RADIANTLY
HEALTHY

New Pediatric Packet

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RADIANTLY HEALTHY

GENERAL INFORMATION

Patient Name: _____
First *Middle* *Last*

PARENT INFORMATION

Parent Name: _____
First *Middle* *Last*

ParentAddress:_____
Street *City* *State* *Zip*

2nd Parent Name: _____
First *Middle* *Last*

2nd Parent Address: _____
Street *City* *State* *Zip*

Preferred Contact Method ☐

Home Phone: _____ ☐ **Work Phone:** _____ ☐

Cell Phone: _____ ☐ **Fax Number:** _____ ☐

Email: _____ ☐

OK to Receive Text Messages About Appts etc? ☐

EMERGENCY CONTACT:

Name: _____ **Phone Number:** _____

Address: _____
Street *City* *State* *Zip*

Referred by:
☐ **Website** ☐ **Magazine Article** ☐ **Friend/Family** _____
☐ **Natural Awakenings** ☐ **Space Coast Living** ☐ **Other Doctor** _____

RADIANTLY
HEALTHY

Pediatric Patient Information

Child's First Name: _____ **Last Name:** _____

Middle Name: _____ **Preferred Name:** _____

Birthdate: _____ / _____ / _____ **Gender:** ☐ **Male** ☐ **Female**

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone #1 (**)** _____- _____ **Type:** _____ **Phone #1 (** **)** _____- _____ **Type:** _____

Place of Birth: City: _____ **State:** _____ **Country:** _____

Primary Care Physician Name: _____

Phone Number: _____ **Fax:**_____

PEDIATRIC MEDICAL ASSESSMENT

Name: _____ **Date:** _____ **DOB:** _____

Allergies

Medication/Supplement/Food	Reaction

Complaints/Concerns

What do you hope to achieve for your child in your visit with us? _____

_____

If you had a magic wand and could erase three problems, what would they be?

1. _____
2. _____
3. _____

When was the last time you child felt well? _____

_____

Did something trigger your child's change in health? _____

_____

Is there anything that makes your child feel worse? _____

_____

Is there anything that makes your child feel better? _____

_____

Please list current and ongoing problems in order of priority:

Describe Problem	Severity: Mild	Moderate	Severe	Prior Treatment/Approach	Success: Excellent	Good	Fair
Example: Post Nasal Drip		*X*		*Elimination Diet*	*X*		

RADIANTLY HEALTHY

HOSPITALIZATIONS

Is your child up to date with immunizations? ☐ Yes ☐ No

Do you feel immunizations have had an impact on your child's health? ☐ Yes ☐ No

If relevant, email a copy of your child's immunization record to newpatient@rh-md.com or see addendum.

PSYCHOSOCIAL

Has your child experienced any major life changes that may have impacted his/her health? ☐ Yes ☐ No

Has your child ever experienced any major losses? ☐ Yes ☐ No

STRESS/COPING

Have you ever sought counseling for your child? ☐ Yes ☐ No

Is your child or family currently in therapy? ☐ Yes ☐ No Describe: _____

Does your child have a favorite toy or object? ☐ Yes ☐ No

Check all that apply: ☐ Yoga ☐ Meditation ☐ Imagery ☐ Breathing ☐ Prayer ☐ Other: _____

Has your child ever been abused, a victim of a crime, or experienced a significant trauma? ☐ Yes ☐ No

SLEEP/REST

Average number of hours your child sleeps at night: ☐ >12 ☐ 10-12 ☐ 8-10 ☐ <8 Does your child snore? ☐ Yes ☐ No

Does your child have trouble falling asleep? ☐ Yes ☐ No Does your child feel rested upon waking? ☐ Yes ☐ No

ROLES/RELATIONSHIP

List Family Members:

Family Member and Relationship	Age	Gender

Who are the main people who care for your child? _____

What is their employment/Occupation? _____

What are your child's resources for emotional support?

