TO: The parent(s)/Guardian of (patient's name):

In preparation for the consultation with Dr. Liss, we would appreciate your taking a few minutes (about 20) to complete these information forms. This will help us be more efficient at the visit and provide better care.

Today's date: _____

Parent/Guardian Information		**Other Parent/Guardian Information**	
Name:		Name:	
Relation to Patient:		Relation to Patient:	
Address:		Address:	
City:	Zip:	City:	Zip:
Phone:	Cell:	Phone:	Cell:
Email:		Email:	
Occupation/Employer:		Occupation/Employer:	

What is your **primary concern** about your child's health?

What do you think is **causing** the problems?

Have you sought information about your child's condition in books, magazines, or the Internet?

☐ No ☐ Yes: If Yes, feel free to bring any written materials to the visit.

Please bring all medications, herbs, vitamins, supplements you've given this child in the past month to the visit.. What has been most useful?

Please check any symptoms/concerns you have about your child at this time:

☐ Abdominal pain	☐ Fatigue	☐ Mood, anxiety
☐ Allergies	☐ Frequent infections	☐ Nutrition
☐ Attention	☐ Headaches	☐ Rashes
☐ Back Pain	☐ Joint pain	☐ Seizures
☐ Behavioral/emotional difficulties	☐ Medication side effects; what medication(s):	☐ Sleep problems
☐ Constipation or diarrhea		☐ Other:

How long has the most bothersome of these problems been going on?

What have you noticed makes these problems *better or worse*?

CHILD'S MOST CONCERNING DIAGNOSES OR SYMPTOMS:

1)	2)

How would you describe this patient's *overall health*? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

For your child's 2 most concerning symptoms, please rate how severe they have been the LAST WEEK in YOUR opinion.

Symptom 1: ☐ 0 (As good as it could be) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (As bad as it could be)

Symptom 2: ☐ 0 (As good as it could be) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (As bad as it could be)

If your child (the patient) experiences *pain* frequently, how severe has it been the past week?

☐ 0 (None) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Severe)

If your child (the patient) has *pain* NOW, how *severe* is it?

☐ 0 (None) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Severe)

We are very interested in helping you achieve your HEALTH GOALS for this patient – body, mind, spirit and relationships (holistic care). Please choose **up to three health goals** you have **TODAY** for the patient.

Physical	Mental-Emotional	Spiritual	Social
☐ Less pain; more comfortable and sense of ease	☐ Better concentration	☐ Kinder	☐ Better listener
☐ Better sleep, more rested	☐ Calmer	☐ More accepting	☐ Better relationships in family or with friends
☐ Better weight	☐ More cheerful or joyful	☐ Move loving	☐ Less isolated
☐ Lower risk of cancer, heart disease or diabetes	☐ More alert	☐ More compassionate	☐ More empathetic
☐ Breathe easier, less coughing or wheezing	☐ Less irritable	☐ More hopeful	☐ More loyal
☐ More energy or vitality	☐ Less worried or anxious	☐ More connected to nature, spirit or something greater than self	☐ More responsible to others
☐ Less nausea, stomach problems	☐ More confident	☐ More ethical	☐ More truthful
☐ Better coordination or balance	☐ More flexible or adaptable	☐ Greater sense of meaning or purpose	☐ Better citizen
☐ Fewer infections, better immunity	☐ More patience	☐ More generous	☐ Better team player
☐ Fewer allergies	☐ More dedicated	☐ More artistic or musical	☐ More generous
	☐ More self-discipline	☐ More present	
	☐ Less impulsive		

Which of these goals is MOST IMPORTANT to you today?

Patient's past medical history:

Any problems with the pregnancy? ☐ No ☐ Yes:

Birth: Term: _____ Premature: ☐ No ☐ Yes: _____ Weight: _____ Breast fed? ☐ No ☐ Yes

Delivery: ☐ Caesarean ☐ Vaginal Apgar Scores: _____ 1 min _____ 5 min

Delivery problems? ☐ No ☐ Yes; please describe:

Immunizations? ☐ No ☐ Yes Up to date? ☐ No ☐ Yes If No; may we catch up today: ☐ No ☐ Yes

Specialty clinic evaluations (list dates, type of clinic, diagnosis/reason):

Does your child take any medications, herbs, vitamins or supplements? ☐ No ☐ Yes (If yes, please complete)

Name of medication, vitamin, mineral, herb or other (fish oil, melatonin), other	What was it used for?	Brand, dosage and how often?	Benefits and side effects?

(Please bring all medications, herbs, teas, dietary supplements, etc. to the appointment with you.)

