DOCUMENTING hope

HEALTH COACH NEW CLIENT INTAKE FORM

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Address:	
Phone:	**Email:**
Mother:	**Father:**
Child lives with: _____ **Mother** _____ **Father** _____ **Both**	
Primary Care Physician:	**Date of last physical exam:**

BIRTH AND INFANCY

Birth was: ☐ Vaginal Delivery ☐ Caesarean Delivery ☐ Unmedicated ☐ Antibiotics Given ☐ Pain Medication Given

Delivery at _____ weeks gestation Weight: _____ lbs, _____ oz

First Feeding was: ☐ Breastmilk ☐ Formula **If Breastfed:** ☐ Exclusively ☐ With Supplementation **Until Age:**

List Any Early Issues:

☐ Allergy or Intolerance to Formula/Breastmilk **Other:**

☐ Colic ☐ Reflux

☐ Constipation or Diarrhea

☐ Slow to gain weight, "Failure to Thrive"

☐ Developmental Delays

Age to sit up? _____ Crawl? _____ What kind of crawling? _____ Age to walk? _____

List Any Pregnancy or Birth Complications Experienced:

CURRENT HEALTH HABITS

What is typical for this child currently?

Bedtime: _____ Waking Time: _____ Naps? _____ Normal Social Play? _____

Breakfast Food: _____ Dinner Foods: _____

Snack Foods: _____ Favorite Foods: _____

Lunch Foods: _____ _____

List All Diagnoses the Child has received to date:		
Diagnosis & Date:	Reason:	Diagnosing Physician:

List all vaccinations received to date:			
Vaccination	**Date(s)**	**Vaccination**	**Date(s)**
Hep B		Meningococcal	
DTaP		Flu	
IPV/OPV		Other:	
MMR		Other:	
Hep A		Other:	
Varicella		Other:	
PCV		Other:	
HIB		Other:	

List all medications, vitamins, and supplements currently being taken:			
Medication or Vitamin	**Dose**	**Medication or Vitamin**	**Dose**

MEDICATION HISTORY

List all medications the child has taken in the past & frequency: **Other:**

☐ Antibiotics: Estimated number of courses? _____

☐ Tylenol: How often? _____

☐ NSAIDS: How often? _____

☐ Benadryl: How often? _____

☐ Asthma/steroid medications (e.g. Pulmicort, Flovent, mometasone, etc.): How often? _____

☐ Mood/Behavior medication (for anxiety, depression, etc.; please indicate specific type/brand) _____

☐ Anesthesia medications (from surgeries/procedures): Estimated number of times? _____

☐ Asthma Medications (indicate type/brand) _____

☐ ADHD/ADD or stimulant medication *(e.g. Ritalin, Adderall, etc.; please indicate specific type/brand)* _____

☐ Other medications (please list) _____

_____

_____

_____

_____

_____

ALLERGIES

List child's known allergies:

FAMILY HEALTH HISTORY

List any medical issues experienced by close family members:

Father:	
Age:	
Mother:	
Age:	
Sibling:	
Age:	
Circle: M / F	
Sibling:	
Age:	
Circle: M / F	
Sibling:	
Age:	
Circle: M / F	

SYMPTOMS		
Check all symptoms that the child has experienced at any point:		
☐ Red ears after eating	☐ Habitual Gagging or Choking while eating	☐ Dry scaly skin (eczema)
☐ Red cheeks after eating	☐ Storing food in cheeks	☐ Frequent diaper rash
☐ Chronic runny nose	☐ Recurrent ear infections	☐ Cradle cap or excessive dandruff
☐ Chronic cough	☐ Chronic or recurrent sinus infections	☐ Thinning hair or hair loss
☐ Chronic mouth breathing	☐ Chronic or recurrent strep infections	☐ Cavities and excessive tartar
☐ Problems with swallowing	☐ Periodic fever syndrome	☐ Bad breath despite good hygeine
☐ Frequent daytime accidents after training	☐ Nighttime bedwetting into grade school	☐ Frequent waking to use bathroom
☐ Dark circles or bags under eyes	☐ Excessive drooling beyond teething years	☐ Frequent temper tantrums
☐ Frequent crying, sadness, or anger	☐ Regurgitation after eating	☐ White coating on tongue
☐ Chronic thrush infections	☐ Unusual finger- and toenail formation	☐ Frequent diarrhea
☐ Undigested food in stool	☐ Blood in stool	☐ Constipation or straining
☐ Excessive gas	☐ Discolored stool (white, yellow, black)	☐ Dry stools, floating stools
☐ Tummy aches	☐ Distended belly	☐ Persistent toe-walking
☐ Delays in crawling, walking, or talking	☐ Speech impairments	☐ Large motor delays (jumping, climbing)
☐ Sideways glancing	☐ Lack of direct eye contact	☐ Auditory sensitivity (ie to vacuum cleaners)
☐ Sensitivity to bright lights	☐ Avoidance of cerain textures (ie sand, wetness)	☐ Sensitivity or emotional reaction to sensory experiences, ie tags in clothing
☐ Reflux	☐ Chronic spitting up as a baby	☐ Avoidance of affection
☐ Avoidance of seams in socks, hairbrushing	☐ Pressure-seeking behavior	☐ Head banging
☐ Tongue hanging out of mouth	☐ Growth delays/failure to thrive	☐ Arm flapping
☐ Low muscle tone	☐ Extreme fatigue	☐ Difficulty waking
☐ Excessive sweating	☐ Hyperactivity	☐ Chronically swollen lymph nodes
☐ Obsessive or compulsive behaviors (ie toy hoarding)	☐ Repetitive behaviors	☐ Persistent oppositional behavior
☐ Tics (throat clearing, blinking)	Anemia	☐ Pale complexion
☐ Recurrent urinary infections	☐ Chronic vaginal infections	☐ Athletes foot, ringworm, or fungal infections
☐ Irritability	☐ Muscle twitches or cramps	☐ Anxiety/nervousness
☐ Craving sweet or salty foods	☐ Craving chocolate	☐ Insomnia, trouble falling asleep
☐ Headaches	☐ Cold hands or feet	☐ Brittle nails
☐ Ridges or white spots on fingernails	☐ Pimply skin on backs of arms	☐ Picky eating
☐ Chronic colds	☐ Emotional meltdowns/mood swings	☐ Hypermobility n joints
☐ Attention deficits	☐ Low body temperature	☐ Thyroid swelling
☐ Immune deficiency	☐ Tingling in the hands	☐ Memory issues/forgetfulness
☐ Cracked lips	☐ Immune deficiency	☐ Hyperactivity
☐ Impaired wound healing	☐ Dry or peeling skin	☐ Aggression
☐ Dry brittle hair	☐ Eating disorder	☐ Excessive or diminished thirst
☐ Asthma	☐ Overweight	☐ Inflamed gums
☐ Bleeding gums	☐ Gum disease	☐ Pale fissured tongue
☐ Swollen tongue (lateral teeth indentations)	☐ Bumpy skin	☐ Acne
☐ Scaly skin on face	☐ Yellow palms	☐ Uncommon bleeds
☐ Delay in sucking reflex	☐ Crossed eye	☐ Wiggly eyes
☐ Reduced visual acuity	☐ Reduced auditory acuity	☐ Developmental delay
☐ Swollen tonsils or adenoids		

Additional Notes: