HALCYON HEALTH & WELLNESS, LLC

Dear Parent: Please fill this out as thoroughly as possible before the child's first visit. In the case of children over age 10, please fill it out with your child. If your child is adopted, please indicate & skip those questions you are unable to answer.

Today's Date:

Child Name: **DOB:** **Age:**

Address: **Gender:** **Height/%:** **Weight/%:**

Siblings:

Parent's Phone: **Gender:**

Parent's Email: **Ages:**

Parent's Name & Ages: **Parent's Occupations:**

Emergency Contact:

Living Arrangements: ☐ both parents ☐ one parent ☐ other

How did you hear about Halcyon Health & Wellness? _____

Are you currently receiving healthcare? ☐ Yes / ☐ No. If yes, who is/are your Pediatrician/Specialist(s)/Alternative practitioners?

Please list health concerns:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

PREGNANCY / LABOR / BIRTH:

How was the mother's pregnancy with this child? Please indicate any major shocks, surgeries, stresses or medications that occurred during the pregnancy?_____

How was the mother's labor & delivery? Indicate length of labor & any complications, medications or interventions?

Any major unusual food cravings during pregnancy with this child? ☐ Yes / ☐ No. _____

Was the child breast-fed? ☐ Yes / ☐ No. If yes, for how long? _____

Please list any severe or life-threatening allergies (include method of testing): _____

FOOD:

Do you have any dietary restrictions or follow a particular dietary regimen? If yes, please describe: _____

List any food that your child craves or requests regularly, include any temperature or special preparation requests that accompany these cravings. (i.e. wants bread with crust removed or toast slightly burnt, also include spices and condiments, etc.) _____

How does the child respond to these foods? _____

List foods your child is sensitive or allergic and describe reaction: _____

List foods your child dislikes or is averse to: _____

Do you need guidance/support with a healthy well-balanced diet? _____

THIRST:

Is your child thirsty? ☐ Yes / ☐ No. Amount of liquid in ounces ingested daily: _____

Preferred temperature of liquid: _____ Does your child like to chew ice? ☐ Yes / ☐ No.

SLEEP:

Average hours sleep per night _____, from _____ to _____ o'clock.

What position does the child sleep in? _____

Is there a position the child cannot sleep in? _____

Is there trouble falling asleep? ☐ Yes / ☐ No. If yes, what keeps the child up? _____

Waking in the middle of the night? ☐ Yes / ☐ No. If yes, what time is common? _____

Are there any recurring dreams or nightmares? ☐ Yes / ☐ No. If yes, what is the theme? _____

What does the child do with their covers at night? Do they wrap up tight? Do they throw them off? Do their feet stick out? _____

Sleep is (check all that apply): Restless ☐ Quiet ☐ Has tooth grinding ☐ Night terrors ☐ Night fears ☐ Gets hot/uncovers ☐ Wants window open ☐ Talks in sleep ☐ Walks in sleep ☐ Unrefreshing sleep ☐ Wakes grouchy ☐ Easily awoken ☐ Comes into parents bed ☐ Wets the bed ☐ Sweats in sleep ☐ Sleeps with eyes open ☐

GENERAL INFORMATION: Check how each of the following influences your child's well-being or problem they may be struggling with...

	BETTER	WORSE	NEITHER		BETTER	WORSE	NEITHER
Cold:	☐	☐	☐	Heat:	☐	☐	☐
Dampness:	☐	☐	☐	Storms:	☐	☐	☐
Sun:	☐	☐	☐	Wind:	☐	☐	☐
Open Air:	☐	☐	☐	Stuffy air:	☐	☐	☐
Change of Weather:	☐	☐	☐	Moonlight:	☐	☐	☐
Ocean/Seashore:	☐	☐	☐	Mountains:	☐	☐	☐
Physical Exertion:	☐	☐	☐	Upon Rising:	☐	☐	☐
Bath:	☐	☐	☐	Warm Application:	☐	☐	☐

Please List any of your observations: _____

_____

What time of the day is your child's highest and lowest moods? Highest?_____ Lowest?_____

PAST HISTORY OF ILLNESSES, HEALTH CHALLENGES AND MEDICAL/SURGICAL PROCEDURES

Hospitalizations:	**Surgeries:**
Serious Illnesses & Injuries:	**Accidents, Traumatic Injuries, Broken Bones:**

HALCYON HEALTH & WELLNESS, LLC

Please check ALL that apply currently or previously and list approximate dates:

- ☐ Allergies
- ☐ Typhoid
- ☐ Cholera
- ☐ Food poisoning
- ☐ Worms
- ☐ Diarrhea
- ☐ Dysentery
- ☐ Blood clots
- ☐ Thyroid problem
- ☐ Asthma
- ☐ Cold-Fever
- ☐ Chill
- ☐ Pneumonia
- ☐ Pleurisy
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Tuberculosis

