

# **Susan M. Seven-Sky, D.C.**

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## **Nutritional Integrative Care of Children**

Welcome to my practice. Over the next few weeks to months, we will work together to help integrate and mold your child's health care in a holistic and thorough fashion. We will look at his/her nutritional status, immunology and biochemistry as well as any medications and therapies. We hope to answer any of your questions and concerns.

To begin, please complete the enclosed questionnaire and return to my office at least two weeks prior to your appointment. It is important to be as complete and detailed as possible. Include any symptoms or signs you may see in your child. They may be important clues.

Include all therapies and therapists working with your child. Also please try to include copies of previous studies.

Please allow at least two hours for your first visit. It is important that your child attend. However, because of the length of the visit, we recommend bringing another adult with you if possible to that you can concentrate on the details of your child's history.

If you are unable to keep your appointment, please call our office at least 24 hours in advance.

We look forward to meeting you and working with you and your child. Please call with any questions.

Sincerely,

Dr. Susan M. Seven-Sky, D.C.

## Pediatric History

Name \_\_\_\_\_ Date \_\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_  
                    First                    MI                    Last

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex \_\_\_\_ Female \_\_\_\_ Male \_\_\_\_ Birthdate \_\_\_\_\_ Birth Place \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Do you prefer to receive calls at: \_\_\_\_ Home \_\_\_\_ Work \_\_\_\_ Either

Are you: \_\_\_\_ Minor \_\_\_\_ Married \_\_\_\_ Divorced \_\_\_\_ Widowed \_\_\_\_ Single  
\_\_\_\_ Separated

Your employer \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse or Parent's Name \_\_\_\_\_ Work Phone \_\_\_\_\_

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## History of Present Illness

Chief Complaint: \_\_\_\_\_ Duration \_\_\_\_\_

When was the patient last entirely well? \_\_\_\_\_

How and when did the condition begin? \_\_\_\_\_

Progress of disease: order and date of new symptoms: \_\_\_\_\_

Specific symptoms and physical signs that may have developed: \_\_\_\_\_

Pertinent negative data obtained by direct questioning: \_\_\_\_\_

Aggravating and alleviating factors: \_\_\_\_\_

Significant medical attention and medications or home therapies given? \_\_\_\_\_

Over what period of time? \_\_\_\_\_

In acute infections, statement of type and degree of exposure, and interval since exposure: \_\_\_\_\_

\_\_\_\_\_ For the well child, factors of significance and general condition since  
the last visit \_\_\_\_\_ Examiners opinion of the  
informants reliability \_\_\_\_\_

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## Birth History

### Antenatal

Basic info on the health of the mother during pregnancy: \_\_\_\_\_

Prenatal Care: \_\_\_\_\_ Diet: \_\_\_\_\_

Any infections while pregnant? \_\_\_\_\_ Vomiting? \_\_\_\_

Bleeding? \_\_\_\_ Preeclampsia/Eclampsia: \_\_\_\_\_ Rh typing/Serological  
tests/Pelvimetry/Meds/X-ray procedures/amniocentesis: \_\_\_\_\_

### Natal

Duration of pregnancy: \_\_\_\_\_ Kind and duration of labor: \_\_\_\_\_

Type of delivery: \_\_\_\_\_ Sedation and anesthesia: \_\_\_\_\_ Birth

weight: \_\_\_\_\_ State of infant at birth: \_\_\_\_\_ Resuscitation  
required? \_\_\_\_\_ Onset of respiration: \_\_\_\_\_ First Cry: \_\_\_\_\_  
Special procedures? \_\_\_\_\_

### Neonatal

Child's apgar score: \_\_\_\_\_ Color (cyanotic, pallor, jaundice) and cry: \_\_\_\_\_  
\_\_\_\_\_ twitching/ excessive mucous \_\_\_\_\_ paralysis/convulsions \_\_\_\_\_  
Fever/hemorrhage \_\_\_\_\_ congenital abnormalities/birth injuries \_\_\_\_\_  
presence of rashes, difficulty sucking or feeding \_\_\_\_\_ length of hospital stay/  
discharge weight \_\_\_\_\_

### Development

#### Milestones

First raised head: \_\_\_\_\_ rolled over: \_\_\_\_\_ sat alone \_\_\_\_\_ pulled up \_\_\_\_\_ walked with  
help \_\_\_\_\_ walked alone \_\_\_\_\_ talked with meaningful words and sentences \_\_\_\_\_  
urinary continence during night \_\_\_\_\_ during day \_\_\_\_\_ control of defecation \_\_\_\_\_  
Comparison of development w/that of siblings and parents \_\_\_\_\_ Any  
period of failure to grow or unusual growth \_\_\_\_\_ School grade or quality of  
work \_\_\_\_\_

### Nutrition

Breast or formula fed \_\_\_\_\_ type of feeding \_\_\_\_\_ Duration \_\_\_\_\_  
major formula changes \_\_\_\_\_ time of weaning \_\_\_\_\_ difficulties \_\_\_\_\_  
\_\_\_\_\_ Any supplements (type, amount, duration of any additional vitamins, fluoride, or iron)  
\_\_\_\_\_ When were solid foods introduced \_\_\_\_\_ How taken?  
\_\_\_\_\_ types \_\_\_\_\_ Unusual family dietary habits \_\_\_\_\_  
\_\_\_\_\_ balancing food groups \_\_\_\_\_ Food likes and dislikes \_\_\_\_\_  
idiosyncrasies \_\_\_\_\_ allergies \_\_\_\_\_ general attitude  
to eating \_\_\_\_\_