Check all that apply: ☐ Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other: _____

GYNECOLOGIC HISTORY *(FEMALES ONLY)*

MENSTRUAL HISTORY

Age at first period: _____ Menses Frequency _____ Length _____

Pain? ☐ Yes ☐ No Clotting? ☐ Yes ☐ No Last Menstural Period? _____

Has your child's period ever skipped? _____ For how long? _____

Use of hormonal contraception such as: ☐ Birth Control Pills ☐ Patch ☐ Nuva Ring How long? _____

Is your child sexually active? ☐ Yes ☐ No

Does your child use contraception? ☐ Yes ☐ No Type: ☐ Condom ☐ Diaphragm ☐ IUD

FEMALE DISORDERS/HORMONAL IMBALANCES

☐ Fibrocystic Breasts ☐ Endometriosis ☐ Fibroids ☐ Infertility ☐ Painful Periods ☐ Heavy Periods ☐ PMDS

GI HISTORY

Foreign Travel? ☐ Yes ☐ No Where? _____

Wilderness Camping? ☐ Yes ☐ No Where? _____

Have you ever had severe: ☐ Gastroenteritis ☐ Diarrhea

DENTAL HISTORY

DENTAL SURGERY

☐ Silver Mercury Filings: How Many? _____ ☐ Gold Fillings ☐ Root Canals ☐ Implants ☐Tooth Pain

Does your child floss regularly? ☐ Yes ☐ No ☐Bleeding Gums ☐Gingivitis ☐ Problems with Chewing

PATIENT BIRTH HISTORY

MOTHER'S PAST PREGNANCIES

☐ Unknown, my child is adopted Number of: Pregnancies: _____ Live Births: _____ Miscarriages: _____

MOTHER'S PREGNANCY

Check box if yes and provide a description if applicable.

☐ Difficulty getting pregnant (more than 6 months) _____

☐ Infertility drugs used. Specify: _____

☐ In Vitro fertilization _____

☐Drank alcohol _____

☐ Drank coffee _____

☐Smoked tobacco _____

☐Took Progesterone _____

☐Took prenatal vitamins _____

☐Took antibiotics O During Labor? _____

☐Took other drugs. Specify _____

☐ Excessive vomiting, nausea (more than 3 weeks) _____

☐ Had a viral infection _____

☐ Had a yeast infection _____

☐ Had amalgam fillings put in teeth _____

☐ Had amalgam fillings removed from teeth _____

☐ Number of fillings in teeth when pregnant? _____

☐ Had bleeding (which months?) _____

☐ Had birth problems _____

☐ Group B strep infection _____

☐ C-section due to: _____

☐ Used induction for labor _____

☐ Had anesthesia -type _____

☐ Used oxygen during labor _____

☐ Had an x-ray _____

☐ Had Rhogam, if so how many shots? _____

How many when pregnant? _____

☐ Gestational Diabetes _____

☐ High blood pressure (pre-eclampsia) _____

☐ High blood pressure/toxemia _____

☐ Had chemical exposure _____

☐ Father had chemical exposure _____

☐ Moved to a newly built house _____

☐ House painted indoors _____

☐ House painted outdoors _____

☐ House exterminated for insects _____

☐ Had Tdap (Whooping Cough) Vaccination _____

PREGNANCY

Total weight gain during pregnancy: _____lb Total weight loss during pregnany: _____lb

Please describe diet during pregnancy: _____

_____

Please describe labor: _____

_____

PATIENT BIRTH HISTORY

PERINATAL

Pregnancy duration: Check following the week of gestation.