Does your child have **allergies**? ☐ **No** ☐ **Yes (If yes, please complete)**

Name of product/medicine/food/other	Age at reaction	Type of reaction

Development	
At what age did your child:	
Sit alone?	Talk in sentences?
Walk alone?	Toilet trained?
School Information:	
Name of School:	Grades on last report card?
What grade is child in?	How many school days has your child missed this year? days

System Review – In the past 6 months:			
General	Chills or feeling cold?	☐ Yes	☐ No
	Fatigue?	☐ Yes	☐ No
	Fevers, night sweats?	☐ Yes	☐ No
	Trouble sleeping?	☐ Yes	☐ No
	Pain?	☐ Yes	☐ No
Eye trouble	Recent earaches or ear infections?	☐ Yes	☐ No
	Burning, stinging, pain, discharge?	☐ Yes	☐ No
Ears, nose, throat	Earaches or ear infections?	☐ Yes	☐ No
	Frequent colds or sinus infections?	☐ Yes	☐ No
	Frequent nosebleeds?	☐ Yes	☐ No
	Frequent sore throats?	☐ Yes	☐ No
	Dental problems?	☐ Yes	☐ No
Heart	Have you been told your child has a heart murmur?	☐ Yes	☐ No
	Had heart trouble or chest pain?	☐ Yes	☐ No
	Had high blood pressure?	☐ Yes	☐ No
	Dizziness or passing out?	☐ Yes	☐ No
	Racing or irregular pulse?	☐ Yes	☐ No
	Intolerance for exercise (easy fatigue)?	☐ Yes	☐ No
Lungs	Wheezing or asthma?	☐ Yes	☐ No
	Cough with laughing or exercise?	☐ Yes	☐ No
Gastro-intestinal Tract	Has your child had nausea or vomiting recently?	☐ Yes	☐ No
	Abdominal pain?	☐ Yes	☐ No
	Been constipated?	☐ Yes	☐ No
	Had diarrhea (loose stools) recently?	☐ Yes	☐ No
Genitourinary Tract	Does your child wet the bed?	☐ Yes	☐ No
	Had a kidney infection?	☐ Yes	☐ No

System Review – In the past 6 months: (Continued)			
Musculoskeletal	Had muscle weakness or soreness?	☐ Yes	☐ No
	Swelling or pain in the joints?	☐ Yes	☐ No
	Back pain?	☐ Yes	☐ No
Rashes or Skin problems	On the skin or scalp?	☐ Yes	☐ No
	Mouth sores?	☐ Yes	☐ No
	Acne?	☐ Yes	☐ No
	Eczema?	☐ Yes	☐ No
Neurologic	Had convulsions, epilepsy or seizures?	☐ Yes	☐ No
	Been unconscious? Passing out?	☐ Yes	☐ No
	Headaches?	☐ Yes	☐ No
	Numbness or tingling in fingers or toes?	☐ Yes	☐ No
	Tics?	☐ Yes	☐ No
Endocrine	Recent weight gain or loss? (circle one)	☐ Yes	☐ No
	Frequent urination or thirst?	☐ Yes	☐ No
	Low blood sugar?	☐ Yes	☐ No

	Early or late sexual development?	☐ Yes ☐ No
	Intolerance of heat or cold (circle one)	☐ Yes ☐ No
Psychologic	Depression, bi-polar, or suicidal thoughts?	☐ Yes ☐ No
	Anxiety or unusual fearfulness?	☐ Yes ☐ No
	ADD/ADHD?	☐ Yes ☐ No
	Alcohol/substance abuse?	☐ Yes ☐ No
	Obsessive or Compulsive behaviors?	☐ Yes ☐ No
	Anger/rage/violence?	☐ Yes ☐ No
Blood	Anemia (low blood)?	☐ Yes ☐ No
	Easy bleeding or bruising?	☐ Yes ☐ No
Allergic/immune	Allergies?	☐ Yes ☐ No
	Recurrent infections?	☐ Yes ☐ No
	Arthritis?	☐ Yes ☐ No

Diet
Usual breakfast:
Usual lunch:
Usual dinner:
Usual snack foods:
Does your child eat a special diet or avoid certain foods? ☐ No ☐ Yes
Favorite foods?
How many servings of fruit per day (1/2 cup fresh; ¼ cup dried):
How many servings of vegetables per day:
Do you usually eat white or whole grain bread? ☐ white ☐ whole grain
How many servings of fish per week?
What kind of cooking oil do you use at home? ☐ corn ☐ soy ☐ canola ☐ olive
Does your child eat *breakfast* at: ☐ school ☐ home ☐ baby-sitter/daycare
Does your child eat *lunch* at: ☐ school ☐ home ☐ baby-sitter/daycare
Diet (Continued)
How many cans/bottles of soda or juice daily?
How many ounces of water daily?
How many evening meals a week does your family eat together?
How many times a week do you eat fast food (like Wendy's or McDonald's)?
Are you interested in advice about optimal nutrition? ☐ No ☐ Yes

