Pediatric NUTRITION By Shari

# PEDIATRIC HISTORY FORM

To help us serve you better, please complete the following information.
We look forward to coaching you to build better health for you and your family.

## PERSONAL INFORMATION:

Name: _____ Age:_____ DOB: _____

Address: _____ City/State/ Zip: _____

Home Phone #: (___)____-_____ Work #: (___)____-_____ Cell #: (___)____-_____

Email Address: _____@_____.com Would you like to receive our Free Wellness E-Newsletter? Yes No

Male: ___ Female: ____ Status: Single/ Married/ Divorced/ Widowed S/S #:_____

Driver's License #:_____ Emergency Contact: _____ Phone: _____

Reason for consulting our office? Wellness Evaluation:_____ or Chief Complaint:_____

Who may we thank for referring you to our office?_____

## Your WELLNESS Profile

*Place an **"X"** on the scale where you above marking your level of health believe your lev-*


*and wellness is **NOW**.*
*Place an **"O"** on the diagram indicating where you would **LIKE** your health and wellness to be.*

## Your HEALTH Profile

What brings you into our office? Please briefly describe your chief concern, including the impact it has it had on your life. If you have no symptoms or complaints and are here for Wellness Services, please skip to the "General History" page.

Rate Severity 1 = mild 10= worst imaginable
Are symptoms Constant or Intermittent?

When did this start?
Did problem begin with injury?

**Health Concerns:**

_____
_____
_____
_____

**Since the problem started, it is**:____The Same _____Getting Better _____Getting Worse
**What makes the problem worse?** _____
**What, if anything makes it feel better?** _____

**Does this interfere with your:** ___Work ___Leisure ___Sleep ___Sports
____Other: _____

**Have you seen other doctors for this condition?** ___Chiropractor ___ Medical Dr. ___Other
Name/ Address: _____
Date: _____ What was the diagnosis? _____
Name/ Address: _____
Date: _____ What was the diagnosis? _____

## Your General History

**List all *Medications* you are taking and why: (Prescription and non-prescription)**
_____
_____

**List all *Supplements* you are taking and why:**
_____
_____

**Primary Care Physician and Location:** _____

**Have you had any *Surgeries or Hospitalizations*? (Please include all surgeries)**
Date: _____ _____
Date: _____ _____
Date: _____ _____

**What do you do for a living?** _____

**Have you ever had any work related injuries?** _____

**Have you ever had any slips, falls or auto accidents?**_____
_____

**On a scale of 1-10 describe your Psychological/Emotional stress levels:**
(1= none/ 10=extreme)
Home: _____ Work: _____ Financial: _____

**On a scale of 1-10, (1 being very poor and 10 being excellent) describe your:**

Eating habits: ____ Exercise habits:_____ Sleep: _____ Mind-set:_____

**Please answer the following *Life Style* Habits:**
Sleeping Position: ____ Back ____ Side ____Stomach (# of pillows used under head: _____)
How many hours per night? _____ How old is your mattress? _____
Do you smoke? ____ (If Yes, how many per day____)

**How Many 8oz glasses per day of the following do you drink:**
___ Water ___ Soda ___ Coffee ___ Juice ___Milk ___Tea ___Alcohol

# Symptom Review

**NAME** _____ **DOCTOR** _____ **DATE** _____

**AGE**_____ **SEX M** ___ **F** ___

**Phone #** (____) _____

**INSTRUCTIONS:** Number the boxes which apply to you with either a 1, 2, or 3
(1) for **MILD** symptoms
(2) for **MODERATE** symptoms
(3) for **SEVERE** symptoms
Leave the box **BLANK** if it does not apply to you!

