**Heartstone Pure Health Consulting**

**Louise Bakley, DMH DHHP**

**Heilkunst New Patient Questionnaire**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mother’s Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Father’s name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Place of Birth**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:**

**Phone number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Briefly explain reason for bringing your child and how you would like me to help you

**Dietary Habits:**

Does your child follow any particular diet? (e.g. SCD, Gluten Free, GAPS, Paleo)

Does your child have any known food allergies or sensitivities?

How would you describe your child’s appetite?

What percentage of your meals are home-cooked?

 Please share what a typical daily diet would consist of :

**Breakfast**:

Does your child eat breakfast every day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lunch**:

**Dinner**:

**Snacks:**

Are there any foods that your child avoids because of the way they make them feel?

If yes, please explain the food, and the symptom(s)

 Does your child experience symptoms immediately after eating like bloating, gas, sneezing or hives? If so, please explain.

 Are you aware of any delayed symptoms after eating certain foods such as fatigue, muscle aches, sinus congestion, etc?

Are there any particular foods that your child craves throughout the day?

When does he/she usually feel these cravings?

Is there anything else I should know about your child’s current diet, history or relationship with food?

**Hydration:**

How much water does your child drink?

 Tap or filtered water?

How much juice does your child drink (commercial juices)

How much milk does your child drink? And what kind?

**Sleep:**

What time does your child generally go to bed each night? Wake up in the morning?

Does he/she fall asleep easily?

Does he/she wake up with/without an alarm?

Does he/she wake up feeling rested or tired?

Does he/she wake up through the night? If so, is there a consistent time each night??

Does your child have more energy in the morning or the evening?

**Intestinal Status:**

Bowel movement frequency

\_\_\_ 1-3 times per day

\_\_\_ More than 3 times per day

\_\_\_ Not regularly every day

Bowel Movement Consistency:

\_\_\_ soft and well formed

\_\_\_ often float

\_\_\_ difficult to pass

\_\_\_ diarrhea

\_\_\_ thin, long or narrow

\_\_\_ small and hard

\_\_\_ loose but not watery

\_\_\_ alternating between hard and loose

Bowel Movement Color

\_\_\_ medium brown

\_\_\_ very dark or black

\_\_\_ greenish

\_\_\_ blood is visible

\_\_\_ variable

\_\_\_ yellow, light brown

\_\_\_ chalky colored

\_\_\_ Greasy, shiny

Does your child experience intestinal gas: If so, please explain if it is excessive, occasional, odorous etc.

 **Energy Level**

How is your child’s energy throughout the day?

Does he/she feel peaks and valleys? If so when do they generally occur?

On a scale of 1-10, one being the worst and 10 being the best, describe their usual level of energy?

 **Recreation**

Would you describe your child as generally active or sedentary?

Are there typical activities that he/she enjoys.

Does your child enjoy and participate in any particular sports?

Are there any particular activities that he/she does just for fun?( hobbies)

**Stress:**

Any fears?

Any nightmares?

Any phobias?

**Developmental Milestones:**

Sitting

Crawling

Walking

Talking

Potty Training

**Nutritional Supplements**: Please list any specific nutritional supplements,(e.g., greens, probiotics, vitamins, power bars, drinks) etc. that your child takes regularly.

**Drugs/Herbs**:

 Please list all prescribed and over the counter drugs that your child is currently on.

Please list all herbal products your child is currently taking.

 **Current Medical/Health Concerns:** digestion, skin, lung etc. problems, conventional diagnoses, behavioral issues, recurrent infections, physical pains, organ dysfunctions, etc

Number of past infections past and present, please list.

Number of surgeries:\_\_\_\_\_\_\_\_\_\_

Metal Amalgam Fillings:\_\_\_\_\_\_\_\_

 **Family History**

 Please indicate which family members have had, or currently have the following conditions.

|  |  |  |  |
| --- | --- | --- | --- |
| Condition |   | Condition |   |
| Alcoholism |   | Cancer |   |
| Allergies |   | Cataracts |   |
| Arteriosclerosis |   | Celiac Disease |   |
| Arthritis |   | Crohn's/Colitis |   |
| Asthma |   | Depression |   |
| Bed Wetting |   | Diabetes |   |
| Birth Defects |   | Epilepsy |   |
| Blindness |   | Osteoporosis |   |
| Heart Disease |   | Ulcers |   |
| Hyperactivity |   | Stroke |   |
| Kidney Disease |   | TB |   |
| Learning Disability |   | Yeast Infections |   |
| Mental Illness |   |   |   |
| MS |   |   |   |
| MD |   |   |   |

Have you or your child received the following vaccinations? Please check those that apply.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Type | 2 months | 4 months | 6 months | 18 months | 4-6year | 14-16years | Boosters |   |
| Diphtheria |   |   |   |   |   |   |   |   |
| Pertussis |   |   |   |   |   |   |   |   |
| Tetanus |   |   |   |   |   |   |   |   |
| Polio (IPV) |   |   |   |   |   |   |   |   |
| Polio (OPV) |   |   |   |   |   |   |   |   |
| Hib |   |   |   |   |   |   |   |   |
| Measles |   |   |   |   |   |   |   |   |
| Rubella |   |   |   |   |   |   |   |   |
| Hepatitis B |   |   |   |   |   |   |   |   |
| Chicken Pox |   |   |   |   |   |   |   |   |
| Meningitis |   |   |   |   |   |   |   |   |
| Influenza |   |   |   |   |   |   |   |   |
| Hepatitis A |   |   |   |   |   |   |   |   |
|   |   |   |   |   |   |   |   |   |

Please note any reactions to immunizations:

**Sequential TImeline:**

Please list any treatments and/or medications your child has had from the present to the past in reverse chronological order with approximate dates. Please include prescriptions, over the counter and recreational, vaccinations, and medical treatments such as MRI’s, X-rays, surgery, dental procedures etc. Please include any exposure to environmental toxins, such as pesticides, paints etc. It is important to consider emotional events in your life as well. The more detailed you can make this, the more useful this information is in helping guide your practitioner in treatment.

Date: (from Present to Past) Medications/Vaccinations/Treatments/Emotional Trauma

Is there any additional information you would like to share?

Client Agreement

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree that my progress and wellness goals are dependent upon me taking responsibility to follow the recommended protocol as set out by my practitioner. I understand that this may require me to modify my regimen including my diet and sleep patterns, and I agree that I am willing to make a concerted effort to make the necessary modifications to achieve optimal wellness. I understand that reversal of disease is a process and that it takes time, and determination to achieve optimal wellness. I agree to keep my regularly scheduled appointments in order to optimize my desired state of health, wellbeing and success.

Signature of patient/Parent or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_