# Aiken-Augusta Holistic Health

## Integrative Medicine initial patient information form (child/teen)

Name: Appointment Date & Time:
Date of birth: Best contact phone number:
E-mail: Mailing address:
Parent/guardian: Name(s)/relationship: _____
Person(s) completing this form: _____
Primary Care Provider: Contact info (phone, e-mail):

Referring Provider: Contact info (phone, e-mail):

Please attach medical records as appropriate
May I send a summary to your doctor? Yes ☐ No ☐

| Concern (please rank by priority) | Onset | Frequency | Severity |
|---|---|---|---|
| *Ex. Headache* | *June 99* | *4 times/wk* | *Mild/mod/severe* |
| 1._____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ |
| 3. _____ | _____ | _____ | _____ |
| 4. _____ | _____ | _____ | _____ |
| 5. _____ | _____ | _____ | _____ |
| 6. _____ | _____ | _____ | _____ |

What are your goals for this visit?

_____
_____
_____
_____

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What medical conditions do you (your child/teen) have or had in the past?
*Ex. Asthma, allergies, seizures, headaches, acne, anemia, ADHD, abdominal pain.*

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Have you (your child/teen) had any surgical procedures or injuries?

| *What* | *When* | *What* | *When* |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Patient Name_____ Reviewed by/date _____

Please list any prescription medications that you (your child/teen) are taking now

| *Medication* | *Reason* | *Year Started* | *Dosage* |
|---|---|---|---|
| *Ex. Flovent 44mcg* | *asthma* | *2015* | *2 puffs twice a day* |
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Do you (your child/teen) have any allergic reactions to medications?

| *Medication* | *Reaction/Intolerance* |
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Please list any supplements, vitamins or herbs you (your child/teen) are taking now

| *Brand or Other name (manufacturer)* | *Reason* | *Year Started* | *Dosage* |
|---|---|---|---|
| *Ex. Echinacea (Natures Way)* | *cough and cold* | *2017* | *500 mg 3 times/day* |
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Patient Name_____ Reviewed by/date _____

In school? What grade? Strengths in school?
Challenges/difficulties in school?

What interests/hobbies do you (your child/teen) have, and what clubs or social groups?

Who lives in the home? (Include children, parents, relatives and pets)

| *Name* | *Age* | *Relationship* | *Name* | *Age* | *Relationship* |
|---|---|---|---|---|---|
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What physical activity do you (your child/teen) participate in?

What are the major stressors of your (your child/teen's) life?

What do you (your child/teen) do to relax?

Religious affiliations, past and present

What complementary and alternative therapies have you (your child/teen) experienced or explored?

Tobacco? Never Past Current
Alcohol? Never Past Current
Other drugs? Never Past Current

Patient Name_____ Reviewed by/date _____

Which medical conditions run in your family *(eg. Heart disease, diabetes, others)*?

| *Specific condition* | *Family member* |
|---|---|
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Nutrition History

Recall of dietary intake

*Please list **all** foods and drinks you (your child/teen) have consumed in the previous 24 hours. Include meals, snacks, beverages and condiments.*

*Breakfast*_____

*Lunch*_____

*Dinner*_____

*Snacks*_____

Is this a typical day? If not, why not? Please describe:

Are there any types or groups of foods you (your child/teen) crave or eat a lot?

Are there any types or groups of foods you (your child/teen) dislike or rarely eat?

What do you (your child/teen) drink on a typical day?

Patient Name_____ Reviewed by/date _____

Who buys groceries in the family?
Who cooks in the family?
How many meals are eaten outside the home per week?
School meals? Restaurant meals?
What type of oil do you cook with? _____
What types of spreads do you add to your (your child's) foods?
_____

How many servings of fruit do you (your child/teen) eat/drink each day? _____
*Serving = 1 small piece of fruit, ½ cup juice, ½ cup canned or chopped fruit, ¼ cup dried fruit*

How many servings of vegetables do you (your child/teen) consume each day? _____
*Serving = ½ cup raw or cooked, 1 cup fresh, green leafy vegetables, ¼ cup dried or 1 small piece.*
How would you describe your (your child/teen's) relationship with food?
_____
_____
_____

How many hours of sleep per night is average for you/your child?

Is there anything else you feel it is important to review today?

Patient Name_____ Reviewed by/date _____