## GROUP 1

1 ☐ Acid foods upset
2 ☐ Get chilled, often
3 ☐ "Lump" in throat
4 ☐ Dry mouth-eyes-nose
5 ☐ Pulse speeds after meals
6 ☐ Keyed up - fail to calm
7 ☐ Cuts heal slowly
8 ☐ Gag easily
9 ☐ Unable to relax; startles easily
10 ☐ Extremities cold, clammy
11 ☐ Strong light irritates
12 ☐ Urine amount reduced
13 ☐ Heart pounds after retiring
14 ☐ "Nervous" stomach
15 ☐ Appetite reduced
16 ☐ Cold sweats often
17 ☐ Fever easily raised
18 ☐ Neuralgia-like pains
19 ☐ Staring, blinks little
20 ☐ Sour stomach frequent

## GROUP 2

21 ☐ Joint stiffness after arising
22 ☐ Muscle-leg-toe cramps at night
23 ☐ "Butterfly" stomach, cramps
24 ☐ Eyes or nose watery
25 ☐ Eyes blink often
26 ☐ Eyelids swollen, puffy
27 ☐ Indigestion soon after meals
28 ☐ Always seems hungry; feel "lightheaded" often
29 ☐ Digestion rapid
30 ☐ Vomiting frequent
31 ☐ Hoarseness frequent
32 ☐ Breathing irregular
33 ☐ Pulse slow; feels "irregular"
34 ☐ Gagging reflex slow
35 ☐ Difficulty swallowing
36 ☐ Constipation, diarrhea alternating
37 ☐ "Slow starter"
38 ☐ Get "chilled" infrequently
39 ☐ Perspire easily
40 ☐ Circulation poor, sensitive to cold
41 ☐ Subject to colds, asthma, bronchitis

## GROUP 3

42 ☐ Eat when nervous
43 ☐ Excessive appetite
44 ☐ Hungry between meals
45 ☐ Irritable before meals
46 ☐ Get "shaky" if hungry
47 ☐ Fatigue, eating relieves
48 ☐ "Lightheaded" if meals delayed
49 ☐ Heart palpitates if meals missed or delayed
50 ☐ Afternoon headaches
51 ☐ Overeating sweets upsets
52 ☐ Awaken after few hours sleeps - hard to get back to sleep
53 ☐ Crave candy or coffee in afternoons
54 ☐ Moods of depression - "blues" or melancholy
55 ☐ Abnormal craving for sweets or snacks

## GROUP 4

56 ☐ Hands and feet go to sleep easily, numbness
57 ☐ Sigh frequently, "air hunger"
58 ☐ Aware of "breathing heavily"
59 ☐ High altitude discomfort
60 ☐ Opens windows in closed room
61 ☐ Susceptive to colds and fevers
62 ☐ Afternoon "yawner"
63 ☐ Get "drowsy" often
64 ☐ Swollen ankles worse at night
65 ☐ Muscle cramps, worse during exercise; get "charley horses"
66 ☐ Shortness of breath on exertion
67 ☐ Dull pain in chest or radiating into left arm, worse on exertion
68 ☐ Bruise easily, "black/blue" spots
69 ☐ Tendency to anemia
70 ☐ "Nose bleeds" frequent
71 ☐ Noises in head or "ringing in ears"
72 ☐ Tension under the breastbone, or feeling of "tightness", worse on exertion

## GROUP 5

73 ☐ Dizziness
74 ☐ Dry Skin
75 ☐ Burning feet
76 ☐ Blurred vision
77 ☐ Itching skin and feet
78 ☐ Excessive falling hair
79 ☐ Frequent skin rashes
80 ☐ Bitter, metallic taste in mouth in mornings
81 ☐ Bowel movement painful or difficult
82 ☐ Worries, feels insecure
83 ☐ Felling queasy; headache over eyes
84 ☐ Greasy foods upset
85 ☐ Stools light-colored
86 ☐ Skin peels on foot soles
87 ☐ Pain between shoulder blades
88 ☐ Use laxatives
89 ☐ Stools alternate from soft to watery
90 ☐ History of gallbladder attacks or gallstones
91 ☐ Sneezing attaches
92 ☐ Dreaming, nightmare type bad dreams
93 ☐ Bad breath (halitosis)
94 ☐ Milk products cause distress
95 ☐ Sensitive to hot weather
96 ☐ Burning or itching anus
97 ☐ Crave sweets