### Illnesses

#### Hospitalizations

Dates and reasons  
\_\_\_\_\_  
\_\_\_\_\_

Any infections? \_\_\_\_\_ If so, age(s) at onset: \_\_\_\_\_  
type(s) of infection(s) \_\_\_\_\_ number of severity episodes? \_\_\_\_\_  
Any contagious diseases? \_\_\_\_\_ Age at exposure to: Measles \_\_\_\_\_ rubella \_\_\_\_\_  
chickenpox \_\_\_\_\_ mumps \_\_\_\_\_ pertussis \_\_\_\_\_ diphtheria \_\_\_\_\_ Scarlet fever \_\_\_\_\_  
Other serious non infectious illnesses \_\_\_\_\_

### Immunizations and Tests

Age at immunizations \_\_\_\_\_ Type and number of \_\_\_\_\_ boosters  
\_\_\_\_\_ reactions if any \_\_\_\_\_

### Surgery

Type \_\_\_\_\_ Child's age \_\_\_\_\_ Complications \_\_\_\_\_

Reasons \_\_\_\_\_ Childs response \_\_\_\_\_  
Any other accidents and/or injuries? \_\_\_\_\_ Nature, severity , and sequellae \_\_\_\_\_  
Any medications? \_\_\_\_\_

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### Family History

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Basic info. About child's parents: \_\_\_\_\_  
Ages and health conditions \_\_\_\_\_  
Basic info. About child's siblings: \_\_\_\_\_  
Ages and health conditions \_\_\_\_\_  
Previous illnesses \_\_\_\_\_  
Child's birth order \_\_\_\_\_  
Mother's childbearing history:  
Any: Stillbirths? \_\_\_\_\_ Abortions? \_\_\_\_\_ Miscarriages? \_\_\_\_\_

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### Personal History

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Social behavior and interests: How does he/she relate to others? (Independent, clingy, shy, aggressive, submissive, extraverted, negativistic) \_\_\_\_\_  
Is there age appropriate separation from parents? \_\_\_\_\_ Does the child have any interests and hobbies that involve interaction to others? \_\_\_\_\_  
Easy or difficult to get along with? \_\_\_\_\_ Is the child similar or different to sibling's \_\_\_\_\_

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### Social History

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Info about the adults at home and their relationship to the child \_\_\_\_\_ Stability to family structure \_\_\_\_\_ sources of income \_\_\_\_\_ description of home \_\_\_\_\_  
Type of neighborhood \_\_\_\_\_  
Access to play facilities \_\_\_\_\_  
Languages spoken at home? \_\_\_\_\_ Child care arrangements \_\_\_\_\_  
Type and location of school \_\_\_\_\_ students per classroom \_\_\_\_\_  
Child's and parents satisfaction \_\_\_\_\_ Type of health coverage \_\_\_\_\_

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### Environmental History

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Indoor air pollution:  
Is Child's health affected by?  
House dust \_\_\_\_\_ Mold \_\_\_\_\_ animal dander \_\_\_\_\_  
Fumes from disinfectants \_\_\_\_\_ ventilation problems \_\_\_\_\_  
Does child have access to pesticides and lawn care products? \_\_\_\_\_  
Are there any lead-based paints on household woodwork/furnishings \_\_\_\_\_  
Location of play areas \_\_\_\_\_ local traffic conditions \_\_\_\_\_  
Adult supervision \_\_\_\_\_ Sturdiness of equipment \_\_\_\_\_ Any electromagnetic hazards? \_\_\_\_\_

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### Personal Habits

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Sleeping:  
Duration \_\_\_\_\_ Any disturbances (snoring, restlessness, dreaming, nightmares) \_\_\_\_\_

Recreation:

Exercise \_\_\_\_\_ favorite sports \_\_\_\_\_

Elimination:

Patterns and age appropriateness of urinary and bowel movements: \_\_\_\_\_

Behavioral concerns:

Problematic behavior? \_\_\_\_\_ Bed wetting \_\_\_\_\_

masturbation \_\_\_\_\_ thumb sucking/nail biting/breath-holding/temper

tantrums /tics/nervousness/undue thirst \_\_\_\_\_

School/adolescent problems:

Smoking \_\_\_\_\_ alcohol/substance abuse \_\_\_\_\_ eating/exercise disorders

\_\_\_\_\_ abuse of steroids \_\_\_\_\_ sexual activity \_\_\_\_\_ birth control

\_\_\_\_\_ knowledge of sexually transmitted disease \_\_\_\_\_

involvement in gangs \_\_\_\_\_ use of guns or other weapons \_\_\_\_\_

Dental Hygiene:

Date of most recent preventative check \_\_\_\_\_

Safety:

Use of child seats in autos? \_\_\_\_\_ bicycle helmets \_\_\_\_\_

careful storage of meds/toxic substances \_\_\_\_\_ covering outlets \_\_\_\_\_

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