

YOUTH HEALTH HISTORY QUESTIONNAIRE

Name _____ Today's date: _____

Age: _____ Birth Date: _____ Weight: _____ Height: _____

This questionnaire is designed to assist in providing a general overview of your child's health habits and history. Please be as detailed as possible when answering these questions!

1. What is the reason for this visit?

2. Please list any known health conditions that your child has been diagnosed with:

3. List any **medications** your child is currently taking, or has taken in the past.

4. Please indicate any history of **antibiotic** use, listing when, what, and for what purpose.

5. Are there any known drug allergies?

6. List supplements, herbs, remedies, including athletic performance supplements that your child is currently taking:

7. Do you suspect your child to use recreational drugs? If so, what:

8. List any hospital procedures/surgeries that your child has had:

LIFESTYLE INDICATORS (please fill in or circle the appropriate answer)

1. Does your child consume any of the following?

Soda	none	< 2 cans / day	> 2 cans / day	
Sweets / Carbs	none	< twice / day	> twice / day	
White Flour	none	< twice / day	> twice / day	
Milk/Dairy Products	none	< twice / day	> twice / day	
Juice	none	< twice / day	> twice / day	
Meat/Fish	none	rarely	< once a week	every day

2. How much water does your child drink each day? _____

3. Are there smokers in the child's home? Yes No

4. Does your child get consistent physical activity? Yes No

5. Please list any regular exercise or sports that your child participates in:

History (please fill in or circle the appropriate answer)

1. Did your child have colic as an infant? Yes No

2. How was your child fed as an infant? Breast Bottle

What brand / kind of formula? _____

3. Has your child had any respiratory infections? Yes No

How often? _____

4. Does your child ever complain of back or neck pain? Yes No

Please explain: _____

5. Does your child ever complain of arm or leg pain? Yes No

Please explain: _____

6. Does your child ever complain of headaches? Yes No

How often? _____

7. Has your child had ear infections? Yes No

Age of the first occurrence and frequency: _____

8. Do they typically occur in the same ear? Yes No Which ear? Right Left Both

9. Please list any illnesses that your child has had and approximate dates of occurrence:

10. Has your child been vaccinated? Yes No Recently? Yes No

11. Please describe any reactions that your child has had to past or recent vaccinations:

12. Please list any other concerns you have regarding your child's health:

Sleep Habits (please fill in or circle the appropriate answer)

1. How well does your child sleep?
Well Trouble falling asleep Trouble staying asleep Insomnia
2. Does your child wake up tired? Yes No
3. How many hours does your child sleep on an average night? _____
4. Does your child take naps? Yes No
5. Does your child have nightmares? No Sometimes Often

For Cycling Females Only (please fill in or circle the appropriate answer)

1. Age of onset of menarche (first period): _____
Approximate Date: _____
2. Is your child currently using any method of birth control? Yes No
What kind? Oral Pill Injected Patch Ring
3. How long has your child been using birth control? _____
4. Please describe any symptoms that your child may have experienced while using birth control (i.e. yeast infections, heavy / light bleeding, moodiness, weight gain, acne, sweet cravings, palpitations, fatigue):

5. First day of last period: _____
6. Length of typical period: _____
7. Is menstrual cycle regular? Yes No Not Always
Details: _____
8. How many pads and / or tampons (please circle) are used on heavy days?

9. Any knowledge of passing clots? Yes No
How often? _____
10. Any spotting between periods? Yes No
At what point in cycle? _____
11. Does your child experience cramping? None Mild Moderate Severe
At what point in the cycle? _____

**INSTRUCTIONS: Please mark the following symptoms as they apply.
Please be as detailed as possible.**

SIGNS & SYMPTOMS	MILD	MODERATE	SEVERE	MORE INFORMATION
Low Mood				
Lowered Self-Esteem				
Discouragement				
Sadness / Crying				
Reserved / Withdrawn				
Decreased Interest in Activities				
Decreased Initiative / Motivation				
Behavior Problems				
Aggression				
Anger				
Anxiety				
Fear				
Difficulty Concentrating				
Foggy Thinking				
Memory Problems				
Constant Hunger				
Never Hungry / Anorexia				
Weight Loss				
Weight gain				
Decrease in Strength / Stamina				
Decrease in Athletic Performance				
Fatigue				
Anemia				
Headaches / Migraines				
Body / Joint / Backaches				
Digestive Problems				
Irritable Bowel				
Constipation				
Loose Stool / Diarrhea				
Bloating				
Frequent Urination				
Bedwetting				
Allergies				
Asthma				
Throat Clearing				
Excessive Mucous / Runny Nose				
Dry Skin				
Acne				
Cold Sores				
Infections / Lowered Immunity				

Lozier Natural Health Center, P.C.

CONFIDENTIAL PATIENT INFORMATION

Name: _____ Today's Date: _____ AGE _____ SEX _____
Birth Date: ___/___/___
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone :(____) _____
Email Address _____
Your Occupation _____ Your Employer: _____
Social Security #: _____
Marital Status: Married Single Divorced Separated Other _____
Name of Spouse or Nearest Relative: _____ Phone :(____) _____
Referred to this Office by: _____

Have you been treated by a physician for any health condition in the last year? Yes No
If yes by whom _____
Describe Condition _____ Date of Last Physical Exam _____

SURGICAL HISTORY:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS: Rate pain (1-10, 0-no pain to 10 worst pain)

1. _____ # _____
2. _____ # _____
3. _____ # _____
4. _____ # _____

HAVE YOU RECEIVED CHIROPRACTIC CARE BEFORE? YES NO

ARE YOU CURRENTLY RECEIVING CHIROPRACTIC CARE? YES NO

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

WHAT NUTRITIONAL SUPPLEMENT ARE YOU CURRENTLY TAKING?

