes/No/unsure. If yes, what location on your child's body and what geographic location?	
Describe any treatment/prophylaxis you had for the exposure:	
Please check (√) where appropriate:	
___ Live in a tick-infested area.	**___Tick found on household pets.**
___ Other household members with tick exposure and/or Lyme.	**___Frequent outdoor activities.**
___ Hiking, fishing, camping, hunting, gardening.	**___Vacation at high risk area.**
Describe your child's bedroom (circle appropriate response):	
• Bedding: Synthetic/Down/Feather Mattress cover: Yes/No Crib, Junior, or Adult bed	
• Flooring: Carpet: Wall to wall or area rug? Wood? Glued down? Synthetic pad?	
• Window treatment: Shades/Blinds/Thin curtains/Valance/Other? If other, please describe:	
• Other items in room including furniture, toys, stuffed animals:	
Flooring in other rooms: Child's bathroom: Living room: Family room/Play room:	

Child's Name:___________________________________

Is your child sensitive to or bothered by any of the following? Please check (√) where appropriate and list specific products, if possible: ___Perfume/Cosmetics? ___Mold? ___Cleaning products? ___Pollens/grasses? ___Soaps? ___Animals (dander)? ___Detergents? ___Gasoline? ___Dust? ___Paint? ___Other?
Please list known allergies:
Please list other occupational exposures in family members (for example: dental office, scientist, pharmacist, painter, building/construction, foundry worker):
DEVELOPMENTAL HISTORY
Please list age when following skills were mastered and any problems associated with these skills:
First words: (Age:_______)
Phrases or sentences: (Age:_______)
Pulling to stand: (Age:_______)
Walking: (Age:______)
Sitting up: (Age:______)
Crawling: (Age:______)
Running: (Age:______)
Walking up and down steps without help: (Age:______)
Jumping: (Age:______)
Learned to pedal: (Age:______)
Rode 2-wheel bicycle: (Age:______)
Put on clothing: (Age:______)

Child's Name:___________________________________

FAMILY HISTORY
List any allergies, major illnesses, genetic diseases or problems for each of the following family members of your child:
Mother:
Father:
Siblings:
Maternal Grandparents:
Paternal Grandparents:
Others:
SOCIAL HISTORY
Who lives in the home with your child:
Are any children in your family adopted:
Pets in the house:
List the people most important in your child's life:
Recent changes, losses, births, deaths, divorce, remarriage or moves:
Child's response to these changes:
Recent travel:
Is your child involved in any sports, music or other activities? Please describe:
How does your child interact with other children?
• **With adults?**
• **What makes your child happy?**
• **Sad?**
• **Angry?**
• **Stressed?**
• **Sleep patterns (past and present):**

Child's Name:___________________________________

IMMUNIZATIONS								
Please indicate date and any reactions for those immunizations that your child has received. If exact date isn't know, please approximate. "Bowel" refers to any bowel symptom such as diarrhea. "Swelling refers to the site of the injection.								
Diptheria/Pertussis/Tetanus	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizures**	**Irritable**	**Fever**	**Other**
DPT 1								
DPT 2								
DPT 3								
DPT 4								
DPT 5								
Adult Diptheris /Tetanus								
Pediatric Diptheris /Tetanus								
H Influenza Type B	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizures**	**Irritable**	**Fever**	**Other**
Hib 1								
Hib 2								
Hib 3								
Hib 4								
Polio (circle oral or injection)	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizures**	**Irritable**	**Fever**	**Other**
OPV 1 / Injection 1								
OPV 2 / Injection 2								
OPV 3 / Injection 3								
OPV 4 / Injection 4								
OPV 5 / Injection 5								
Measles/Mumps/Rubella	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizures**	**Irritable**	**Fever**	**Other**
MMR 1								
MMR 2								
Hepatitis B Vaccine	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizures**	**Irritable**	**Fever**	**Other**
HBV 1								
HBV 2								
HBV 3								
Prevnar (pnemococcal)								
Miscellaneous	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizures**	**Irritable**	**Fever**	**Other**
Varivax (Chicken Pox)								
Tine Test								
Flu Vaccine								
Other								

Child's Name:______________________________________