

NEW PATIENT INSTRUCTIONS – ALL PATIENTS

If you are interested in making an appointment, please be sure you have reviewed all information on our website www.carolinacenter.com under “NEW PATIENTS”, then “HOW TO BECOME A PATIENT” before completing these forms.

- Please review “Type of New Patients” and then indicate which type office visit you prefer:**
 - Comprehensive New Patient Visit – Includes initial Meridian Stress Assessment testing**
 - _____ **Adult – Includes 2 hour MSA - \$650**
 - _____ **Pediatric (under age 18) – Includes 1 hour MSA - \$585**
 - _____ **Urgent New Patient Visit for Acute Lyme – (rate will vary based on time spent)**
 - _____ **Combined Family Visits – check adult or pediatric above as well as this line.**
 - _____ **60 Minute “Fast Track” New Patient Visit, for approval for Colon Hydrotherapy - \$338**
 - _____ **45 Minute “Fast Track” New Patient Visit, for medical clearance for the HCG Weight Loss program. Must be done in conjunction with a 30-minute nutritional counseling session - \$224 + \$64.**
- Please **complete** the *Medical History Form*. (Adult, Pediatric or Autism Spectrum)
- Complete and sign** the *Patient Registration/Insurance Authorization Form*
- Provide us a **copy** of your insurance card, both front and back and a copy of your Driver’s License or other official identification (required by the US Patriot Act). Failure to provide these documents will delay scheduling your appointment. We will also need you to provide your social security number.
- Fill out the *Request for Medical Records* and *give this to your primary care and/or specialty physicians* to have them send us copies of any pertinent medical records and recent laboratory results. Do not have copies of x-rays sent as we only need the reports. **Do not return this form to us.**
- We require a non-refundable \$200 deposit to reserve your initial evaluation and the New Patient Orientation, which you should attend prior to (or the day of) the initial evaluation. At Orientation, the balance for your initial visit will be due and your appointment for the initial MSA and your office visit will be made. This balance can be refunded up to 2 weeks prior to your actual office visit, less the fee for the MSA if this has already been done. **The \$200 deposit is not refundable.** Send a check payable to The Carolina Center or complete the following if you wish to make a credit / debit card payment.

___ Visa ___ MasterCard ___ American Express ___ Discover
Account # _____ Expiration: _____
Cardholder Name: _____
Cardholder Signature: _____

- Please be aware of our **No Perfume-Scented Toiletries** policy and refrain from wearing any perfume or scented toiletries while at the clinic.
- I have read all the information on the Carolina Center website under “New Patients” and “How to become a patient” and understand these procedures. I request to attend the New Patient Orientation at which time I will complete the process of becoming a patient of the Carolina Center. I understand that I will not be undergoing an evaluation at this Orientation. I understand that the \$200 deposit is non-refundable.**

Signature

Date

- Collect the following completed information:
 - Medical History Form (large questionnaire)*
 - Patient Registration/insurance Authorization Form*
 - Copy of Insurance Card*
 - Medical records from previous doctor(s)*
 - Payment information, either a check or credit card information*
- Send all of this information to our office: **The Carolina Center for Integrative Medicine, P.A.
Younger Mattox, New Patient Coordinator
4505 Fair Meadow Lane #111, Raleigh, NC 27607**

THE CAROLINA CENTER FOR INTEGRATIVE MEDICINE, P.A. - PATIENT REGISTRATION/INSURANCE FORM

Patient's Legal Name: (First, Middle Initial, Last): _____ Social Security #: _____

Patient Address: _____ County: _____

Home #: _____ Cell #: _____

Sex M or F Birth date: _____ Email address: _____

Marital Status: _____ Single _____ Married _____ Divorced _____ Widowed _____ Domestic Partnership

Spouse's Name (if applicable): _____ # of household members: _____ Ethnicity: _____

Person responsible for payment: _____

Patient's Employer and Occupation: _____

Employer Address: _____ Work #: _____ Ext: _____

Primary Care Physician Name: _____ Phone #: _____

DO YOU HAVE HEALTH INSURANCE? YES NO (Circle one) - If you answered YES, please provide a copy of your insurance card and complete the following:

Primary Insurance: _____ Subscriber's Name: _____

Sex of Subscriber: M F Birth date of Subscriber: _____ Social Security #: _____

Relationship to Patient: _____ Policy #: _____ Group #: _____

Secondary Insurance: _____ Subscriber's Name: _____

Sex of Subscriber: M F Birth date of Subscriber: _____ Social Security #: _____

Relationship to Patient: _____ Policy #: _____ Group #: _____

Emergency Contact: Name: _____ Phone #: _____

Please tell us how you heard about our practice (circle one or more): Yellow Pages Newspaper Website Internet Family/Friend

Other: _____

Who can we thank for referring you to our practice? _____

PLEASE READ. ALL CHARGES ARE DUE AT THE TIME OF SERVICE. ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS MAY BE COMPLETED TO HELP EXPEDITE INSURANCE REIMBURSEMENT; HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE AS APPLICABLE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH THE PHYSICIAN.

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I request that payment of authorized insurance company benefits be made either to me or on my behalf to John C. Pittman, M.D. for any services furnished to me by that party who accepts assignment. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier of any other insurance company any information needed for this or related insurance company claim. I understand that my signature requests that payment be made and authorizes release for medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In insurance company assigned cases, the physician or supplier agrees to accept the charge determination of the insurance company as the full charges as determined by the insurance contract, and the patient is responsible only for the deductible, coinsurance and non-covered services as applicable. Coinsurance and the deductible are based upon the charge determination of the insurance company.

Patient/Guardian Signature: _____

Date: _____

John C. Pittman, M.D.
4505 Fair Meadow Lane, Suite 111
Raleigh, NC 27607
(919) 571-4391 Fax: (919) 571-8968

REQUEST FOR MEDICAL RECORDS

Authorization to Use/Release/Disclose Medical Information

Please give this form to your primary care doctor or any other physicians you have seen within the last several years so they are able to send copies of your medical records to us.

DO NOT RETURN THIS FORM TO THE CAROLINA CENTER

THIS IS FOR YOU TO TAKE TO YOUR REGULAR DOCTOR TO GET RECORDS SENT TO US

Patient Name (please print) _____

Date of Birth _____ / _____ / _____ Social Security Number _____

Street Address _____

City _____ State _____ Zip _____

Home Telephone _____ Work Telephone _____ Ext. _____

I request that copies of my complete medical records for the last three years be sent to the Carolina Center for Integrative Medicine, P.A. at the above address

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

DO NOT RETURN THIS FORM TO THE CAROLINA CENTER – TAKE THIS TO YOUR REGULAR DOCTOR.

Signature of Patient or Guardian

Date

Autism Spectrum Disorder - New Patient Medical History Form

Child's Name: _____ DOB _____

Mother's Name: _____ Father's Name: _____

Address: _____

Home Phone: _____ Other Phone: _____

E-mail Address: _____

Child's Social Security Number: _____

Primary Care Physician: (PCP) _____

Location of PCP: _____ PCP Phone Number: _____

Health Insurance Carrier: _____

Current Weight: _____ Height: _____

Referred by: _____

Siblings: Please indicate whether Male or Female

Name: _____ DOB _____

Name: _____ DOB _____

Name: _____ DOB _____

Diagnosis given about your child: _____

Date diagnosis given: _____

Other problems to be addressed: _____

Allergies

	Side Effects
Medications: _____	_____
_____	_____
_____	_____
Chemicals: _____	_____
_____	_____
_____	_____
Foods: _____	_____
_____	_____
_____	_____

Current Medications

Please list your child's current medications, supplements, and allergies.

Current Medications:

Medication	Frequency	Dosage	Taken Since

Current Vitamins and Nutritional Supplements

Medication	Frequency	Dosage	Taken Since

Describe your child to us, including his/her history. Please be as detailed as possible.

When did you first notice your child's problem?

What did you first notice?

Was the onset of your child's problem sudden or gradual?