# Symptom Review

## GROUP 6

98 ☐ Loss of taste for meat
99 ☐ Lower bowel gas several hours after eating
100 ☐ Burning stomach sensations, eating relieves
101 ☐ Coated tongue
102 ☐ Pass large amounts of foul-smelling gas
103 ☐ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
104 ☐ Mucus colitis or "irritable bowel"
105 ☐ Gas shortly after eating
106 ☐ Stomach "bloating" after eating

## GROUP 7

### (A)

107 ☐ Insomnia
108 ☐ Nervousness
109 ☐ Can't gain weight
110 ☐ Intolerance to heat
111 ☐ Highly emotional
112 ☐ Flush easily
113 ☐ Night sweats
114 ☐ Thin, moist skin
115 ☐ Inward trembling
116 ☐ Heart palpitates
117 ☐ Increased appetite without weight gain
118 ☐ Pulse fast at rest
119 ☐ Eyelids and face twitch
120 ☐ Irritable and restless
121 ☐ Can't work under pressure

### (B)

122 ☐ Increase in weight
123 ☐ Decrease in appetite
124 ☐ Fatigue easily
125 ☐ Ringing in ears
126 ☐ Sleepy during day
127 ☐ Sensitive to cold
128 ☐ Dry or scaly skin
129 ☐ Constipation
130 ☐ Metal sluggishness
131 ☐ Hair coarse, falls out
132 ☐ Headaches upon arising wear off during day
133 ☐ Slow pulse, below 65
134 ☐ Frequency of urination
135 ☐ Impaired hearing
136 ☐ Reduced initiative

## GROUP 7 (continued)

### (C)

137 ☐ Failing memory
138 ☐ Low blood pressure
139 ☐ Increased sex drive
140 ☐ Headaches, "splitting or rending" type
141 ☐ Decreased sugar tolerance

### (D)

142 ☐ Abnormal thirst
143 ☐ Bloating of abdomen
144 ☐ Weight gain around hips or waist
145 ☐ Sex drive reduced or lacking
146 ☐ Tendency to ulcers, colitis
147 ☐ Increased sugar tolerance
148 ☐ Women: menstrual disorders
149 ☐ Young girls: lack of menstrual function

### (E)

150 ☐ Dizziness
151 ☐ Headaches
152 ☐ Hot flashes
153 ☐ Increased blood pressure
154 ☐ Hair growth on face or body (female)
155 ☐ Sugar in urine (not diabetes)
156 ☐ Masculine tendencies (female)

### (F)

157 ☐ Weakness, dizziness
158 ☐ Chronic fatigue
159 ☐ Low blood pressure
160 ☐ Nails weak, ridged
161 ☐ Tendency to hives
162 ☐ Arthritic tendencies
163 ☐ Perspiration increase
164 ☐ Bowel disorders
165 ☐ Poor circulation
166 ☐ Swollen ankles
167 ☐ Crave salt
168 ☐ Brown spots or bronzing of skin
169 ☐ Allergies - tendency to asthma
170 ☐ Weakness after colds, influenza
171 ☐ Exhaustion - muscular and nervous
172 ☐ Respiratory disorders

## FEMALE ONLY

173 ☐ Very easily fatigued
174 ☐ Premenstrual tension
175 ☐ Painful menses
176 ☐ Depressed feeling before menstruation
177 ☐ Menstruation excessive and prolonged
178 ☐ Painful breasts
179 ☐ Menstruate too frequently
180 ☐ Vaginal discharge
181 ☐ Hysterectomy/ovaries removed
182 ☐ Menopausal hot flashes
183 ☐ Menses scanty or missed
184 ☐ Acne, worse at menses
185 ☐ Depression of long standing

## MALES ONLY

186 ☐ Prostate trouble
187 ☐ Urination difficult or dribbling
188 ☐ Night urination frequent
189 ☐ Depression
190 ☐ Pain on inside of legs or heels
191 ☐ Feeling of incomplete bowel evacuation
192 ☐ Lack of energy
193 ☐ Migrating aches and pains
194 ☐ Tire too easily
195 ☐ Avoid activity
196 ☐ Leg nervousness at night
197 ☐ Diminished sex drive

## IMPORTANT

TO THE PATIENT: Please list below the five main health complaints you have in order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

**YOUR WELLNESS GOALS:** At our office we concern ourselves with YOUR health and YOUR wellness goals. (Please list your goals for your health and wellness in the spaces provided).

| Physical Goals: | Nutritional/Biochemical Goals: | Psychological/Emotional Goals: |
|---|---|---|
| Ex. Sleep Better | Ex. Lose Weight | Ex. Be More Organized |
| | | |
| | | |

**Have you ever:**

| | | |
|---|---|---|
| Bought bottled water: | ☐ Yes | ☐ No |
| Belonged to a health club: | ☐ Yes | ☐ No |
| Consumed vitamins or supplements | ☐ Yes | ☐ No |
| If there is a need for dietary changes would you like to know? | ☐ Yes | ☐ No |
| If there is a need for specific exercises would you like to know? | ☐ Yes | ☐ No |
| If there is a need for support in the psychological/mind/body/stress dimension of health would you like assistance? | ☐ Yes | ☐ No |
| Do you exercise | ☐ Yes | ☐ No |

If Yes, What do you do and how often? _____
_____

Food Diary for the past 2 full days:

| | |
|---|---|
| Day 1—Breakfast | Day 2—Breakfast |
| Day 1—Lunch | Day 2—Lunch |
| Day 1—Dinner | Day 2—Dinner |
| Day 1—Snacks | Day 2—Snacks |

I consent to a professional and complete Nutrition Response Testing examination. understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature_____ Date: _____

Thank you for filling out this form. It is your first step to Optimal Health!
Return this to our staff along with your Driver's License

# Informed Consent for Nutrition Respons eTesting

**PLEASE READ BEFORE SIGNING:**

I specifically authorize the natural health practitioners at the Nutrition by Shari to perform a Nutrition Response Testing health analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, **and not for the treatment, or "cure" of any disease.**

I understand that **Nutrition Response Testing is a safe, non-invasive, natural method** of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems.

I understand that Nutrition Response Testing is not a method for "diagnosing" or "treating" of any disease including conditions of cancer, AIDS, Infections, or other medical conditions, and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of Nutrition Response Testing or any natural health, nutritional or dietary programs recommended, but rather I understand that Nutrition Response Testing is a means by which the body's natural reflexes can be used as an aid to determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

I have read and understand the foregoing.

This permission form applies to subsequent visits and consultations.

Print Name: _____ Signature: _____
Date:_____

# Privacy Notice

## TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

I, _____, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Privacy Notice of Nutrition by Shari/Quantum Chiropractic will be provided to me upon my request. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for Quantum Chiropractic to provide treatment to me, and also necessary for Quantum Chiropractic to obtain payment for that treatment and to carry out its health care operations. Bruce Steinberg, DC and/or Shari Trombley has further explained my right to obtain a copy of this Privacy Notice prior to signing this Consent, and has encouraged me to read this Privacy Notice prior to my signing this Consent.

2. Quantum Chiropractic reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable laws.

3. I understand that, and consent to, the following appointment reminders or communications that will be used by Quantum Chiropractic.

   a.) a postcard mailed to me at the address provided by me; and

   b.) Telephoning my home or cellular phone and leaving a message on my answering machine or with the individual answering the phone.