☐ 24 ☐ 25 ☐ 26 ☐ 27 ☐ 28 ☐ 29 ☐ 30 ☐ 31 ☐ 32 ☐ 33 ☐ 34 ☐ 35

☐ 36 ☐ 37 ☐ 38 ☐ 39 ☐ 40 (full term) ☐ 41 ☐ 42 ☐ 43 ☐ 44 Weeks

Very active before birth? ☐ Yes ☐ No

Hospital/Birthing Center? ☐ Yes ☐ No

Needed newborn special care? ☐ Yes ☐ No

Appeared healthy? ☐ Yes ☐ No

Easily consoled during first month? ☐ Yes ☐ No

Antibiotics in the first month? ☐ Yes ☐ No

Experienced no complications first month of life? ☐ Yes ☐ No

BIRTH WEIGHT AND APGAR

Weight at birth: _____lbs Apgar score at one minute: _____ Apgar score at 5 minutes _____

EARLY CHILDHOOD ILLNESSES

Number of ear aches in the first two years: _____

Number of other infections in the first two years: _____

Number of times you had antibiotics in the first two years of life:_____

First antibiotic at _____ months.

First illness at _____ months.

DESCRIPTION OF DEVELOPMENTAL PROBLEMS

If your child has developmental problems, at what age did they occur?

☐ 0-1 months ☐ 2-6 months ☐ 7-15 months ☐ 16-24 months ☐ After 24 months

Is this impression shared among parents and others caring for the child? ☐ Yes ☐ No

Is the impression, as to the timing of onset, weak? ☐ Yes ☐ No

Is the impression strong? ☐ Yes ☐ No

DEVELOPMENTAL HISTORY

Please indicate the approximate age in months for the following milestones: (example: walking 14 months)

Sitting up _____ months ☐ Never

Crawling _____ months ☐ Never

Pulled to stand _____ months ☐ Never

Potty trained _____ months ☐ Never

Walked alone _____months ☐ Never

Dry at night _____months ☐ Never

First words _____months ☐ Never

Spoke clearly _____months ☐ Never

Lost language _____months ☐ Never

Lost eye contact _____months ☐ Never

MEDICATION

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date Mo/Yr	Reason For Use

PREVIOUS MEDICATIONS *Last 10 years*

Medication	Dose	Frequency	Start Date Mo/Yr	Reason For Use

Has your child's medications or supplements ever caused him/her unusual side effects or problems? ☐ Yes ☐ No

Describe: _____

Has your child had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, or Aspirin? ☐ Yes ☐ No

Has your child had prolonged or regular use of Tylenol? ☐ Yes ☐ No

Has your child had prolonged or regular use of Acid Blocking Drugs? (Tagamet, Zantac, Prilosec, etc. ☐ Yes ☐ No

No Frequent antibiotics> 3 times/year? ☐ Yes ☐ No

Long term antibiotics? ☐ Yes ☐ No

Use of steroids (prednisone, nasal allergy inhalers) in the past? ☐ Yes ☐ No

Use oforal contraceptives? ☐ Yes ☐ No

FAMILY HISTORY

☐ **Unknown, my child is adopted**

Check family members that apply	Mother	Father	Brother(s)	Sisters(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Spondylitis												
Inflammatory Bowel Syndrome												
Multiple Sclerosis												
Auto Immune Diseases (such as lupus)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema/Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												
Other												

NUTRITION HISTORY

Has your child ever had a nutrition consultation? ☐ Yes ☐ No

Have you made any changes in your child's diet because of health issues? ☐ Yes ☐ No Describe: _____

_____

Does your child follow a special diet or nutritional program? ☐ Yes ☐ No

Check all that apply

☐ Yeast Free ☐ Feingold ☐ Weight management ☐ Diabetic ☐ Dairy Free ☐ Wheat Free D Ketogenic

☐ Specific Carbohydrate ☐ Gluten Free ☐ Gluten Restricted ☐ Vegetarian ☐ Vegan D Low Oxalate

☐ Food Allergy (Ex. Peanuts, Eggs, etc}: _____

Height (feet/inches) _____ Current Weight _____

Unusual weight fluctuations? ☐ Yes ☐ No +/- _____ lbs

Does your child avoid any particular foods? ☐ Yes ☐ No If yes, what are the types and reasons? _____

