Plant Wisdom Within

Herbs, Nutrition, Wellness

PEDIATRIC

INSTRUCTIONS FOR YOUR FIRST CONSULTATION

I invite you to enjoy this period of focus & reflection while you turn your attention to completing this Pediatric New Client Questionnaire. We will review any areas of concern which arise during its completion in our appointments together. This questionnaire may be completed by the parent/guardian, the minor, or by both working together, as age-appropriate, whichever provides the most honest and full answers.

REQUIRED FOR YOUR FIRST VISIT:

- ☐ Completed Pediatric Questionnaire -- to receive optimized care, please return completed form two days prior to initial appointment. *Please allow 30-45 minutes to complete this questionnaire.*

PLEASE ALSO BRING THE FOLLOWING

- ☐ Any labs, blood tests, or other pertinent medical information you think may be helpful.
- ☐ If you're taking any pharmaceuticals, over-the-counter drugs, herbs, &/or supplements, please bring them in their original containers for accurate assessment of ingredients, dosage, & form by your practitioner.
- ☐ If breastfeeding, please bring any medications, herbs, &/or supplements the mother is taking.

If you have any questions, please contact me:

JOAN GREELEY, PLANT WISDOM WITHIN | 302.245.0691 | PLANTWISDOMWITHIN@GMAIL.COM

Plant Wisdom Within

New Client Questionnaire, Pediatric

Please answer the questions below as thoroughly as possible so that we may make the best possible clinical assessment and develop a realistic and workable plan for supporting you in living a vibrant life! Your honest and full answers will greatly assist us in reaching your health goals. Please feel free to put question marks next to any section you are unclear about. Client confidentiality will be maintained at all times. The information provided on this questionnaire may only be disclosed with the express written consent of the minor's legal guardian. Unless indicated, all questions are asked of the minor.

Today's date:

Basic Information

Contact Information:
Name: Address:
Parents' Names: City, State, Zip:

Work phone: Home phone: Mobile phone:
Email (parent's):
Preferred contact method:
Anything helpful to know about contacting you:

Emergency Contact:
Name: Relationship: Phone:
Occupation:
How long?: # Days/hrs worked/wk:

Physical:
Age: Date of Birth: Gender: Ancestral descent:
Birth Height: Birth Weight: lbs
Current Height: Current Weight: lbs

Personal Information:
Grade in School:
Childcare Arrangements (if any):
At home Group setting School setting
Hours
Caregivers

With whom (persons/animals) do you share your home? (indicate any shared custody arrangements here.)

What are Your interests/passions?

Where and when have you lived or traveled outside of the U.S. & Canada?
Where Date

What are your primary reasons for coming to Plant Wisdom Within?

1.

2.

3.

Medical Information

Health practitioners: With what types are you currently working?

Practitioner Type	Name	Reason for Seeing	City, State	Phone Number

Is there anything that surfaced during a recent medical test, lab work, or doctor's visit that you would like to report?

Allergies & Chemical Exposures

Which allergies to foods, medications, chemicals, &/or other environmental substances do you have?

What is your typical reaction, and how severe is it?

Allergen	Typical Reaction	Severity

Have you had lengthy exposure to secondhand smoke, lead paint, or other chemical exposure? Y/N
If so, when, and to what?

Surgeries/operations/hospitalizations: what, if any, have you undergone, & when?

Procedure(s)	Reason(s)	Date

immunizations

Do you follow immunization schedules as recommended by your doctor? Y/N
Explain or attach immunization record as necessary.

Immunization	Date	Immunization	Date

Childhood Illnesses

Illness	Severity	Date

Injuries/Broken Bones

Injury	Treatment	Date

Conditions

Please check any of the following you have noticed, indicating current "C" or past "P" history as appropriate.