Operations:

- ☐ Tonsils
- ☐ Adenoids
- ☐ Abdomen
- ☐ Appendix
- ☐ Hernia
- ☐ Uterus
- ☐ Renal stones
- ☐ Gallstones
- ☐ Phimosis
- ☐ Hydrocele
- ☐ Cataract
- ☐ Lasik
- ☐ Cosmetic
- ☐ Other:_____

Mode of Anesthesia:

- ☐ General
- ☐ Local

How many times? _____

Antibiotics:

- ☐ Never
- ☐ Less than once/yr
- ☐ More than once/yr

- ☐ Vaccine reaction
- ☐ Modified Vaccine Schedule
- ☐ Unvaccinated

Childhood Diseases:

- ☐ Measles
- ☐ German measles
- ☐ Mumps
- ☐ Chicken-pox
- ☐ Small-pox
- ☐ Whooping cough

- ☐ Major accident or injury to body or head
- ☐ Occasion of unconsciousness
- ☐ Major bleeding from any part of the body

Infections:

- ☐ Recurrent
- ☐ Otitis Media (Ear)
- ☐ Sinusitis
- ☐ Bronchitis
- ☐ Tonsils
- ☐ Adenoids
- ☐ Diphtheria
- ☐ Cystitis (Bladder)
- ☐ Colitis
- ☐ Eosinophilia
- ☐ Pelvic infection
- ☐ Yeast Infection
- ☐ Candida
- ☐ Septic

- ☐ Malaria
- ☐ Jaundice
- ☐ Any Liver, Spleen or Gall bladder disease
- ☐ Hepatitis

- ☐ Malnutrition
- ☐ Failure to thrive

- ☐ Rickets
- ☐ Arthritis
- ☐ Gout
- ☐ Rheumatism
- ☐ Backache/problems

- ☐ Other_____

Female:

- ☐ Irregular menses
- ☐ PMS
- ☐ Miscarriage(s)
- ☐ Abortion(s)
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Breast lumps

Male:

- ☐ Circumcised
- ☐ Undescended testicle

Venereal Disease:

- ☐ Chlamydia
- ☐ Condylomata
- ☐ Gonorrhea
- ☐ Herpes
- ☐ Syphilis

Skin Diseases:

- ☐ Acne
- ☐ Allergy
- ☐ Boils
- ☐ Carbuncles
- ☐ Eczema
- ☐ Fungus
- ☐ Herpes
- ☐ Hives (Urticaria)
- ☐ Moles
- ☐ Ringworm
- ☐ Scabies
- ☐ Ulcers on body parts
- ☐ Warts

- ☐ Insomnia
- ☐ Nightmares
- ☐ Sleep disorder
- ☐ Anorexia/bulimia
- ☐ Binge eating
- ☐ Overweight
- ☐ Chemical Sensitivity
- ☐ Periodontal disease
- ☐ Glaucoma
- ☐ Hearing problems
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Phlebitis

Circulatory:

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart Failure
- ☐ Heart Murmurs
- ☐ Heart Attack
- ☐ Palpitations
- ☐ Anemia
- ☐ Hemorrhoids
- ☐ Varicose Veins

- ☐ Kidney stones
- ☐ Nephritis
- ☐ Diabetes
- ☐ Prostate
- ☐ Cancer
- ☐ Prostatitis
- ☐ AIDS

Mental / Emotional:

- ☐ Serious shock
- ☐ Grief
- ☐ Disappointments
- ☐ Fright
- ☐ Mental upset
- ☐ Mental Illness
- ☐ Anxiety
- ☐ Depression
- ☐ Nervous breakdown
- ☐ Panic attack
- ☐ Psychotherapy
- ☐ Suicide attempt
- ☐ Alcohol/Drug problems
- ☐ Steroid use

- ☐ Chronic fatigue
- ☐ Chronic headaches
- ☐ Migraines
- ☐ Numbness
- ☐ Cramps
- ☐ Fits
- ☐ Neurological problems
- ☐ Seizures/epilepsy
- ☐ Convulsions
- ☐ Polio
- ☐ Paralysis
- ☐ Meningitis
- ☐ Any Lumbar Puncture

HALCYON HEALTH & WELLNESS, LLC

FEMALE Only

Date of last menstrual period: _____
Date of last pelvic exam: _____
Date/results of last pap smear _____
Ever had abnormal pap smear? _____
Sexually Transmitted Disease _____
History of sexual disease _____
Frequent yeast infections _____
Frequent bladder infections _____
Vaginal discharge/leakage _____
Age period began _____
Regular periods: Yes ☐ No ☐ _____
Flow: Heavy ☐ Medium ☐ Light ☐ _____
Length of cycle _____ Days of Flow _____
Spotting ☐ Cramps ☐ PMS ☐ _____
Endometriosis ☐ PID ☐ Fibroids ☐ _____
Ever used Birth Control pills? _____

