105 Tenpenny St
Freeport, ME 04032

219 Mill St.
Rockport, ME 04856

Name:_____ Date of Birth:_____

Main Health Concerns Today:

1._____ 3._____

2._____ 4._____

For your child's most pressing health concern, please describe:

Current symptoms, with as much detail as possible:

How this affects their life:

What makes this better or worse (medications, activities, therapies, supplements):

What testing or evaluations have been done:

What treatments you have tried for this problem, and how they have worked:

Medical History

Please list any past or current medical problems, especially anything that required hospitalization, surgery, or long term medical therapy.

Describe your child's strengths. This could be things they are particularly skilled at, moral/character attributes, or attitudes with which they approach the world.

Please list any significant events in your child's life. This can include trauma, but should also include major accomplishments, or significant life changes (moves, arrival of siblings, etc.) Please include dates.

Describe the highlights of your child's birth story:

How often does your child get sick? How long does it usually last?
Is there a typical illness that they get (i.e. runny nose, cough, stomach ache)?

How many bowel movements does your child have per day? Are they easy or hard?

How long did your child breastfeed?

When did your child lose their first tooth?

Has your child ever had a high fever (103-104F or higher)?

How does your child move? Do they seem clumsy or skillful? Do they pick up complex movements quickly or does it take some time?

Do your child's interests ever feel obsessive?

Does your child have a good memory for details?

Does your child have good friendships? Is it easy or hard for them to make new friends?

Medications

Please list any medications or supplements your child is taking (with dose). If you cannot remember everything, please bring a current list, or all the pill bottles, to each and every visit.

Allergies

Please list allergies, especially to medications

Family Medical History

What is your family's ancestry?

Please list any medical problems, including anything they take medication for:
Mother

Father

Siblings

Lifestyle

What is your child's home situation (who do they live with, do they split time between locations, are there animals?)

How long and how well does your child sleep?

What is your bedtime routine? How much does it vary from night to night?

Does your child sleep alone, with siblings, parents or anyone else?

Does your child have any specific fears?

How many hours per week is your child in front of a screen? How do you manage screen time?

What do you do when your children misbehave? Here, I am looking for what you do in the ideal sense, when you are well rested and in a good mood.

What chores does your child do? How do you make sure they do it?

Is there smoking in the home?
Does your family have spiritual practice? If so, what?

Diet

Please list what your child ate on their most recent school day:
Breakfast:

Lunch:

Dinner:

Snacks:

Please list what your child ate on their most recent day off:
Breakfast:

Lunch:

Dinner:

Snacks:

How many cups daily of water? milk? soda? other beverages? (specify)?

Does your child have trouble digesting any foods?

Do any foods give your child bad reactions?

Is your child a picky eater?

Do they have foods they particularly crave?

Do you restrict any foods from them?

Preventative Medicine

Has your child's lead level been checked? Has hearing and vision screening been done?

Conclusions

If you could help your child to transform anything about themselves, what would that be? Do you have any idea how you might do it?

Is there anything you would like me to know that has been missed in these questions?

Review of Symptoms Check of any of these symptoms you have had in the last 2 weeks.

GENERAL:

☐ weight gain ☐ weight loss ☐ tired/weak ☐ dizzy/fainting ☐ fever/chills ☐ night sweats

HEAD:

☐ headaches ☐ head trauma ☐ hearing loss ☐ noise in ears ☐ earaches
☐ eye pain ☐ vision loss ☐ itchy eyes ☐ eye discharge ☐ blurry vision
☐ crossed eyes ☐ painful teeth ☐ bleeding gums ☐ nosebleeds ☐ runny/ stuffy nose
☐ sore throat ☐ swollen glands ☐ voice change ☐ room spins ☐ wear glasses/contacts

RESPIRATORY:

☐ cough (w/blood? w/phlegm? ☐ wheezing ☐ short of breath ☐ other trouble breathing

HEART & CIRCLATION:

☐ chest pain ☐ heart races or skips beats ☐ short of breath after climbing steps
☐ high blood pressure ☐ legs swell ☐ short of breath while lying in bed
☐ heart murmur ☐ dizzy when standing up ☐easy bruising/bleeding
☐ legs hurt or cramp when walking

DIGESTIVE:

☐ trouble swallowing ☐ heartburn ☐ poor appetite ☐ indigestion ☐ nausea
☐ vomiting (w/blood?) ☐ diarrhea ☐ constipation ☐ change in stool size or color
☐ blood in stool ☐ hemorrhoids ☐ rectal pain ☐ excess belching or passing gas
☐ 5+ bowel movements daily ☐ less than 3 bowel movements weekly ☐ undigested food in stool

URINARY:

☐ burning with urination ☐ frequent urination ☐ slow/weak urine stream ☐ blood in urine
☐ accidentally lose urine ☐ kidney stones ☐ bedwetting

MUSCULOSKELETAL:

☐ pain in muscles ☐ pain in joints ☐ swollen joints ☐ redness around joints ☐ arthritis
☐ back pain ☐muscle spasms ☐ scoliosis ☐ unexpected limb shape or position

NEUROLOGICAL:

☐ blackouts ☐ seizures ☐ numbness or loss of sensation (where?)
☐ tingling or "pins and needles" (where?) ☐ tremors or other involuntary movements
☐ weakness (where?) ☐ trouble with balance/unsteadiness

SKIN:

☐ rash ☐ hair loss ☐ itching ☐ skin pain ☐ moles ☐ sores ☐ nail changes (specify:)

ENDOCRINE:

☐ heat or cold intolerance ☐ cold hands or feet ☐ excessive thirst/hunger ☐excessive urination

PSYCHIATRIC

☐ nervousness ☐ anxiety ☐depression ☐ difficulty with memory ☐ hallucinations
☐ worrying change in behavior ☐ trouble with attention ☐ trouble making social connections
☐ clingy/fussy ☐ low energy ☐ not meeting development milestones

MALE PATIENTS:

☐ lumps or pain in testicles ☐ discharge from penis

FEMALE PATIENTS:

☐ vaginal sores or discharge ☐ breast lumps ☐ nipple discharge ☐ breast tenderness or pain
☐ irregular periods ☐ painful or heavy periods. Age at first period (if applicable):