Was there any event or illness that you or others think brought on your child's symptoms?

Please make note of any other action that you think may have some bearing to your child's condition

Health Care Providers

Primary Care Doctors

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Therapists

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Other Care Givers

Please specify field of expertise

Name _____ Phone _____

City _____ Date of Evaluation _____

Name _____ Phone _____

City _____ Date of Evaluation _____

Name _____ Phone _____

City _____ Date of Evaluation _____

Name _____ Phone _____

City _____ Date of Evaluation _____

Name _____ Phone _____

City _____ Date of Evaluation _____

Name _____ Phone _____

City _____ Date of Evaluation _____

Prenatal History

Maternal Age at Delivery: _____

Medication during pregnancy: _____

Illness during pregnancy: _____

Other complications during pregnancy: _____

Complications during labor and delivery: _____

Mode of delivery: C-Section Vaginal If C-section, explain why: _____

If vaginal delivery, did you have forceps/vacuum? _____

Medications during labor and delivery? _____

Circle One: Full Term Premature How many weeks? _____

Complications after delivery? _____

Medications given to child during hospital stay? _____

Dietary/Nutritional History

Breast-Fed? Yes/No (circle one) If yes, how long? _____

Bottle Fed? Brand of formula? _____

Began at what age? _____ For how long? _____

Foods? Began at what age? _____ First Foods? _____

Whole milk? Circle one: Yes No If yes, at what age? _____

Known allergies to foods? (Please List) _____

Suspected allergies to foods? (Please List) _____

Food Cravings: (Please List) _____

Check the most appropriate description below of your child's diet:

<input type="checkbox"/>	Mostly baby foods
<input type="checkbox"/>	Mostly carbohydrates (bread, pasta, etc.)
<input type="checkbox"/>	Mostly dairy (milk, cheese)
<input type="checkbox"/>	Mostly meat
<input type="checkbox"/>	Mostly vegetarian (vegetables, fruits, grains, etc.)
<input type="checkbox"/>	Other. Describe: _____

Describe your child's food stool pattern (Daily, foul, large, mushy, etc.) _____

Please place a check mark in the appropriate column of foods your child eats.

Food	Daily	3-5x/week	1-3x/week	Never	Used to, but no longer does
Cookies					
Candy					
Sweet foods					
Caffeine					
Chocolate					
Milk: Whole					
2%					
1%					
Skim					
Cheese					
Ice cream					
Salty Foods					
Meat					
Pasta					
Bread: White					
Wheat					
Other					

Please list all of the foods and beverages normally consumed by your child for three typical days:

Day 1	
Breakfast	
Morning Snack	
Lunch	
Afternoon Snack	
Dinner	

Day 2	
Breakfast	
Morning Snack	
Lunch	
Afternoon Snack	
Dinner	

Day 3	
Breakfast	
Morning Snack	
Lunch	
Afternoon Snack	
Dinner	

Family History

Has any relative had one or more of the following? (Please check all that apply)

