Systems Health Care
Integrative Wellness
Chiropractic Physicians

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HEALTH QUESTIONAIRE
Personal Information

Child's full name: _____Name they wish to be called:_____

Street Address_____

City_____ State_____Zip_____

Phone: H) _____ W) _____ E-Mail:_____

Date of birth____/____/____ Sex: M / F Health Insurance Company: _____

Who were you referred by? _____

Name of parent/guardian: _____Phone: _____

I, _____, read and understood Dr. Gangemi's Office Policies sheet regarding appointments, fees, billing, and emergencies, and have had all my questions and concerns answered.

Signature of parent/guardian _____ Date_____/_____/_____

Primary Concern

What brings you to my office? _____

_____

Date you noticed original problem: _____

Was there an event that created the problem?_____

Has the child had this or similar conditions in the past?_____

What makes your child better?_____ Worse?_____

Is the issue(s) getting worse?_____Constant?_____Worse at a certain time of day?_____

Is this problem interfering with School?_____Sleep?_____Activity?_____Other?_____

Please list your goals for treatment, both immediate and future:

_____

_____

_____

Health History

List all current health issues & problems: _____

_____

List other practitioners seen, treatments, self-care activities, and results:_____

_____

List any illness they have had not previously mentioned, if any: _____

_____

List all surgeries they have had, with dates and results: _____

_____

Have they ever been in an accident or seriously injured? (if so, please describe)_____

_____

Are there any dental or TMJ problems? _____

List all medications, vitamins, herbs and other supplements they are now taking:_____

_____

_____

List all medications and other substances (i.e.: foods) to which they are allergic:_____

Family History

Please list age(s) and health problems (if any); if deceased, please list age at death and cause of death:

Father _____ Mother_____ Sisters _____

Grandparents _____ Brothers _____

General

*How many hours per night do they sleep? ____ * Do they fall right asleep? **Y** **N** * Do they wake up feeling refreshed? **Y** **N**
*Do they sleep through the night without awaking? **Y** **N** * Do they remember their dreams? **Y** **N** **Unsure**
* Do they have night sweats? **Y** **N** * Nightmares? **Y** **N**

Vaccines

Please mark the vaccines, if any, your child has had with dates:

Hib _____ DtaP or DTP_____
IPV_____ MMR _____
Varicella _____ Hep. B _____
Other_____ Covid-19: _____

DIET HISTORY

How many (cups) do they drink each day: Water?___Milk?____Juice?_____Caffeinated sodas/tea?_____ Diet Sodas? ____

List oils or fats that you use in cooking: _____
Do they frequently skip meals? **Y N**

Are they on any special diet or nutrition program? **NO YES (list)** _____

List the diets you have tried in the past with results:
1>_____

2>_____

3>_____

Are they allergic or sensitive to any foods? **Y N** If yes, name the foods and describe the problem.
_____

What foods do they dislike?_____

Circle the foods they crave: Meats Fats Sweets Salty foods Vegetables Fruits Breads Fatty foods
Spicy foods Sour foods Cereals Dairy Other individual _____

*Do you use butter or margarine in your house? (circle)
*Do you know what partially hydrogenated fats are? **Y N** If yes, does your child eat them? **Y N**

What do they usually eat for **breakfast**? _____

What do they usually eat for **lunch**? _____

What do they usually eat for **dinner**? _____

What do they usually eat for **snacks** (in between meals and/or before bed)? _____

What foods do they eat a lot of (at least once a day, every day)? _____

How many bowel movements do they have per day? _____ Are the stools formed? **Y N**

Please list all lab work your child has had done and include a copy:

_____ _____ _____

Is there anything else you would like to tell me or feel that I should know? _____

_____

_____