_____

_____

If your child could only eat a few foods daily, what would they be? _____

_____

_____

Who does the grocery shopping in your household? _____

Who does the cooking in your household? _____

How many meals does your child eat out per week? ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ >5 meals per week

Check all the factors that apply to your child's current lifestyle and eating habits:

☐ Fast Eater
☐ Erratic eating pattern
☐ Eat too much
☐ Dislike healthy food
☐ Time constraints
☐ Eat more than 50% meals away from home
☐ Poor snack choices
☐ Sensory issues with food
☐ Most family meals together
☐ Use food as bribe or reward
☐ Erratic mealtimes
☐ Picky eater
☐ Prefers cold food
☐ Prefers hot food
☐ Every meal is a struggle
☐ High juice intake
☐ Low fruit/vegetable intake
☐ High sugar/sweet intake
☐ Drinks soda or diet soda
☐ Cow's milk 1 2 3+
☐ Eat too little under stress
☐ Caffeine intake
☐ TV or videos with meals
☐ Challenges with food served outside the home (ex: childcare)

BREASTFED HISTORY

Breastfed? ☐ Yes ☐ No How long?_____ Problems latching on? ☐ Yes ☐ No

Sucking quality: ☐ Very Good ☐ Good ☐ Poor Exclusively breastfed for _____ months

BOTTLEFED HISTORY

Bottle fed? ☐ Yes ☐ No Type of formula: ☐ Soy ☐ Cow's Milk ☐ Low Allergy

Introduction of cow's milk at _____ months. Introduction of solid foods at _____ months.

Introduction of wheat or other grain at _____ months.

Choke/Gas/Vomit on milk? ☐ Yes ☐ No Refused to chew solids? ☐ Yes ☐ No

List mother's know food allergies of sensitivities: _____

Please list any other eating concerns you have regarding your child: _____

ACTIVITY

List daily type and amount of activity

Type	Amount Daily

How much time does your child spend watching television? _____

How much time does your child spend on the computer, tablet, smart phone, or playing video games? _____

ENVIRONMENTAL HISTORY

Please check appropriate box

EXPOSURES

Past/Current

- ☐ ☐ **Mold in bathroom**
- ☐ ☐ **Damp cellar**
- ☐ ☐ **Pest extermination - Inside**
- ☐ ☐ **Pest extermination - Outside**
- ☐ ☐ **Forced hot air heat**
- ☐ ☐ **Had water in basement**
- ☐ ☐ **Mold visible on exterior of house**
- ☐ ☐ **Heavily wooded or damp surroundings**
- ☐ ☐ **Mold in cellar, crawl space, or basement**
- ☐ ☐ **Moldy, musty school/daycare**
- ☐ ☐ **Tobacco smoke**
- ☐ ☐ **Well water**
- ☐ ☐ **Carpet in bedroom**
- ☐ ☐ **Carpet in most parts of the house**
- ☐ ☐ **Feather or down bedding**

ABOUT YOUR PARENTS

When were your parents marries? _____ **If separarted, when?** _____

If divorced, when? _____ **If remarried, when?** _____

Custody arrangements: _____

MOTHER - PERSONAL

Age at your birth _____

Education _____

Ethnicity _____

Blood Type _____

FATHER - PERSONAL

Age at your birth _____

Education _____

Ethnicity _____

Blood Type _____

SYMPTOM REVIEW

Please check all current symptoms occurring or present in the past 6 months

STRENGTHS

☐ Especially attractive
☐ Accepts new clothes
☐ Cuddle
☐ Physically coordinated
☐Happy
☐ Pleasant/easy to care for
☐ Sensitive/affectionate
☐ Wants to be liked
☐ Responsible
☐ Draws accurate pictures
☐ Sensitive to peoples feelings
☐ OK if parents leave
☐ Answers parents
☐ Follows instructions
☐ Pronounces words well
☐Unusual memory
☐ Perfect musical pitch
☐ Good with math
☐ Good with computer
☐ Good with fine work
☐ Good throwing and catching
☐ Good climbing
☐Strong desire to do things
☐ Swimming
☐ Bold, free of fear
☐ Likes to be held
☐ Likes to be swaddled