ARE YOU PREGNANT NO YES DATE OF LAST MENSTRUAL PERIOD _____

HISTORY

PLEASE CIRCLE THE NUMBER TO INDICATE CURRENT SYMPTOMS
PLEASE PLACE A (X) NEXT TO ANY ON GOING OR PAST PROBLEMS

GENERAL

1. FEVER
2. CHILLS
3. NIGHTS SWEATS
4. LOSS OF SLEEP
5. FATIGUE
6. NERVOUSNESS
7. WEIGHT LOSS OR GAIN
8. ALLERGIES
9. BLEEDING PROBLEMS
10. ANEMIA
11. DIABETES
12. CANCER
13. THYROID PROBLEMS
14. ALCOHOLISM
15. DRUG ABUSE

EAR, EYE, NOSE, THROAT

16. POOR VISION
17. PAIN IN EYE(S)
18. DEAFNESS OR HEARING
19. NOSEBLEEDS
20. SINUS PROBLEMS
21. NOSE PROBLEMS
22. DENTAL PROBLEMS
23. HOARSENESS
24. TONSILLECTOMY

GASTROINTESTINAL

25. POOR APPETITE
26. POOR DIGESTION
27. DIFFICULTY SWALLOWING
28. BELCHING OR GAS
29. FREQUENT NAUSEA
30. VOMITING
31. VOMITING BLOOD
32. PAIN OVER ABDOMEN
33. ULCER
34. BLACK OR BLOODY STOOL
35. LIVER PROBLEMS
36. GALL BLADDER PROBLEMS
37. JAUNDICE
38. HERNIA
39. DIARRHEA
40. CONSTIPATION
41. HEMORRHOIDS
42. APPENDICITIS

MEN ONLY

43. TESTICULAR SWELLING/PAIN
44. PROSTATE

RESPIRATORY

45. DIFFICULTY BREATHING
46. CHRONIC COUGH
47. SPITTING PHLEGM
48. SPITTING BLOOD
49. WHEEZING/ASTHMA
50. PNEUMONIA
51. TUBERCULOSIS

CARDIOVASCULAR

52. IRREGULAR HEARTBEAT
53. HIGH BLOOD PRESSURE
54. PAIN OVER HEART
55. PREVIOUS HEART TROUBLE
56. ANKLE SWELLING
57. VARICOSE VEINS
58. RHEUMATIC FEVER
59. STROKE

GENITOURINARY

60. FREQUENT URINATION
61. PAINFUL URINATION
62. BLOOD IN URINE
63. KIDNEY DISEASE
64. URINARY INFECTION
65. INABILITY TO CONTROL URINE
66. DIFFICULTY STARTING URINE
67. GET UP A NIGHT TO URINATE
68. BREAST LUMP OR PAIN
69. VENERAL INFECTION
70. SEXUAL DIFFICULTIES

SKIN

71. ITCHING
72. BRUISING EASILY
73. CHANGE IN MOLE(S)
74. SKIN CANCER
75. SCARS LOCATION

NEUROLOGIC

76. WEAKNESS
77. TWITCHING
78. TREMORS
79. HEADACHE
80. FAINTING
81. DIZZINESS
82. CONVULSIONS
83. EPILEPSY/SEIZURES
84. NUMBING/TINGLING
85. ARM/LEG PAIN
86. MENTAL DISORDER

MUSCULOSKELETAL

87. NECK STIFFNESS/PAIN
88. PAIN BETWEEN SHOULDERS
89. LOW BACK PAIN
90. SWOLLEN JOINTS
91. PAINFUL JOINTS
92. MUSCLES ACHES/SORENESS
93. SPINAL CURVATURE
94. ARTHRITIS

WOMEN ONLY

95. PAINFUL PERIODS
96. EXCESSIVE FLOW
97. IRREGULAR CYCLES
98. VAGINAL BURNING/ITCHING
99. HOT FLASHES
100. DATE LAST PERIOD BEGAN
101. DATE OF LAST PAP SMEAR

EXERCISE

102. NONE

103. 1-2 TIMES/WEEK

104. 3-5 TIMES/WEEK

105. 6-7 TIMES/WEEK

HABITS

106. SMOKING _____ #PACKS, DAY

107. DRINKING

108. RECREATIONAL DRUG USE

109. CAFFEINE

FAMILY HISTORY: BROTHERS,
SISTERS, PARENTS, GRANDPARENTS.

110. DIABETES

111. THYROID DISEASE/GOITER

112. TUBERCULOSIS

113. KIDNEY DISEASE

114. HIGH BLOOD PRESSURE

115. HEART DISEASE

116. CANCER

117. MUSCLE, BONE, NERVE DISEASE

118. LUNG DISEASE

119. ULCERS

120. ARTHRITIS

121. SEIZURES/STROKE