MALE Only

Change in force of urine stream _____
Difficulty starting urination _____
History of undescended testicles _____
Pain / lump in scrotum _____
Discharge from penis _____
Painful intercourse _____
Difficulty with erections _____
Change in sex drive _____
Sexually Transmitted Diseases _____
History of sexual abuse _____

PERSONAL HABITS:

Please indicate use:	How Much?	How Long?
Soda		
Diet Soda		
Artificial Sweeteners		
Refined Sugar		
Processed Food		

LIFE CHANGES

In the past year, what changes have occurred in your:

Family life:
School life:
Social life:
Puberty/Sex life:

FAMILY HISTORY:

Check (double click box and select 'checked') items that apply to blood relatives and list relationship:

☐ Alcohol/drug problem _____
☐ Allergy/asthma _____
☐ Anemia _____
☐ Arteriosclerosis _____
☐ Arthritis _____
☐ Binge eating/bulimia _____
☐ Bleeding problem _____
☐ Cancer _____
☐ Diabetes _____
☐ Epilepsy/seizure _____
☐ Heart disease _____
☐ Skin disease _____
☐ High blood pressure _____
☐ High cholesterol _____
☐ Kidney disease _____
☐ Liver disease _____
☐ Mental illness _____
☐ Obesity _____
☐ Stroke _____
☐ Suicide _____
☐ Thyroid disease _____
☐ Tuberculosis _____
☐ Ulcer _____
☐ Syphilis _____
☐ Gonorrhea _____

Please list all prescription and over-the-counter medications you are currently taking:

Medication	Dose	Date Started	Prescribed By

List vitamins, minerals, herbs, homeopathic remedies that you are currently taking:

Supplement	Dose	Date Started

ANGER

Do they get angry often or easily? ☐ Yes / ☐ No. If yes, what makes your child angry? _____

_____

Do they experience uncontrollable rage? ☐ Yes / ☐ No. Any difficulty expressing anger? ☐ Yes / ☐ No

How do they express anger? _____

SADNESS

What makes your child sad? _____

What do they do when they are sad? _____

Does your child cry easily and/or often? ☐ Yes / ☐ No. Does your child prefer to be alone when sad? ☐ Yes / ☐ No.

Does being consoled help? ☐ Yes / ☐ No. If yes, please explain. _____

GRIEF

List major experiences of grief/loss in your child's life: _____

SYMPTOMS: Please mark (1) = Mild, (2) = Moderate, (3) = Severe, next to the following symptoms which apply to your child now or in the past.

	CURRENT	PAST		CURRENT	PAST
Prefer to be with company	☐	☐	Assertive, Powerful	☐	☐
Prefer to be alone	☐	☐	Bossy	☐	☐
Afraid when left alone	☐	☐	Confident, Secure	☐	☐
Would rather be left alone when not feeling well	☐	☐	Easily bullied	☐	☐
Forgetful	☐	☐	Shy with others	☐	☐
Mental Confusion	☐	☐	Lies	☐	☐
Decreased Concentration, comprehension	☐	☐	Does things without conscience	☐	☐
Makes many mistakes	☐	☐	Anxiety	☐	☐
Critical of self	☐	☐	Restlessness	☐	☐
Critical of others	☐	☐	Excessive Worry	☐	☐

Lacks self-confidence	☐	☐	Depression	☐	☐
Suspicious/Jealous	☐	☐	Despair/Discontent:	☐	☐
Sensitive to Noise	☐	☐	Loneliness	☐	☐
Organized, Neat and Clean	☐	☐	Mood Swings	☐	☐
Messy	☐	☐	Argumentative	☐	☐
Affectionate	☐	☐	Defiant	☐	☐
Intimate with others	☐	☐	Violent	☐	☐
Hot	☐	☐	Abusive	☐	☐
Warm	☐	☐	Obstinate	☐	☐
Chilly	☐	☐	Cranky	☐	☐
Sad	☐	☐	Sad	☐	☐
Timid	☐	☐	Clingy	☐	☐
Placid	☐	☐	Afraid / Fearful	☐	☐

FEARS

What fears does your child have? _____

Are any of your child's fears unmanageable? _____

Are there any known episodes of physical, emotional, or sexual abuse in your child's history? ☐ Yes / ☐ No. If yes, please explain. _____

Who are the most important people in your child's life? _____

How does your child relate to most people outside of the family circle? _____

What do you feel is your child's major mental and/or emotional limitations? _____

Do you have specific spiritual practice? ☐ Yes / ☐ No. If so, please describe: _____

What does your child do for enjoyment? _____