Activity
Does your child have PE or an activity period at school? How often? day(s) per week
Does your child participate in organized sports/dance/teams? ☐ No ☐ Yes:
Unstructured play (walking, shooting hoops, riding bikes, swimming, swinging, etc.)? ☐ No ☐ Yes
What is your child's favorite physical activity?
How many days a week does your child play or do chores outside?
What does your child do after school on weekdays?
What does activities does your family do together for fun?
Are you interested in advice about optimal activity levels to promote health? ☐ No ☐ Yes

Stress

Has your child and/or family experienced any recent stressful events? (i.e. arguments with family/friend, peer problems, death, divorce, illness, financial problems) ☐ No ☐ Yes, please explain:

Everyone has some stress in their lives. How much stress does this **patient** have?

☐ 0 (No stress) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Extreme)

Relaxation and Stress Management. What does your child do to relax or manage stress? (check all that apply)

☐ take time out	☐ watch TV	☐ listen to music
☐ spend time in nature	☐ take a bath or shower	☐ eat
☐ hit things	☐ talk with family member	☐ talk on phone
☐ go to bed	☐ exercise	☐ meditate
☐ yoga	☐ deep breathing	☐ biofeedback
☐ calming self-talk	☐ pray	☐ punch a pillow

☐ Other:

Favorite music?

Are you interested in exploring new ways to relax or manage stress? __ No __ Yes

Sleep

What is your child's usual bedtime? Wake up time?

Does your child nap? ☐ No ☐ Yes; how long and how often?

Does your child have difficulty falling asleep or waking during the night? ☐ No ☐ Yes

If Yes, what strategies have you tried to improve sleep? How well do they work?

Are you interested in any tips on improving sleep? ☐ No ☐ Yes

Environment

Are you concerned about toxic chemicals, loud sounds or noise, excessive light or darkness, mold or obnoxious odors in your child's food or environment? ☐ No ☐ Yes

If Yes, please describe:

Family Life

Does your child also live at another home? ☐ No ☐ Yes, with whom:

How many times have you moved in the last year? ☐ 0 ☐ 1 ☐ 2 ☐ 3 times

Does anyone in your household or the child's daycare smoke? ☐ No ☐ Yes; Packs/day

How many hours a day does your child watch TV? hours

How many hours a day does your child play or work on a computer or play video games? hours

How often does your child use a seatbelt (carseat)? ☐ Never ☐ Sometimes ☐ Always

How often does your child use a bike helmet? ☐ Never ☐ Sometimes ☐ Always

How many guns do you have in your home? guns. Are they locked? ☐ No ☐ Yes

In the past year, has your child ever felt threatened or unsafe in your home? ☐ No ☐ Yes

In the past year, has your partner or other family member pushed you, hit you, or threatened you with something? ☐ No ☐ Yes

Does the patient drink alcohol? ☐ No ☐ Yes

Has anyone in the household tried to cut down on alcohol in the past year? ☐ No ☐ Yes

Does anyone in the household ever have more than 5 drinks at one time? ☐ No ☐ Yes

Has anyone in the household ever had a drug problem? ☐ No ☐ Yes

Has anyone in the household tried to cut down on drugs in the past year? ☐ Not Applicable ☐ No ☐ Yes

Does your family attend church, temple, mosque or other regular religious meeting? ☐ No ☐ Yes, which?
Do you observe a daily religious practice? ☐ No ☐ Yes, what?
How strong are your family's religious beliefs? ☐ Strong ☐ Moderate ☐ A little ☐ Not at all

Describe your current discipline strategies and how effective you think they are. For example, spanking, time out, losing privileges.
How effective are the discipline strategies? ☐ Very effective ☐ Somewhat effective ☐ Not very effective

Good Things
What are you most proud of about your child?
What three things has your child said or done this week that are kind, helpful or loving? 1) 2) 3)
What about your child gives you the most joy and pleasure?
What is your greatest hope for your child?
What are the resources that are most helpful for your child in achieving these hopes?
What else do you think is important for us to take the best care of your child?
What is the **main thing** you would like to accomplish at today's visit?

Any other comments?