MGM=Maternal Grandmother, PGM=Paternal Grandfather

PGM=Paternal Grandmother, PGF=Paternal Grandfather

Cancer and Type	<input type="checkbox"/> PGF <input type="checkbox"/> Sister	<input type="checkbox"/> PGM <input type="checkbox"/> Brother	<input type="checkbox"/> MGM <input type="checkbox"/> Aunt	<input type="checkbox"/> MGF <input type="checkbox"/> Uncle	<input type="checkbox"/> Mother <input type="checkbox"/> Father
Diabetes	<input type="checkbox"/> PGF <input type="checkbox"/> Sister	<input type="checkbox"/> PGM <input type="checkbox"/> Brother	<input type="checkbox"/> MGM <input type="checkbox"/> Aunt	<input type="checkbox"/> MGF <input type="checkbox"/> Uncle	<input type="checkbox"/> Mother <input type="checkbox"/> Father
Heart Disease	<input type="checkbox"/> PGF <input type="checkbox"/> Sister	<input type="checkbox"/> PGM <input type="checkbox"/> Brother	<input type="checkbox"/> MGM <input type="checkbox"/> Aunt	<input type="checkbox"/> MGF <input type="checkbox"/> Uncle	<input type="checkbox"/> Mother <input type="checkbox"/> Father
High Blood Pressure	<input type="checkbox"/> PGF <input type="checkbox"/> Sister	<input type="checkbox"/> PGM <input type="checkbox"/> Brother	<input type="checkbox"/> MGM <input type="checkbox"/> Aunt	<input type="checkbox"/> MGF <input type="checkbox"/> Uncle	<input type="checkbox"/> Mother <input type="checkbox"/> Father
Stroke	<input type="checkbox"/> PGF <input type="checkbox"/> Sister	<input type="checkbox"/> PGM <input type="checkbox"/> Brother	<input type="checkbox"/> MGM <input type="checkbox"/> Aunt	<input type="checkbox"/> MGF <input type="checkbox"/> Uncle	<input type="checkbox"/> Mother <input type="checkbox"/> Father
High Cholesterol	<input type="checkbox"/> PGF <input type="checkbox"/> Sister	<input type="checkbox"/> PGM <input type="checkbox"/> Brother	<input type="checkbox"/> MGM <input type="checkbox"/> Aunt	<input type="checkbox"/> MGF <input type="checkbox"/> Uncle	<input type="checkbox"/> Mother <input type="checkbox"/> Father
Bowel/Colon Disorders	<input type="checkbox"/> PGF <input type="checkbox"/> Sister	<input type="checkbox"/> PGM <input type="checkbox"/> Brother	<input type="checkbox"/> MGM <input type="checkbox"/> Aunt	<input type="checkbox"/> MGF <input type="checkbox"/> Uncle	<input type="checkbox"/> Mother <input type="checkbox"/> Father
Alcoholism	<input type="checkbox"/> PGF <input type="checkbox"/> Sister	<input type="checkbox"/> PGM <input type="checkbox"/> Brother	<input type="checkbox"/> MGM <input type="checkbox"/> Aunt	<input type="checkbox"/> MGF <input type="checkbox"/> Uncle	<input type="checkbox"/> Mother <input type="checkbox"/> Father
Lung Disease	<input type="checkbox"/> PGF <input type="checkbox"/> Sister	<input type="checkbox"/> PGM <input type="checkbox"/> Brother	<input type="checkbox"/> MGM <input type="checkbox"/> Aunt	<input type="checkbox"/> MGF <input type="checkbox"/> Uncle	<input type="checkbox"/> Mother <input type="checkbox"/> Father
Glaucoma	<input type="checkbox"/> PGF <input type="checkbox"/> Sister	<input type="checkbox"/> PGM <input type="checkbox"/> Brother	<input type="checkbox"/> MGM <input type="checkbox"/> Aunt	<input type="checkbox"/> MGF <input type="checkbox"/> Uncle	<input type="checkbox"/> Mother <input type="checkbox"/> Father

Relationship	Present Age or age at death	State of Health	Major Illnesses or Cause of Death
Paternal Grandfather	<input type="checkbox"/> Ex	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Paternal Grandmother	<input type="checkbox"/> Ex	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Maternal Grandfather	<input type="checkbox"/> Ex	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Maternal Grandmother	<input type="checkbox"/> Ex	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Father	<input type="checkbox"/> Ex	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Mother	<input type="checkbox"/> Ex	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Brothers	<input type="checkbox"/> Ex	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
	<input type="checkbox"/> Ex	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Sisters	<input type="checkbox"/> Ex	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
	<input type="checkbox"/> Ex	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
	<input type="checkbox"/> Ex	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	

Social History

Who lives in the home with your child: _____

Are any children in your family adopted? _____

Pets in the house? How many? What kind? _____

Caregivers besides parents: _____

List the people most important in your child's life: _____

Recent changes, losses, births, deaths, divorce, remarriage or moves? _____

Recent Travel: _____

Child's response to these changes: _____

Is your child involved in any sports, music, or other activities? Please describe: _____

How does your child interact with other children? _____

With adults: _____

What makes your child happy? _____

Sad? _____

Angry? _____

Stressed? _____

How do you as a parent deal with these emotions in your child? _____

Environmental History

Do you, your child, or any family members practice any relaxation/stress management techniques?