SLEEP

☐ Sleeps in own bed
☐ Sleeps with parent(s)
☐ Awakens screaming/crying
☐ Awakes at night
☐ Difficulty falling asleep
☐ Early waking
☐ Insomnia
☐ Sleeps less than normal
☐ Daytime sleepiness
☐ Jerks during sleep
☐ Nightmares
☐ Sleeps more than normal

PHYSICAL

☐ Looks sick
☐ Glazed look
☐ Overweight
☐ Underweight
☐ Pupils unusually large
☐ Unusual long eye lashes
☐ Red lips
☐ Red fingers
☐ Red toes
☐ Webbed toes
☐ Red ears
☐ Double jointed
☐ High arched palate
☐ Lymph nodes enlarged in neck
☐ Head warm
☐ Head sweats
☐ Night sweats
☐ Abnormal fatigue
☐ Failure to thrive
☐ Cold all over
☐ Cold hands and feet
☐ Cold intolerance
☐ Sweaty hands/feet
☐ Sweaty /hot head
☐ Perspiration - odd odor

SKIN

☐ Paleness, severe
☐ Fingernail fungus
☐ Toenail fungus
☐ Dandruff
☐ Chicken skin
☐ Oily skin
☐ Patchy dullness
☐ Seborrhea on face
☐ Thick calluses
☐ Athletes foot
☐ Stinky feet
☐ Diaper Rash
☐ Strong body odor
☐ Acne
☐ Eczema
☐ Flushing
☐ Red face
☐ Sensitive to insect bites
☐ Stretch Marks
☐ Blotchy skin
☐ Frequent bug bites
☐ Cradle cap
☐ Dry hair
☐ Dry scalp
☐ Unmanageable hair
☐ Bites nails
☐ Brittle nails
☐ Frayed nails
☐ Pitted nails
☐ Soft nails
☐ Dark birth marks
☐ Bruises easily
☐ Inability to tan
☐ Light birth mark
☐ Ragged cuticles
☐ Thickening finger nails
☐ Thickening toenails
☐ Vitiligo
☐ White spots or lines in nails
☐ Dry skin
☐ Feet cracking
☐ Feet peeling
☐ Hands cracking
☐ Hands peeling
☐ Lower legs dry
☐ Lackluster skin
☐ Itchy skin in general
☐ Itchy scalp
☐ Itchy ear canals
☐ Itchy eyes
☐ Itchy nose
☐ Itchy roof of mouth
☐ Itchy arms
☐ Itchy hands
☐ Itchy legs
☐ Itchy feet
☐ Itchy anus
☐ Itchy penis
☐ Itchy vagina

DIGESTIVE

☐ Bad breath
☐ Increased Salivation
☐ Drooling
☐ Cracked lip corners
☐ Cold sores on lips/face
☐ Geographic tongue (map-like)
☐ Sore tongue
☐ Tongue coated
☐ Canker sores in mouth
☐ Bleeding gums
☐ Teeth grinding
☐ Tooth cavities

☐ Tooth with amalgam fillings
☐ Mouth thrush (yeast)
☐ Sore throat
☐ Fecal belching
☐ Burping
☐ Nausea
☐ Reflux
☐ Spitting up
☐ Vomiting
☐ Abdominal bloating
☐ Lower abdominal bloating
☐ Colic
☐ Abdomen distended
☐ Abdominal pain
☐ Intestinal parasites
☐ Pinworms
☐ Crampy pain with pooping
☐ Constipation
☐ Diarrhea
☐ Gas - regular
☐ Gas - Stinky
☐ Anal fissures
☐ Red ring around anus
☐ Stools bulky
☐ Stools light color
☐ Stools very stinky
☐ Stools with blood
☐ Stools with mucous
☐ Stools with undigested food
☐ Stool odor yeasty
☐ Stools slimy
☐ Stools watery