Condition	C	P	Condition	C	P	Condition	C	P
Anxiety	☐	☐	Headache	☐	☐	Phobias	☐	☐
Fearfulness	☐	☐	Seizures	☐	☐	Heart palpitations	☐	☐
Low appetite	☐	☐	Chemical sensitivity	☐	☐	Bruise easily	☐	☐
Overeating	☐	☐	Hearing issues	☐	☐	Skin rashes	☐	☐
Digestive issues	☐	☐	Earaches	☐	☐	Eczema/psoriasis	☐	☐
Frequent diarrhea	☐	☐	Ear infections	☐	☐	Asthma	☐	☐
Upset stomach	☐	☐	Sinus infections	☐	☐	Seasonal allergies	☐	☐
Frequent gas	☐	☐	Nose bleeds	☐	☐	Poor concentration	☐	☐
Constipation	☐	☐	Cold sores	☐	☐	Lethargy	☐	☐
Restlessness	☐	☐	Swollen glands	☐	☐	Aggressive behavior	☐	☐
Urinary tract infection	☐	☐	Gum/dental problems	☐	☐	Depression	☐	☐

Gastrointestinal

Age toilet training began: Age completed:

Regular bowel movements? Y/N #/day? #/week?

☐ Difficulty moving bowels	☐ Loose stools	☐ Odd-colored stools	☐ Blood in stools
☐ Undigested food in stools	☐ Bloating	☐ Pain/cramping	☐ Straining
☐ Gas	☐ Nausea	☐ Constipation	☐ Diarrhea
☐ mouth ulcers	☐ Bad breath	☐ incontinence	

Medications & Supplements

Medications (Over-the-Counter & Prescription)

Dose (IU/MG/CAPS)	#times/ day	Name	Length of use	reason for taking

Are you sensitive to low levels of medications &/or caffeine?

Vitamins, Minerals, & Herbal Supplements

Dose (IU/MG/CAPS)	#times/ day	Name	Length of use	reason for taking

Family History

Relation	Deceased(D) Living (L)?	Present Health or Cause of Death
Maternal grandmother		
Maternal grandfather		
Paternal grandmother		
Paternal grandfather		
Mother		
Father		
Brother(s)		
Sister(s)		

Any family history of allergies? Y/N If so, to what?

Prenatal & Birth History

Birth location: ☐homebirth ☐birth center ☐hospital

Mother's age at your birth? Length of labor: Gestational age at birth? weeks

Any complications during the pregnancy?

Any complications or emergencies during the birth?

Delivery: ☐vaginal ☐ cesarean

Interventions: ☐forceps ☐suction ☐anesthesia (mom)

Any complications during early months or infancy?

List any of the following used during pregnancy: vitamins, herbal supplements, over-the-counter meds, prescription meds:

Lifestyle

Activities

	Frequency				
	Never or rarely <1x/month	Occasion - ally <1x/week	Regularly >2-3x/wk	Most days of the week	Comments (Type, Details, etc.)
Exercise/ Movement	☐	☐	☐	☐	
Daily hours spent sitting	☐	☐	☐	☐	
Socializing w/ Friends	☐	☐	☐	☐	
Relaxation	☐	☐	☐	☐	
Play / Fun	☐	☐	☐	☐	

Sleep

Typical bedtime: With whom do you share sleep space?

☐ Difficulty falling asleep?

☐ Nighttime waking? ☐Nightmares? ☐Bed-wetting? ☐ Sleep-walking?

Describe evening /bedtime routine:

Morning wake time:

Usually wake (check all that apply) ☐quietly ☐content ☐crying ☐ restless ☐rested ☐to alarm clock

Morning nap: Y/N Time: Length:

Afternoon nap: Y/N Time: Length:

Temperament

How would you describe your general disposition?

Do you seem to feel happier when the weather is (check all that apply)

☐warm ☐hot ☐cool ☐cold ☐dry ☐damp

On a scale of 1-10, (1=low; 10=high) how would your rate your vitality?