Circle the appropriate answers to the following questions:

Location of home: City Suburban Wooded area Farm

Water: City Well Purification system? Y/N

Type of Heat: Electric Gas Oil Other: _____

Do you live near: Power lines Woods Industrial area Water

Do you live near water: Swamp River Ocean Other: _____

Does your home have a lot of: Dust Mold Down or feather items

Describe your child's bedroom:

Bedding: Synthetic Down Feather

Flooring: Carpet Wood Synthetic Glued down?

Mattress Cover: Yes No

Bed: Adult bed Crib Junior bed

Window Treatment: Shades Blinds Valance Curtains

Other items in room including furniture, toys, stuffed animals: _____

Describe the flooring in other rooms of the house:

Child's Bathroom: _____

Living Room: _____

Family/Play room: _____

Is your child sensitive to or bothered by any of the following?

- | | | | |
|----------------------------------|----------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Perfume | <input type="checkbox"/> Paint | <input type="checkbox"/> Animals | <input type="checkbox"/> Cleaning Products |
| <input type="checkbox"/> Soaps | <input type="checkbox"/> Mold | <input type="checkbox"/> Grass | <input type="checkbox"/> Gasoline |
| <input type="checkbox"/> Dust | <input type="checkbox"/> Pollens | <input type="checkbox"/> Detergents | |

Developmental History

Please list the age when the following skills were mastered and any problems associated with these skills.

First Words: (Age: _____)
Phrases or sentences: (Age: _____)
Pulling to Stand: (Age: _____)
Walking: (Age: _____)
Sitting Up: (Age: _____)
Crawling: (Age: _____)
Running: (Age: _____)
Walking up/down steps without help: (Age: _____)
Jumping: (Age: _____)
Learned to pedal: (Age: _____)
Rode 2-wheel bicycle: (Age: _____)
Put on clothing: (Age: _____)

Medical History

Please mark which tests have been done and provide date and results.

Evaluation/Test	Date	Results
24 Hour Amino Acids		
Amino Acid Screen		
Blood Chemistry Screen		
Blood Count (CBC)		
Blood Test-Fatty Acid		
Blood Test-Food Allergies		
CT Scan		
Colonoscopy		
DMSA Loading Study		
EEG		
Folic Acid		
Fragile X Chromosome Study		
Hair Elements		
Hearing Test		
Immune Profile		
MRI		
Organic Acids-fungal/bacteria		
Organic Acids-Metabolism		
PET Scan		

Medical History

Please mark which tests have been done and provide date and results.

Evaluation/Test	Date	Results
Pinworm Prep		
Plasma Amino Acids		
Plasma or Serum Zinc		
RBC Elements		
Serum Ferritin (Iron stores)		
Serum Methylmalonic Acid		
Serum Vitamin A		
Small Bowel Biopsy		
Stool Culture		
Stool Parasites		
Thyroid Profile		
Uric Acid (blood or urine)		
Urinary Peptides		
Urine Elements		
Urine Kryptopyrrole		
X-Rays (specify)		
Other:		

Immunizations

Please indicate date and any reactions for those immunizations that your child has received.

If exact date isn't know, please approximate.

"Bowel" refers to any bowel symptom such as diarrhea.

"Swelling" refers to the site of the injection.