EATING

☐ Poor appetite
☐ Thirst
☐ Extreme water drinking
☐ Binging
☐ Bread craving
☐ Craving for carbohydrates
☐ Craving for juice
☐ Craving for salt
☐ Diet soda craving
☐ Pica (eating non-edibles)
☐ Abnormal food cravings
☐ Carbohydrate intolerance
☐ Starch intolerance
☐ Sugar intolerance
☐ Salicylate intolerance
☐ Oxalate intolerance
☐ Phenolic intolerance
☐ MSG intolerance
☐ Food coloring intolerance
☐ Gluten intolerance
☐ Casein intolerance
☐ Specific food(s) intolerance
☐ Lactose intolerance
☐ Behavior worse with food
☐ Behavior better when fasting

BEHAVIOR

☐ Behavior purposeless
☐ Unusual play
☐ Uses adults hand for activity
☐ Aloof, indifferent, remote
☐ Doesn't do for self
☐ Extremely curious
☐ Hides skill/knowledge
☐ Lacks initiative
☐ Lost in thought, unreachable
☐ No purpose to play
☐ Poor focus, attention
☐ Sits long time staring
☐ Uninterested in live pet
☐ Watches television long time
☐ Won't attempt/can't do
☐ Poor sharing
☐ Rejects help
☐ Curious/gets into things
☐ Erratic
☐ Unable to predict actions
☐ Destructive
☐ Hyperactive
☐ Constant movement
☐ Melt downs
☐ Tantrums
☐ Self mutilation
☐ Runs away
☐ Jumps when pleased
☐ Whirls self like a top
☐ Climbs to high places
☐ Insists on what is wanted
☐ Tries to control others
☐ Head banging
☐ Falls, gets hurt running/climbing
☐ Does opposite of asked
☐ Teases others
☐ Silly
☐ Shrieks
☐ Holds hands in strange pose
☐ Spends time w / pointless task
☐ Stares at own hands
☐ Toe walking
☐ Arched back with bright lights
☐ Imitates others
☐ Finger flicking
☐ Flaps hands
☐ Licking
☐ Likes spinning objects
☐ Likes to flick finger in eye
☐ Like to spin things
☐ Rhythmic rocking
☐ Slapping books
☐ Tooth tapping
☐ Visual stims
☐ Wiggle finger front of face
☐ Wiggle finger side of face
☐ Bites or chews fingers
☐ Bites wrist or back of hands
☐ Chews on things

MOOD

☐ Apathy
☐ Blank look
☐ Depression
☐ Detached
☐ Disinterested
☐ Eye contact poor
☐ Isolates
☐ Negative
☐ Fright without cause
☐ Always frightened
☐ Anguish
☐ Discontented
☐ Does not want to be touched
☐ Inconsolable crying
☐ Irritable
☐ Looks like in pain
☐ Moaning, groaning
☐ Phobias
☐ Restless
☐ Severe mood swings
☐ Unhappy
☐ Agitated
☐ Anxious

SENSORY

☐ Bothered by certain sounds
☐ Covers ears with sounds
☐ Ear pain
☐ Ear ringing
☐ Hearing acute
☐ Hearing loss
☐ Likes certain sounds
☐ Sensitive to loud noise
☐ Sounds seem painful
☐ Tinnitus
☐ Acute sense of smell
☐ Examines by smell
☐ Intensely aware of odors
☐ Blinking
☐ Bothered by bright lights