On a scale of 1-10, (1=low; 10=high) how stressful is your:

School:___ Social/Family situation:___ Current Health status:___ Life in general:___

Are you satisfied to be alone? Y/N Do you prefer company? Y/N Do you express feelings? Y/N Do you hold feelings in? Y/N

Do you feel that what you do & want matters? Y/N

What do you believe you can do to make a difference in your current health status?

If so, what 1-2 key steps have you already taken?

Moods you Experience Frequently

Check the boxes of all that apply.

☐accepting	☐anxious/ nervous	☐angry	☐capable	☐compassionate
☐determined	☐dreadful	☐empowered	☐enthusiastic	☐fortunate
☐guilty	☐happy	☐hopeful	☐hurt	☐inspired
☐lonely	☐loved	☐peaceful	☐resentful	☐resigned
☐sad	☐scared	☐terrified	☐tired	☐uncertain
☐other:				

Nourishment

early life

Breastfed? Y/N	Until what age?	Are you currently breastfeeding? Y/N	If so, how often?
If so, any difficulties?	☐with milk supply	☐With suck	☐With latch
Was breastfeeding bottle-supplemented? Y/N with what product(s)?	How often?		Beginning at what age?
How were you fed?	☐on demand	☐on a schedule	
Did you have digestive difficulties during infancy? ☐colic ☐vomiting ☐diarrhea ☐ constipation ☐ reflux ☐other			
At what age were you given water/ juice?		At what age were solid/pureed foods introduced?	
What were your first foods & when were they introduced? Food	Reaction	Age at introduction	

current

Who does family food shopping?	Food preparation?		Do they like to cook?		
How weekly meals do you eat at home (vs. out)?			___Breakfast___Lunch___Dinner		
Do you follow any particular cultural or dietary food practices in your household?					
How often, weekly, do you eat...	store-bought prepared foods x/wk		carry out x/wk	in a restaurant x/wk	
List your favorite foods			List foods you dislike		
List any foods you're allergic or sensitive to:					

Food Intake -- Please give examples, including beverages:

	most nutritious	usual	least nutritious
Breakfast			
Lunch			
Dinner			
Snacks			

Typical meal times

Breakfast	morning snack	lunch	afternoon snack	dinner	evening snack

How many ounces of water do you drink per day? ___Oz ☐Tap ☐Bottled ☐Filtered

Mother's diet if currently breastfed

	Never or rarely <1x/month	Occasion - ally <1x/week	Regularly >2-3x/wk	Most days of the week	Comments
Caffeine	☐	☐	☐	☐	Type(s)
soda	☐	☐	☐	☐	Type(s)
Alcohol	☐	☐	☐	☐	Type(s)
Red Meat	☐	☐	☐	☐	Type(s)
White Meat	☐	☐	☐	☐	Type(s)
Eggs	☐	☐	☐	☐	Type(s)
Seafood/Fish	☐	☐	☐	☐	Type(s)
Nuts & seeds	☐	☐	☐	☐	Type(s)
Fruits	☐	☐	☐	☐	Type(s) ☐canned ☐Frozen ☐Fresh
Vegetables	☐	☐	☐	☐	Type(s) ☐canned ☐Frozen ☐Fresh
Plant Oils (olive, etc.)	☐	☐	☐	☐	Type(s)
Dairy Products	☐	☐	☐	☐	Type ☐Milk ☐Butter ☐Cheese ☐Yogurt
Soy Products	☐	☐	☐	☐	Type(s)
Bread/Grains	☐	☐	☐	☐	Type(s)
Junk/Fast food	☐	☐	☐	☐	Type(s)
Fried foods	☐	☐	☐	☐	Type(s)

How many ounces of water do you drink per day? ___Oz ☐Tap ☐Bottled ☐Filtered

Significant Life Events

Please list major events in the last ten years of your life and the dates they occurred. Include births, deaths, marriage, divorce, accidents, moves, job changes, miscarriages, illness, & anything else you feel greatly impacted your life.

