

HEALTH QUESTIONNAIRE

Personal Information

Child's full name: _____ Name they wish to be called: _____

Street Address _____

City _____ State _____ Zip _____

Phone: H) _____ W) _____ E-Mail:) _____

Date of birth ___/___/___ Gender: M / F Health Insurance Company:) _____

Who were you referred by? _____

Name of parent/guardian: _____ Phone: _____

I, _____, read and understood Dr. Gangemi's Office Policies sheet on the previous page regarding appointments, fees, billing, and emergencies, and have had all my questions and concerns answered.

Signature of parent/guardian _____ Date ___/___/___

Primary Concern

What brings you to my office? _____

Date you noticed original problem: _____

Was there an event that created the condition? _____

Has the child had this or similar conditions in the past? _____

What makes your child better? _____

Worse? _____

Is the condition getting worse? _____ Constant? _____

Worse at a certain time of day? _____

Is this condition interfering with
School? _____ Sleep? _____ Activity? _____ Other? _____

Please list your goals for treatment, both immediate and future:

Health History

List all current health issues & problems: _____

List other practitioners seen, treatments, self-care activities, and results: _____

List illness they have had not previously mentioned, if any: _____

List all surgeries they have had, with dates and results: _____

Have they ever been in an accident or seriously injured? (if so, please describe) _____

Are there any dental or TMJ problems? _____

List all medications, vitamins, herbs and other supplements they are now taking: _____

List all medications and other substances (i.e.: foods) to which they are allergic: _____

Family History

Please list age(s) and health problems (if any); if deceased, please list age at death and cause of death:

Father _____ Mother _____

Grandparents _____ Brothers _____ Sisters _____

General

*How many hours per night does he/she sleep? ____ *Do they fall right asleep? Y N *Do they wake up feeling refreshed? Y N

*Do they sleep through the night without awaking? Y N *Do they remember their dreams? Y N Unsure

" R they have night sweats" Y N * Nightmares? Y N

Vaccines

Please mark the vaccines, if any, your child has had with dates:

Hib _____

DtaP or DTP _____

IPV _____

MMR _____

Varicella _____

Hep. B _____

Other _____

DIET HISTORY

How many (cups) does he/she drink each day: Water? _____ Juice? _____ Milk? _____

Caffeinated sodas/tea? _____ Diet Sodas? _____

List oils or fats that you use in cooking: _____

Does he/she frequently skip meals? Y N

Is he/she on any special diet or nutrition program? NO YES (list)

List the diets you have tried in the past with results:

1> _____

2> _____

3> _____

Are they allergic or sensitive to any foods? Y N If yes, name the foods and describe the problem.

What foods do they dislike? _____

Circle the foods they crave:

Meats Fats Sweets Salty foods Vegetables Fruits Breads Fatty foods
Spicy foods Sour foods Cereals Dairy Other individual _____

*Do you use butter or margarine in your house? (circle)

*Do you know what partially hydrogenated fats are? Y N If yes, does your child eat them? Y N

What do they usually eat for **breakfast**? _____

What do they usually eat for **lunch**? _____

What do they usually eat for **dinner**? _____

What do they usually eat for **snacks** (in between meals and/or before bed)? _____

What foods do they eat a lot of (at least once a day, every day)? _____

How many bowel movements do they have per day? _____ Are the stools formed? Y N

Please list all lab work your child has had done and include a copy:

_____ _____ _____ _____
_____ _____ _____ _____

Is there anything else you would like to tell me or feel that I should know?