☐ Distorted vision
☐ Conjunctivitis
☐ Eye crusting
☐ Eye problem
☐ Lid margin redness
☐ Examines by sight
☐ Fails to blink at bright light
☐ Likes fans
☐ Likes flickering lights
☐ Looks out of corner of eye
☐ Poor vision
☐ Puts eye to bright light or sun
☐ Strabismus (crossed eyes)
☐ Fearful of harmless object
☐ Fearful of unusual events
☐ Unaware of danger
☐ Unaware of people's feelings
☐ Unaware of self as person
☐ Upset if things change
☐ Upset if things aren't right
☐ Adopts complicated rituals
☐ Car, truck, train obsession
☐ Collects particular things
☐ Draws only certain things
☐ Fixated on one topic
☐ Lines objects precisely
☐ Repeats old phrases
☐ Repetitive play/objects
☐ Finger tip squeezing
☐ Hates wearing shoes
☐ Insensitive to pain
☐ Likes head burrowed
☐ Liked head pressed hard
☐ Likes head rubbed
☐ Likes head under blanket
☐ Likes to be held upside down
☐ Likes to be swung in the air
☐ Very insensitive to pain
☐ Very sensitive to pain

NEUROMUSCULAR

☐ Clumsiness
☐ Coordination
☐ Poor fine motor skills
☐ Poor gross motor skills
☐ Holds bizarre posture
☐ Hyperactivity
☐ Physically awkward
☐ Rocking
☐ Stiffens body when held
☐ Calf cramps
☐ Foot cramps
☐ Muscle pain
☐ Muscle tone tense
☐ Muscle twitches
☐ Fist clenching
☐ Jaw clenching
☐ Poor muscle tone/limp
☐ Tics
☐ Muscle tone low trunk
☐ Muscle weakness, atrophy
☐ Muscle tone low all over
☐ Tremors
☐ Cognitive delays
☐ Memory poor
☐ Poor attention
☐ Slow and sluggish
☐ Expressive language delay

SPEECH

☐ Never spoke
☐ Occasional words when excited
☐ Expressive language poor
☐ Doesn't simple questions
☐ Points to objects/can't name
☐ Speech apraxia
☐ Does not ask questions
☐ Babbling
☐ Asks using "you" not "I"
☐ Answers by repeating questions
☐ Receptive language poor
☐ Says "I"
☐ Says"no"
☐ Says"yes"
☐ Lost language at 12-24 months
☐ Lost language after 24 months
☐ Scripting
☐ Stuttering
☐ Talks to self
☐ Poor auditory processing
☐ Unusual sound of cry
☐ Uses one word for another
☐ Rigid behaviors
☐ Poor confidence
☐ Timid
☐ Corrects imperfections
☐ Tidy

RESPIRATORY

☐ Pneumonia
☐ Bad odor in nose
☐ Breath holding
☐ Bronchitis
☐ Congestion chg. Season
☐ Congestion in the fall
☐ Congestion in the spring
☐ Congestion in the summer
☐ Congestion in the winter
☐ Cough
☐ Post nasal drip
☐ Runny nose
☐ Sighing
☐ Sinus fullness
☐ Wheezing
☐ Yawning

REPRODUCTIVE

☐ Early pubic hair
Girls:
  ☐ Early first period
  ☐ Early Breast Development
  ☐ Vaginal odor
Boys:
  ☐ Large testicles
  ☐ Large breasts

URINARY

☐ Frequent urination
☐ Bed wetting after age 4
☐ Odd urinary odor
☐ Urinary hesitancy
☐ Urinary tract infections
☐ Urinary urgency
☐ Dry at night

OTHER

☐ Seizures -focal
☐ Seizures - generalized
☐ Seizures - grand mal
☐ Unusual fast heart beat
☐ Heart murmur
☐ Headaches
☐ Joint pains
☐ Leg pains
☐ Muscle pains

READINESS ASSESSMENT

Rate on a scale of: 5 (very willing) to 1 (not willing).

In order to improve your child's health, how willing is the patient in:

Significantly modify diet: ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Take several nutritional supplements each day: ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Keep a record of everything you eat each day: ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Modify lifestyle ['e.g., school/home demands, sleep habits): ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Practice a relaxation technique: ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Engage in regular exercise: ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Have periodic lab tests to assess progress: ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Comments: _____

_____

_____

Rate on a scale of: 5 (very confident) to 1 (not confident at all)

How confident are you of your ability to organize and follow through on the above health related activities to help your child?

☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

If you are not confident of your ability, what aspects of yourself or life lead you to question your capacity to fully engage in the above activities? _____

_____

_____

_____

Rate on a scale of: 5 (very supportive) to 1 (very unsupportive)

At the present time, how supportive do you think the people in your household will be to your implementing the above changes?

☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Comments: _____

_____

_____

_____

Rate on a scale of: 5 (very frequent contact) to 1 (very infrequent contact)

How much on-going support and contact (e.g. telephone consults, email correspondence) from our professional staff would be helpful to you as you implement a personal health program for your child? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Comments: _____

_____

_____

_____

RADIANTLY HEALTHY

Diet, Nutrition, and Lifestyle Journal - 3 Day

Patient Name: _____ Date _____

Food Plan Type: _____

DAY 1

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast Time		_____P _____F _____C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-AM Snack Time		_____P _____F _____C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Lunch Time		_____P _____F _____C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-PM Snack Time		_____P _____F _____C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Dinner Time		_____P _____F _____C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
PM Snack Time		_____P _____F _____C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Bed Time		

P: Proteins F: Fats C: Carbohydrates R: Red; O: Orange; Y: Yellow; G: Green; B/P/BL: Blue/Purple/Black W/T/BR: White/Tan/Brown

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
SLEEP Quantity:_____ (hours) Quality: ☐Poor ☐Fair ☐Good RELAXATION ☐ Yes ☐ No Type/amount:	Type, Duration, & Intensity ☐ Aerobic: ☐ Strength: ☐ Flexibility:	Stress Reduction Practices: Stressors:	Supporting: Non-supporting:

Mental	Emotional	Spiritual

RADIANTLY HEALTHY

Diet, Nutrition, and Lifestyle Journal - 3 Day

Patient Name: _____ Date _____

Food Plan Type: _____

DAY 2

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast Time		_____P _____F _____C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-AM Snack Time		_____P _____F _____C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Lunch Time		_____P _____F _____C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-PM Snack Time		_____P _____F _____C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Dinner Time		_____P _____F _____C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
PM Snack Time		_____P _____F _____C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Bed Time		

P: Proteins F: Fats C: Carbohydrates R: Red; O: Orange; Y: Yellow; G: Green; B/P/BL: Blue/Purple/Black W/T/BR: White/Tan/Brown

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
SLEEP Quantity:_____ (hours) Quality: ☐Poor ☐Fair ☐Good RELAXATION ☐ Yes ☐ No Type/amount:	Type, Duration, & Intensity ☐ Aerobic: ☐ Strength: ☐ Flexibility:	Stress Reduction Practices: Stressors:	Supporting: Non-supporting:

Mental	Emotional	Spiritual

RADIANTLY HEALTHY

Diet, Nutrition, and Lifestyle Journal - 3 Day

Patient Name: _____ Date _____

Food Plan Type: _____

DAY 3

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast Time		_____P _____F _____C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-AM Snack Time		_____P _____F _____C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Lunch Time		_____P _____F _____C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-PM Snack Time		_____P _____F _____C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Dinner Time		_____P _____F _____C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
PM Snack Time		_____P _____F _____C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Bed Time		

P: Proteins F: Fats C: Carbohydrates R: Red; O: Orange; Y: Yellow; G: Green; B/P/BL: Blue/Purple/Black W/T/BR: White/Tan/Brown

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
SLEEP Quantity:_____ (hours) Quality: ☐Poor ☐Fair ☐Good RELAXATION ☐ Yes ☐ No Type/amount:	Type, Duration, & Intensity ☐ Aerobic: ☐ Strength: ☐ Flexibility:	Stress Reduction Practices: Stressors:	Supporting: Non-supporting:

Mental	Emotional	Spiritual