Immunization	Date	Bowel	Swelling	Crying	Seizure	Irritable	Fever
Diphtheria/Pertussis/ Tetanus							
DPT 1							
DPT 2							
DPT 3							
DPT 4							
DPT 5							
Immunization	Date	Bowel	Swelling	Crying	Seizure	Irritable	Fever
Adult Dip/Tet							
Pediatric Dip/Tet							
H Influenza Type B							
HIB 1							
HIB 2							
HIB 3							
HIB 4							
Polio Oral/Inject (Please circle)							
OPV 1 Inject 1							
OPV 2 Inject 2							
OPV 3 Inject 3							
OPV 4 Inject 4							
OPV 5 Inject 5							
Measles/Mumps Rubella							
MMR 1							
MMR2							
Hepatitis B							
HBV 1							
HBV 2							
HBV 3							
Prevnar (Pneumococcal)							
Miscellaneous							
Varivax (Chicken Pox)							
Tine Test							
Flu Vaccine							
Other							

Therapies and Diets

Now	Past	Therapies	Results
		Acupuncture	
		Auditory Training	
		Craniosacral	
		Energy Therapy	
		Naturopathy	
		Neural Therapy	
		Occupational Therapy	
		Osteopathy	
		Physical Therapy	
		Sensory Diet	
		Speech Therapy	
		Other	

Now	Past	Diets	Results
		Gluten Free	
		Casein Free	
		Yeast Free	
		High Protein/Low Carb	
		Salicylate Free	
		Low Phenolics	
		IgG reactive food avoidance	
		Specific Carb Diet	
		Other	

Signs and Symptoms

*Please check any signs/symptoms your child may demonstrate
and note duration and details if applicable.*

Description	Mild	Moderate	Severe	Duration	Details
Stimming (repetitive actions or movements)					
Rocking					
Head banging					
Self-mutilation					
Nail Biting					
Hand/arm biting					
Nail/skin picking					
Aggressiveness (Hitting, kicking, biting others)					
Mood swings					
Irritability/tantrums					
Fears/anxieties					
Hyperactivity					
Inability to concentrate					
Always fidgety in his/her seat					
Impulsive					
Breath holding					
Dizziness					
Seizures					
Poor Coordination					
Problems with buttons, ties, snaps or zippers					
Processing problems Visual, motor, etc.					
Problems with social interactions					
Sensitive to crowds					
Trouble remembering					
Low self-esteem					
Fatigue					
Cold hands/feet					
Cold intolerance					
Heat intolerance					
Recurrent/chronic fever					
Flushing					
Difficulty falling to sleep					
Night waking					
Nightmares					
Difficulty waking					
Bed Wetting/soiling					
Day time wetting/soiling					
Numbness/Tingling in hands/feet					
Headache					
Blinking					
Tics					

Description	Mild	Moderate	Severe	Duration	Details
Eye Discharge					
Dark circles/Puffiness under eyes					
Night-blindness in child/family					
Congestion					
Dripping nose					
Sensitive to sounds/noise					
Bad breath					
Nose bleeds					
Acute sense of smell					
Sore throats					
Hoarseness					
Cough					
Wheezing					
Geographic Tongue					
Swollen gums					
Canker Sores					
Dry lips/mouth					
Diarrhea					
Constipation					
Bloating					
Passing Gas					
Belching					
Stomach Ache					
Refusal to eat					
Sensitive to texture of food					
Difficulty swallowing					
Food craving					
Grinding teeth					
Mucous/blood in stool					
Anal itching					
Calf cramps					
Other muscle cramps/spasms					
Tremors					
Weakness					
Stiffness					
Eczema					
Psoriasis					
Hives					
Acne					
Seborrhea					
Other rashes					
Easy bruising					
Itchy scalp					
Dry skin					
Oily skin					
Pale skin					
Sensitivity to insect bites					
Sensitive to texture of clothes					
Cracking/peeling hands					

Description	Mild	Moderate	Severe	Duration	Details
Cracking/peeling feet					
Strong body odor					
Strong urine odor					
Strong stool odor					
Soft nails					
Thickening of nails					
Ridges/pitting of nails					
White spots/lines on nails					
Brittle nails					
Any OCD behaviors					
Reflux					
Persistent Colic					
Toe walking					

Signs and Symptoms

Please describe any other symptoms you would like us to know about your child:

List any other history, pertinent thoughts or questions that you want to address:

I certify that the above information is true and correct to the best of my knowledge. It is my responsibility to inform my health care provider if there are any changes in the information contained in this form.

Parent/Guardian Signature: _____ Date: _____

Health Care Provider Signature: _____ Date: _____