WELCOME QUESTIONNAIRE

YOUNG ADULT / CHILD

Today's Date_____

General Information: *(if you are completing the forms for yourself, please answer to your best ability. If you are a parent or guardian completing the forms, please answer for your child to the best of your ability)*

Name: _____ Age: _____ Date of Birth: _____

Nickname or preferred name: _____ Grade in School: _____

Parent / Mother's Name: _____ Phone: (_____) _____

Parent / Mother's Email address: _____

Preferred method of contact: ☐ Cell Phone ☐ Email ☐ Other Phone ☐ Other: _____

Parent / Father's Name: _____ Phone: (_____) _____

Parent / Father's Email address: _____

Preferred method of contact: ☐ Cell Phone ☐ Email ☐ Other Phone ☐ Other: _____

Other Caregiver Name: _____ Phone: (_____) _____

Email address: _____

Preferred method of contact: ☐ Cell Phone ☐ Email ☐ Other Phone ☐ Other: _____

Home / Mailing Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____

Primary Phone: (_____) _____ Other Phone: (_____) _____

If Applicable:

Client Preferred Phone: (_____) _____ Other Phone: (_____)_____

Client Email address: _____

Preferred method of contact: ☐ Cell Phone ☐ Email ☐ Other Phone ☐ Other: _____

Messages regarding my appointments or health concerns may be left on: ☐ Cell Phone ☐ Email ☐ Other Phone

Most of our patients are referred by a caring family or friend. Whom may we thank for referring you to our office? Or how did you hear about us? _____

Pagosa is a small town. In an effort to maintain confidentiality, please let me know if you would like to be addressed upon meeting in public or remain anonymous: _____

WELLNESS INFORMATION

***Health Challenges / Concerns*:** Please list your (child's) current health challenges, or items you would like to address in order of priority:

1) _____

2) _____

3) _____

Successful care is made possible when we have a thorough understanding of the current situation. The nature of your (child's) responses to the following questions, as well as your (child's) thoughtfulness and honesty, will assist in my understanding of your (child's) goals and desires pertaining to your (child's) health.

***Goals, Outcomes & Expectations*:** What are your (child's) goals & expectations for today's visit? _____

_____

_____

What are your (child's) long-term outcomes / goals & expectations for working together? _____

_____

_____

_____

What is your (child's) present level of commitment toward addressing any underlying causes of your symptoms?

0% 1 2 3 4 5 6 7 8 9 10 100%

What behaviors or lifestyles habits do you (your child) engage in regularly that you (your child) believe support your (child's) health?

_____

_____

_____

What behaviors or lifestyles habits do you (your child) engage in regularly that you (your child) believe are harmful to your (child's) health? _____

_____

_____

_____

What potential obstacles do you (your child) foresee in addressing lifestyle factors and in adhering to the recommended therapeutic protocol?

_____

_____

_____

_____

General Information:

Height: _____ Comparison to others (other children) of same age / grade: _____

Weight: _____ Comparison to others (other children) of same age / grade: _____

Recent Weight Loss ☐ / Gain ☐ Amount: _____ lbs

Pregnancy History *(If adopted, please answer to the best of your ability)*

- ❑ Severe viral infection during the first trimester
- ❑ Breech position during pregnancy
- ❑ Accident or Infections
- ❑ Smoking
- ❑ Severe stress
- ❑ Pre-eclampsia
- ❑ C-section
- ❑ "Blue baby"
- ❑ Alcohol consumption and/or drug use
- ❑ Radiation exposure
- ❑ Hypertension (high blood pressure)
- ❑ Toxoplasmosis
- ❑ Uncontrolled Diabetes
- ❑ Toxemia
- ❑ Premature (2+ weeks)

Comments:_____

_____

_____

Newborn History

- ❑ Difficulty latching/sucking
- ❑ Breast fed – length of time _____
- ❑ Sleep through the night
- ❑ Frequent Infections
- ❑ Formula / bottle fed
- ❑ Colic
- ❑ Difficulty sleeping
- ❑ Other: _____

Developmental History

- ❑ Difficulty with crawling (on all fours)
- ❑ Difficulty learning to ride a bike
- ❑ Difficulty learning to read
- ❑ Difficulty using utensils
- ❑ Difficulty tying shoes
- ❑ Poor hand-eye coordination
- ❑ Did not crawl on all fours
- ❑ Appeared clumsy
- ❑ Difficulty with writing
- ❑ Difficulty buttoning clothing
- ❑ Difficulty or awkward with walking/running
- ❑ Difficulty sitting still or paying attention

Began walking unassisted at what age: _____

Comments: _____

_____

Neurological / Other

- ❑ Hearing loss or impairment
- ❑ Neurological disorders
- ❑ Obsessive Compulsive Disorder (OCD)
- ❑ ADD/ADHD
- ❑ Dyslexia
- ❑ Visual impairment
- ❑ Anxiety/Depression
- ❑ Autism/Autism Spectrum Disorder
- ❑ Tourette's Syndrome
- ❑ Other_____

Childhood Illnesses

❑ Scarlet fever ❑ Diphtheria ❑ Rheumatic Fever ❑ Mumps ❑ Measles

❑ Rubella ❑ Chicken pox ❑ Mononucleosis ❑ Pertussis

Immunizations

Polio ☐ Y ☐ N Diphtheria ☐ Y ☐ N Tetanus ☐ Y ☐ N

Pertussis ☐ Y ☐ N Measles/Mumps/Rubella ☐ Y ☐ N Other:_____

❑ Adverse reaction to any vaccinations (even if mild) If yes, please explain: _____

_____

Some health issues can be related to our familial nationality or heritage. Please list your family heritage below:

Mother's Family _____ Father's Family_____

What is your (child's) cultural upbringing? _____

Were you (your child) born in, or ever lived in or travelled to a foreign country? ☐ Y ☐ N Please provide details: _____

_____

Have you (your child) recently moved? ☐ Y ☐ N Please provide details: _____

Have you (your child) recently lost any close family members, friends or pets? ☐ Y ☐ N Please provide details: _____

_____

Lifetime or recent stressful / challenging events (trauma?): _____

_____

Have you (your child) ever lived near farming, a golf course, powerlines, known chemicals in the water, soil etc? ☐ Y ☐ N

Please provide details: _____

How often do you (your child) get outside per week? _____ For how long (average time)? _____

Do you (your child) exercise outside? ☐ Y ☐ N Types of Activities: _____

Do you (your child) go outside barefoot? ☐ Y ☐ N Do you (your child) wear sunblock? ☐ Y ☐ N Drink water with activity? ☐ Y ☐ N

Recent Energy Level: (10 = highest) 1 2 3 4 5 6 7 8 9 10 Bedtime: _____ Awaken: _____

Average number of hours of sleep per night: _____ Awaken during nights? ☐ Y ☐ N

Difficulty falling asleep? ☐ Y ☐ N Difficulty staying asleep? ☐ Y ☐ N Tired after full night's sleep? ☐ Y ☐ N

Number of Bowel Movements per day _____ Use of coffee or other means to stimulate a movement? ☐ Y ☐ N

If eating habits have recently changed, please complete the following questions with the OLD way of eating, and then explain in the space below each item how the eating habits have changed.

What time is **Breakfast**? _____ Breakfast beverages: _____

Usual Breakfast foods: (List at least 5) _____

_____

Recent Changes? _____

What time is **Lunch**? _____ Lunch beverages: _____

Usual Lunch foods: (List at least 5) _____

_____

Recent Changes? _____

What time is **Dinner**? _____ Dinner beverages: _____

Usual Dinner foods: (List at least 5) _____

_____

Recent Changes? _____

Any times for **Snacks**? _____ Usual snacks: _____

_____

Recent Changes? _____

Lightheaded / irritable when hungry? ☐ Y ☐ N Crave sugar / salt? ☐ Y ☐ N Fatigue after meals? ☐ Y ☐ N

Need coffee/sweets 3-5pm? ☐ Y ☐ N Past / current Eating Disorder? ☐ Y ☐ N Currently dieting? ☐ Y ☐ N

List the three healthiest foods eaten during the average week: _____ _____ _____

List the three "worst" foods eaten during the average week: _____ _____ _____

Any dietary restrictions / allergies? ☐ Y ☐ N Please explain current eating philosophy or plan: (vegetarian, gluten / dairy intolerance, Kosher, paleo, keto, weigh-watchers, carnivore, autoimmune paleo, etc.) _____

_____

Watch TV / Movies / use a computer? ☐ Y ☐ N How many hours per day? TV: _____ Computer: _____

Use of "blue light blocking" glasses or filters? ☐ Y ☐ N How many hours per day? _____

Corrective lenses? ☐ Y ☐ N Contacts? ☐ Y ☐ N Date of last check-up / prescription change? _____

Please answer the following questions as completely and thoroughly as you can. Though some questions may not seem to pertain to your (child's) current concerns, they are very important to help formulate an understanding of your (child's) current situation, and possible treatment plan, as well as to make proper referrals if necessary.

Most Recent Exams: (dates) **General Physical:** _____ **Vision:** _____

Dental: _____ **Specialist:** _____ **Other:** _____

Are you (your child) currently under the care of any medical doctor? Please explain: _____

Have you (your child) received any of the following therapies? (Please check all that apply)

☐ Acupuncture ☐ Chiropractic ☐ Energy Medicine ☐ Herbal Medicine (Chinese or Naturopathic)
☐ Nutritional Therapy ☐ Spiritual Medicine ☐ Therapeutic Massage ☐ Other _____

Have you (your child) had covid-19? ☐ Y ☐ N Has anyone in the home or school had covid-19? ☐ Y ☐ N

Have you (your child) received a covid vaccine? ☐ Y ☐ N Which version? _____

Please provide any additional details: _____

MEDICAL HISTORY:

Have you (your child) ever experienced the following or been diagnosed as having any of the following:

- ❑ Illnesses accompanied by a high fever
- ❑ Frequent headaches
- ❑ Seizures / Convulsions
- ❑ Chronic ear infections / earaches
- ❑ Head injury
- ❑ Serious fall(s) or repetitive falls
- ❑ Serious illness
- ❑ Epilepsy
- ❑ Meningitis
- ❑ Allergies to foods
- ❑ Environmental allergies
- ❑ Chemical insensitivities
- ❑ Neck or back problems
- ❑ Dizziness
- ❑ Diabetes
- ❑ Hypoglycemia (low blood sugar)
- ❑ Trouble with bladder control (including bed wetting)
- ❑ Fainting
- ❑ High blood pressure
- ❑ Heart disease
- ❑ Asthma
- ❑ Sinus problems
- ❑ Constipation
- ❑ Diarrhea
- ❑ Digestive disorders
- ❑ Joint or muscle problems

HEALTH & FAMILY HISTORY:

Mark an X for any conditions that **you / your child**, or any of **your family members** have now or have had in the past:

	Self	Mother	Father	Sibling(s)	Paternal Grandparent	Maternal Grandparent
Alcoholism						
Alzheimer's Disease						
Anemia						
Autism (spectrum disorders)						
Cancer						
Cold sores						
Covid-19						
Deep vein thrombosis						
Depression/Anxiety						
Diabetes						
Dementia						
Eczema/Psoriasis						
Epilepsy						
Epstein Barr / mononucleosis						
Goiter						
Gout						
Heart disease						
Hepatitis A/B/C						
Herpes						
High Blood Pressure						
HIV/AIDS						
Lyme						
Parkinson's Disease						

Pleurisy						
Pneumonia						
Stroke						
Tumor(s)						
Ulcer(s)						
Other:						

ACCIDENTS: Have you (your child) been involved in any of the following types of accidents? (check all that apply)

☐ Automobile ☐ Motorcycle ☐ Bicycle ☐ Sports ☐ Playground ☐ Violence ☐ Other

Year ***(approximate)***	**Please describe** ***(injuries, treatment, outcome)***

INJURIES: Have you (your child) ever injured any of the following regions? (check all that apply)

☐ Head ☐ Neck ☐ Rib/Chest ☐ Back ☐ Pelvis/Hip ☐ Arm/Hand ☐ Leg/Foot

Year ***(approximate)***	**Please describe** ***(injuries, treatment, outcome)***

SERIOUS ILLNESSES / HOSPITALIZATIONS / SURGERIES: Please detail hospitalizations / serious illnesses / surgeries

Year ***(approximate)***	**Reason**	**Outcome**

MEDICATIONS: Please list all medications you (your child) are currently or have recently taken (prescribed or over-the-counter)

Medication Name	**Condition**	**Date Started**	**Prescribed By?**

NUTRITIONAL SUPPLEMENTS: Please list all Vitamins and Nutritional Supplements

Supplement	**Brand & Amount Consumed**	**Date Started**	**Prescribed by?** *(if applicable)*

PREVIOUS MEDICATION HISTORY: Please list an approximate number of times you (your child) have taken antibiotics for ear infections, illnesses, skin disorders (including acne), dental procedures, surgery etc._____

Any long term antibiotic (1 month or more) or Intravenous (IV) ? ☐Y ☐N Ever taken probiotics? ☐Y ☐N

ALLERGIES / SENSITIVITIES: Please check and list all allergies / sensitivities

☐ **Food:** ☐Gluten ☐Dairy ☐Soy ☐Nuts ☐Other _____

☐ **Medications:** _____

☐ **Seasonal/Latex/Other:** _____

Have you (your child) taken oral steroids (Cortisone, Prednisone) If yes: _____

If applicable: **HABITS:** Please include current and previous amounts –

	Daily	Weekly	Monthly	Never	Amount	
Alcohol	☐	☐	☐	☐	_____	_____
Coffee	☐	☐	☐	☐	_____	
Soda/Diet Soda	☐	☐	☐	☐	_____	_____
Tobacco	☐	☐	☐	☐	_____	
Rec. Drugs	☐	☐	☐	☐	_____	_____

If you no longer consume the above, please note length of consumption and date stopped.

How much water / day	8+ cups	4-7 cups	2-4 cups	<8 oz
	☐	☐	☐	☐

Number of times per week you (your child) eat out?: _____ Number of times per week you (your child) eat fish? _____

Number of times a week you (your child) eat raw nuts or seeds?: _____

If you have any concerns or questions you would like to note here, or issues you think might be related to your (child's) health challenges, please do not hesitate to discuss any matter with Dr. Jacqui at any time.

_____

_____

_____

_____ _____ _____

Client Name (Printed) Client Signature Date

_____ _____

Parent 1 and/or Guardian Printed Parent 1 and/or Guardian Signature

_____ _____

Parent 2 and/or Guardian Printed Parent 2 and/or Guardian Signature