Preliminary Questionnaire for Prospective Consultative Pediatric Patient

We ask that you fill out this brief questionnaire before you can schedule an appointment with our office. The purpose of this questionnaire is to determine if there is a good fit between your needs and our practice, and to determine starting points from which to prepare more detailed intake materials for you to fill out.

If after reviewing your responses on this form we determine our practice is likely to be able to help the child you describe here, we will contact you to schedule the initial consultative appointment, and also send you a detailed historical questionnaire to complete before that appointment. Otherwise, we will provide you with referrals, if possible, to other practitioners.

Please understand that the completion of this brief questionnaire and a provider's reviewing it prior to the initial face-to-face appointment does **not** establish a doctor-patient relationship. If the child has a severe or potentially life-threatening physical or emotional situation(s) arise while awaiting an appointment with our practice, you should seek medical care from a hospital emergency department or from the child's primary care physician. Do not contact our office as we will not be able to provide any advice or care until that first face-to-face appointment.

Demographics

Patient

Child's name: ____________ first name ____ m.i. ____________ last name

Date of Birth: ____ / ____ / ______ Age: ________ Gender: ____________

Weight: ________ lb Height: ________ ft ________ in

Child's Residence: ______________________ street

______________ city, ______ state ________ zip code

Legal Guardian #1

Name: ____________ first name ____ m.i. ____________ last name

Date of Birth: ____ / ____ / ______ Relationship to child: ____________

Preferred phone: ____________ Preferred email: ____________

Legal Guardian #2

Name: ____________ first name ____ m.i. ____________ last name

Date of Birth: ____ / ____ / ______ Relationship to child: ____________

Preferred phone: ____________ Preferred email: ____________

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Referred by

- ☐ Family/Friend: ______
- ☐ Other Physician/Therapist: ______
- ☐ Support group (including online group): ______
- ☐ Website: ______
- ☐ Newspaper article/interview: ______
- ☐ Magazine article/interview: ______
- ☐ Internet search: ______
- ☐ Internet article/interview: ______
- ☐ Radio/TV interview/presentation: ______
- ☐ Conference/webinar presentation: ______
- ☐ Other: ______

1. Concisely, what do you hope to achieve overall from your treatment in this practice?

______

______

______

2. Chief Complaint/Concerns

a. Please list and briefly describe the child's top 3-5 concerns/symptoms/challenges in order of priority.

1) ______

______

2) ______

______

3) ______

______

4) ______

______

5) ______

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b. Are there any specific types of treatments that you hope to incorporate in the child's treatment:

c. Please list and briefly describe any integrative/holistic approaches that you already use to help the child, e.g. herbal therapies, homeopathy, etc.

3. Readiness assessment

Please rate by choosing on a scale from 5 (very willing) to 1 (not willing).

a. In order to achieve your health goals for the child, how willing are you to:
   - i. Improve/change the child's diet and water intake? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
   - ii. Give nutritional supplements to the child 2-3 times per day? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
   - iii. Support the child's lifestyle changes, e.g. sleep, exercise, relaxation? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
   - iv. Do lab testing, e.g. collecting urine and/or stool, blood draw? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

b. How willing are those closest to you to support/assist/help you make changes? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

c. Would anyone close to you be an obstacle to you as the child gets well? ☐ Yes ☐ No

d. How certain/confident are you in your ability to make changes in the child's diet, water consumption, exercise, supplements, lifestyle? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

e. If you are not very confident in your ability to make necessary changes or to get the help you need to make changes, what obstacles do you foresee?

4. If the patient is a minor or has a legal guardian, with whom does the child live?

5. If the parents of the minor child are not married, who has legal custody?

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6. Do both parents of the child have legal medical decision making authority?

☐ Yes ☐ No

If no, explain: ______________________________

____

7. Are both parents supportive of alternate/integrative medical treatments?

☐ Yes ☐ No

If no, explain: ______________________________

____

8. Are both parents willing to either attend the first appointment or one attend and the other participate by phone or video call for at least 15-20 minutes during the initial visit?

☐ Yes ☐ No

If no, explain: ______________________________

____

9. Does the child have a known or suspected genetic or chromosomal disorder, such as Downs Syndrome?

☐ Yes ☐ No

If yes, please indicate the condition (do not include genetic SNPs such as CBS, MTHFR or COMT variants): __________

____

10. Has the child been diagnosed with a neurological condition other than a seizure disorder?

☐ Yes ☐ No

If yes, please specify the condition(s): ______________________________

____

11. Has the child had any of the following recently?

Indicate "R" for recent (in the last 2 months) or "P" for past (more than 2 months) or both.

a. Thoughts of harming himself/herself ☐ No ☐ R ☐ P

b. Suicide attempts ☐ No ☐ R ☐ P

c. Thoughts of harming others ☐ No ☐ R ☐ P

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d. Self-injurious behaviors (cutting, head-banging, etc.) ☐ No ☐ R ☐ P
e. Destructive behavior towards things or environments ☐ No ☐ R ☐ P
f. Aggressive behavior toward people or animals ☐ No ☐ R ☐ P
g. Alcohol abuse or dependence ☐ No ☐ R ☐ P
h. Recreational drug use ☐ No ☐ R ☐ P
i. Psychosis ☐ No ☐ R ☐ P
j. Periods of mania ☐ No ☐ R ☐ P
k. Eating disorder (purging, laxatives, etc.) ☐ No ☐ R ☐ P

If you marked recent or past to any of the issues above, please comment further below. Include dates the child experienced symptoms and/or received treatments, and also indicate if the child is currently under the care of a psychologist or psychiatrist.

____

____

____

If not under the care of a psychologist or psychiatrist, please explain why: ______________________________

____

____

12. Do you speak English?

☐ Yes ☐ No

If no, will you have an interpreter available for all consultations and phone calls? ☐ Yes ☐ No

If the patient or family does not speak English, you will be required to bring a medical translator to all appointments.

Mail the completed questionnaire to:

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