PEDIATRIC NEW PATIENT QUESTIONNAIRE

Dear Client/Patient,

Our ability to draw effective conclusions about your child's present state of health and how to improve it depends to a significant extent on your ability to respond thoughtfully and accurately to this written questionnaire. The doctor is the only person who will review this form and your confidentiality will be strictly maintained. Your careful consideration of each of the following questions will enhance the doctor's efficiency and will provide for more effective use of your scheduled consultation time. If you come across questions you don't know the answers to, simply leave these blank and proceed from there. Thank you for your time in advance and we look forward to working together to help your child.

Joseph Debé, D.C., D.A.C.B.N., C.D.N.
Board Certified Nutritionist
265 Sunrise Highway, Suite 51
Rockville Centre, NY 11570
(516) 829-1515
www.drdebe.com

New Patient Questionnaire

Name: Date of Birth: (mm) (dd) (yy)
Age: Height: Weight:
Address:
City: State: Zip Code:
Home Phone: ( ) Parent's Cell phone: ( )
Parent's Bus. Phone: ( ) Parent's E-mail:

How did you hear about our clinic?

1. Please state your primary reason for attending our clinic. If this involves a specific health condition, please describe it in detail. List the very first time you noticed the condition and describe carefully any factors that you suspect may have played a role in its onset and perpetuation. Please list every detail and give the Doctor the opportunity to distinguish what may or may not be relevant to your case. (Please use the back of this sheet or attach another sheet if more space is required).

2. How long has your child had his/her current condition? What changed in your child's life prior to the onset of the current complaint (e.g. diet, activity level, toxin exposure, injury, illness, medication, travel, relationships, sleep, stress levels, etc.)?

3. Is your child happy? If not, please explain.

4. Is your child's health currently getting better, worse or staying the same?

5. What are the most significant measures that you have taken to date to improve your child's state of health?

6. Please list the 5 most significant, stressful events in your child's life, from the most recent to the most distant. Are any of these situations continuing to impact his/her life? If so, please indicate these clearly.

7. Is your child currently working with a professional counselor, psychologist, social worker, or therapist? (Y/N)_____
   Has he/she in the past? (Y/N)_____
   Does your child have a medical doctor? (Y/N)_____
   Medical Doctor's Name:_____

8. Have you consulted a medical doctor regarding the aforementioned condition(s)? Please explain his/her diagnosis, therapy and the result.

9. Have you consulted any other health practitioners regarding the aforementioned condition(s)? Briefly describe, listing practitioner's name, specialty, treatment suggested or rendered, and the results.

10. Does your child attend any other healthcare professionals on a regular basis? (e.g. Chiropractor, Naturopath, Osteopath, Dentist, Acupuncturist, Optometrist, Massage Therapist, etc.

11. Please list all of your child's secondary health concerns/conditions that you are aware of whether you feel they are related to your primary reason for attending our clinic or not.

12. Please list any and all drugs (prescription or otherwise) which your child is presently using or has used in the past and why. Indicate which are current.

13. Does your child supplement his/her diet with vitamins, minerals, herbs or related substances? (Y/N)_____ Please list the brand name, content and potencies of all products used. Indicate who prescribed these for you and how he/she determined your specific needs and dosages.

Family Health History:

14. Please indicate whether there is any history of the following conditions in your family (please circle) and give the details below:
    Heart Disease, Stroke, Cancer, Osteoarthritis, Type 2 Diabetes, Osteoporosis, Alzheimer's Disease, Parkinson's Disease, Celiac disease, Crohn's Disease, Ulcerative Colitis, Thyroid disease, Rheumatoid Arthritis, Multiple Sclerosis, Systemic Lupus Erythematosus, Autoimmune Disorders, Asthma, Allergies, Psoriasis, Eczema, Mental Illness, Alcoholism, Drug Abuse or any other conditions which may be pertinent to your present state of health (please attach sheet if space is required):

15. Are you interested in preventing any particular disease or condition?

16. Was the patient's mother in excellent health throughout her pregnancy while carrying the child?

17. What was the child's birth weight?_____Was the birth premature (Y/N)_____ If so, how early?

18. Was the patient delivered by C-section? (Y/N)_____

19. Was the patient separated from his/her mother during the first six months after birth? (Y/N)_____ For approximately how long and why?

20. Was the patient breast-fed? (Y/N)_____

21. Was your child fed anything other than breast milk during the first six months of life? (Y/N)_____ If so, which foods?

22. Did your child require any medical attention, hospitalization, or medication as an infant (before age 2) (Y/N)_____ As a child (age 2 to 10)? (Y/N)_____ Please explain any "Yes" answers in detail.

23. How are the relationships between the patient and parents?

24. Has the child had any surgery? (Y/N)__Please list all surgeries, their approximate dates, and if you feel they were successful.

25. Has your child had any illness other than the ordinary self-limiting childhood diseases of the measles, mumps and chickenpox? (Y/N)____ Please explain.

26. Has your child ever been diagnosed as having ADD, ADHD, Autism, Diabetes, or any other condition? (Y/N)__ Please explain.

27. Has the patient had any bad sprains or broken bones due to accidents or sports? (Y/N)_____ Please provide the details.

28. Has the patient ever had X-rays, C.T. scans, or M.R.I.s done? (Y/N)_____ When? Were any abnormalities found?

29. Has the patient had any re-occurring infections or inflammations? i.e. periodontal disease, Gingivitis, Tonsillitis, Vaginitis, Colitis, Sinusitis, Yeast overgrowth, Bladder or Ear infections, etc.? (Y/N)_____ Please explain fully.

32. Does the child have silver (mercury amalgam) fillings in his/her teeth? (Y/N)____

33. What do you feel is your child's weakest organ system is, and why? (i.e. lungs, colon, etc.)

34. How many times each year does your child have a Cold, Sinusitis, the Flu, Sore throat or bronchitis? How long do they usually last and are they severe?

35. Do you give your child any medication for the above? (Y/N)_____ If so, what kind?

36. About how many courses of antibiotics has your child had in total?

37. Has your child ever fainted, blacked out or had a convulsion? (Y/N)_____ Please describe.

38. Are you aware of your child having any allergies to foods, drugs or inhalants? (Y/N) ___ How does he/she react? Please list and describe in detail.

39. How much detail would you like in regard to personalized health education? (Please circle or underline one response)

    A. Just tell me what I need to do for my child.

    B. Give me a summary of what's going on with my child.

    C. I would like a lot of information.

Nutritional Informed Consent

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: *"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."*

A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biochemical processes of the human body.

I have read and understand the above:

Signature _____ Date _____

Note:

This questionnaire is strictly confidential between you and the Doctor and your accurate responses are vital to effective health care at this office. Please go back over your responses and consider their accuracy. *Thank you!*