4. Quantum Chiropractic may use and/or disclose my PHI to the third party (which includes information about my health or condition and the treatment provided to me) in order to treat me and obtain payment for that treatment, and as necessary for Quantum Chiropractic to conduct its specific health care operations.

5. I understand that I have a right to request that Quantum Chiropractic restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, Quantum Chiropractic is not required to agree to any restrictions that I have requested. If Quantum Chiropractic agrees to a requested restriction, then the restriction is binding.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocations shall not apply to the extent that Quantum Chiropractic has already taken action in reliance on this consent.

7. I understand that if I revoke this Consent at any time, Quantum Chiropractic has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above in this Privacy Notice and contained in the enclosed Releases, then Queensbury Family Chiropractic will not treat me.

**I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.**

Name of Individual (Printed) Signature of Individual _____

Signature of Legal Guardian/if a minor Relationship _____

Date Signed: ____/____/_____ Witness: _____

# Releases

I hereby request and consent to receive nutrition response testing, for me (or for the patient named below, for whom I am legally responsible) by any Clinical Nutritionist or coach who now or in the future treat me while employed by, working with, are associated with, or providing coverage services for this office (collectively known as the “Treating Doctor(s)”), including those working at any office associated with the Treating Doctor(s) (collectively known as the “Staff”.) I authorize the Treating Doctor(s) and Staff to request medical records as needed from any source.

**Initials**: _____

I clearly understand that all services rendered me are charged directly to me and that I am personally responsible for payment. I authorize and assign any benefits to be paid directly to the Doctor’s Office. Any payments will be immediately credited to my account upon receipt. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered me will be immediately due and payable.

**Initials**: _____

In consideration of services rendered, I hereby assign to the provider of the services and his assignees so much of my third party insurer, first party no-fault automobile or Worker’s Compensation insurance benefits and rights, attendant thereto, as shall equal the full amount of the bill for such services and the provider or his assign may secure in my name.

**Initials**: _____

Kindly furnish my doctors, insurance company, attorney and any other involved parties or their representatives all information you may have regarding my condition while under your treatment or observation, including but not limited to the history obtained, X-ray, testing, physical findings, diagnosis and prognosis.

**Initials**: _____

I have had the opportunity to review and understand a Privacy Notice. I understand that I have the right to review the complete policy prior to signing this consent. I understand that the organization reserves the right to change their notice and practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. There are no restrictions, unless explicitly noted here.

**Initials**: _____

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I have read and understood the above information:

Patient /Guardian Name: _____

Patient/Guardian Signature: _____ Date: _____

# Financial Policy & Profile

## PAYMENT IS DUE AS SERVICES ARE RENDERED

Our office is a cash practice, all services are due when rendered, unless other arrangements have been made prior to treatment.

Method of Payment:

Cash: _____ Check: _____ Credit Card: _____ HAS: _____ Insurance: _____

### Group Insurance

Patients are responsible for payment at the time of their visit. Nutrition response testing is a non-covered service a

### Medicare

The doctor is a non-participating Medicare provider. Medicare patients are required to pay cash as services are rendered and we will submit your claims as a courtesy to you. Medicare patients must present their Medicare card at the onset of treatment. The only treatment Medicare covers is acute care.

### Workers Compensation and Personal Injury

We are a cash practice, if you have been injured; you are still required to pay at the time of service. You will be reimbursed by your insurance carrier.

### My Certification

(Assignment & Release)

I certify that the above information is correct and I request services. I certify that I, and/or my dependant(s), assign directly to Dr. Bruce P. Steinberg all insurance benefits, if any, otherwise payable to me for services rendered. I understand that any services rendered, including Nutrition Response Testing deemed "not medically necessary" or "maintenance care" may not be covered by my insurance company and ***I understand that I am financially responsible for all charges whether or not they are covered and/or paid for by insurance.*** I understand that as of the date of this release the fee for visit is $40.00 and is subject to change. I accept full financial responsibility for all services rendered. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____/_____/_____

Signature of Patient Date