Event	Date

Review of Body Systems

Please indicate if you are currently experiencing any of the following. Also, kindly provide detail wherever there's a "**?**". As "pediatrics" encompasses birth to age 18, not all questions will apply to all ages. Please simply answer what's appropriate.

Head
☐Seizure
☐Headache
☐Migraines

Eyes
☐Vision loss
☐Tearing
☐Discharge
☐Redness
☐Pain
☐Corrective lenses

Ears
☐Hearing loss
☐Ringing in the ears
☐Discharge
☐Itching
☐History of infection

Nose
☐Discharge
☐Blood
☐Congestion
☐Snoring/blockage

Neck & Throat
☐Pain
☐Lump
☐Enlarged thyroid
☐Stiffness
☐Tonsillitis

Urinary
Urinations per day?
Color of urine?
☐History of urinary tract infection
☐History of bladder infection
☐History of kidney infection
☐Kidney stones
☐Swelling of ankles or legs
☐Incontinence
☐Urgency
☐Frequency
☐Pain on urination
☐Blood in urine
☐Lower back pain
☐Dark circles under eyes

Musculoskeletal
☐ muscle pain
☐Stiffness
☐Joint pain
☐Backache – *upper/ lower?*
☐Mobility restrictions
☐History of broken bones

Respiratory
☐Congestion
☐Sinus pain/inflammation
☐Difficulty breathing
☐Cough
☐Wheezing
☐Tuberculosis

Cardiovascular
☐High blood pressure
☐Low blood pressure
☐Heart palpitations
☐Rapid heart beat
☐Chest pain
☐High cholesterol
☐Varicose veins
☐Spider veins
☐Cold hands & feet
☐Clotting tendency
☐Stroke

Lymphatics
☐Congestion - *where?*
☐Swollen nodes- *where?*
☐Painful nodes - *where?*
☐Infection - *where?*
☐Drainage - *where?*

Endocrine
☐Low energy level
☐Hypothyroid (low)
☐Hyperthyroid (high)
☐Low blood sugar
☐Diabetes
☐Hormone imbalance

Allergic & Immunologic
☐Respiratoryallergy
☐Frequent cold/ flu
☐Food allergies
☐Food sensitivities
☐Immune disorder

Neuropsychiatric
☐Phobias
☐Stress
☐Insomnia
☐Depression
☐Anxiety
☐Attention deficit/ hard to concentrate
☐Mentally sluggish
☐Shingles
☐*Other mental disorder* ?
☐Abnormal movement (tremors, etc.)

Skin/ Integumentary
☐Rash
☐Dry skin
☐Itching
☐Acne
☐Rosacea
☐Eczema
☐Changing moles
☐Nail growth
☐Hair loss
☐Hair quality change
☐Bruise easily
☐Slow wound healing

Male Reproductive
☐Urination difficulty
☐Genital masses
☐Penile discharge
☐Pain/swelling in testes
☐Blood in semen
☐STDs
☐Birth control, *what form*? _____

Female Reproductive
<u>Breasts</u>
☐Tenderness
☐Lumps
☐Discharge
☐Changes in shape
☐Perform breast self-exams?
☐Abnormalities
<u>Genitals</u>
☐Vaginal discharge
☐Redness
☐Recurrent yeast infections
☐STDs
☐Pelvic pain or masses
☐Abnormal pap smear, *resulting action*?
<u>Menses</u>
Age at onset of menses?_____
bleeding starts approx every ___ days
Bleed for ___days?
Amount of bleeding?
Light moderate heavy
Quality of bleeding?
Bright red/ brown/ clotting
☐Painful cramps
☐Bleeding between cycles
☐Mood swings around cycle
☐Absence of menstrual cycles
☐Birth control,
Current? _____
Past hormonal contraceptive Type?
_____ *#YRS*____