

# YOUTH HEALTH HISTORY QUESTIONNAIRE

Name \_\_\_\_\_ Today's date: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

*This questionnaire is designed to assist in providing a general overview of your child's health habits and history. Please be as detailed as possible when answering these questions!*

1. What is the reason for this visit?

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2. Please list any known health conditions that your child has been diagnosed with:

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3. List any **medications** your child is currently taking, or has taken in the past.

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4. Please indicate any history of **antibiotic** use, listing when, what, and for what purpose.

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5. Are there any known drug allergies?

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6. List supplements, herbs, remedies, including athletic performance supplements that your child is currently taking:

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7. Do you suspect your child to use recreational drugs? If so, what:

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8. List any hospital procedures/surgeries that your child has had:

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**LIFESTYLE INDICATORS** (please fill in or circle the appropriate answer)

1. Does your child consume any of the following?

Soda	none	< 2 cans / day	> 2 cans / day	
Sweets / Carbs	none	< twice / day	> twice / day	
White Flour	none	< twice / day	> twice / day	
Milk/Dairy Products	none	< twice / day	> twice / day	
Juice	none	< twice / day	> twice / day	
Meat/Fish	none	rarely	< once a week	every day

2. How much water does your child drink each day? \_\_\_\_\_

3. Are there smokers in the child's home? Yes No

4. Does your child get consistent physical activity? Yes No

5. Please list any regular exercise or sports that your child participates in:

\_\_\_\_\_

**History** (please fill in or circle the appropriate answer)

1. Did your child have colic as an infant? Yes No

2. How was your child fed as an infant? Breast Bottle

What brand / kind of formula? \_\_\_\_\_

3. Has your child had any respiratory infections? Yes No

How often? \_\_\_\_\_

4. Does your child ever complain of back or neck pain? Yes No

Please explain: \_\_\_\_\_

5. Does your child ever complain of arm or leg pain? Yes No

Please explain: \_\_\_\_\_

6. Does your child ever complain of headaches? Yes No

How often? \_\_\_\_\_

7. Has your child had ear infections? Yes No

Age of the first occurrence and frequency: \_\_\_\_\_

8. Do they typically occur in the same ear? Yes No Which ear? Right Left Both

9. Please list any illnesses that your child has had and approximate dates of occurrence:

\_\_\_\_\_  
\_\_\_\_\_

10. Has your child been vaccinated? Yes No Recently? Yes No

11. Please describe any reactions that your child has had to past or recent vaccinations:

\_\_\_\_\_  
\_\_\_\_\_

12. Please list any other concerns you have regarding your child's health:

\_\_\_\_\_  
\_\_\_\_\_

**Sleep Habits** (please fill in or circle the appropriate answer)

1. How well does your child sleep?  
Well                      Trouble falling asleep                      Trouble staying asleep                      Insomnia
2. Does your child wake up tired?                      Yes                      No
3. How many hours does your child sleep on an average night? \_\_\_\_\_
4. Does your child take naps?                      Yes                      No
5. Does your child have nightmares?                      No                      Sometimes                      Often

**For Cycling Females Only** (please fill in or circle the appropriate answer)

1. Age of onset of menarche (first period): \_\_\_\_\_  
Approximate Date: \_\_\_\_\_
2. Is your child currently using any method of birth control?                      Yes                      No  
What kind?                      Oral Pill                      Injected                      Patch                      Ring
3. How long has your child been using birth control? \_\_\_\_\_
4. Please describe any symptoms that your child may have experienced while using birth control (i.e. yeast infections, heavy / light bleeding, moodiness, weight gain, acne, sweet cravings, palpitations, fatigue):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. First day of last period: \_\_\_\_\_
6. Length of typical period: \_\_\_\_\_
7. Is menstrual cycle regular?                      Yes                      No                      Not Always  
Details: \_\_\_\_\_
8. How many pads and / or tampons (please circle) are used on heavy days?  
\_\_\_\_\_
9. Any knowledge of passing clots?                      Yes                      No  
How often? \_\_\_\_\_
10. Any spotting between periods?                      Yes                      No  
At what point in cycle? \_\_\_\_\_
11. Does your child experience cramping?                      None                      Mild                      Moderate                      Severe  
At what point in the cycle? \_\_\_\_\_

**INSTRUCTIONS: Please mark the following symptoms as they apply.  
Please be as detailed as possible.**

<b>SIGNS &amp; SYMPTOMS</b>	<b>MILD</b>	<b>MODERATE</b>	<b>SEVERE</b>	<b>MORE INFORMATION</b>
Low Mood				
Lowered Self-Esteem				
Discouragement				
Sadness / Crying				
Reserved / Withdrawn				
Decreased Interest in Activities				
Decreased Initiative / Motivation				
Behavior Problems				
Aggression				
Anger				
Anxiety				
Fear				
Difficulty Concentrating				
Foggy Thinking				
Memory Problems				
Constant Hunger				
Never Hungry / Anorexia				
Weight Loss				
Weight gain				
Decrease in Strength / Stamina				
Decrease in Athletic Performance				
Fatigue				
Anemia				
Headaches / Migraines				
Body / Joint / Backaches				
Digestive Problems				
Irritable Bowel				
Constipation				
Loose Stool / Diarrhea				
Bloating				
Frequent Urination				
Bedwetting				
Allergies				
Asthma				
Throat Clearing				
Excessive Mucous / Runny Nose				
Dry Skin				
Acne				
Cold Sores				
Infections / Lowered Immunity				



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*An Integrated Approach to Wellness*

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### **NUTRITIONAL HEALTH HISTORY FORM**

Please print clearly

#### **PERSONAL INFORMATION**

Name: \_\_\_\_\_ Sex: M F Date: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mobile: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Occupation: \_\_\_\_\_ Marital Status (Circle): S M D Number of Children: \_\_\_\_\_

#### **PERSONAL HEALTH HISTORY**

List any major illnesses with approx. dates \_\_\_\_\_  
\_\_\_\_\_

List any surgery or operations with approx. dates \_\_\_\_\_  
\_\_\_\_\_

Past accidents, injuries or falls with approx. dates \_\_\_\_\_  
\_\_\_\_\_

Do you smoke? Yes / No If yes, how long? \_\_\_\_\_ How many per day? \_\_\_\_\_

To your knowledge, have you ever had long-term exposure to chemicals, pesticides, herbicides, radiation and/or chemotherapy, solvents or heavy metals? Yes/No

If yes, explain \_\_\_\_\_

Do you have, or have you ever had, "silver" fillings in your teeth? Yes/No

Do you have any Root canal(s)? Yes/No If yes, how many? \_\_\_\_\_

Have you had tooth extractions? Yes/No If yes, how many? \_\_\_\_\_

Are you currently having any trouble with your teeth?

If yes Please explain: \_\_\_\_\_

Do you or anyone in your family have Sickle Cell Anemia or Sickle Cell Trait? Yes/No

If yes, please explain: \_\_\_\_\_

**WOMEN ONLY:**

Date of last menstrual period \_\_\_\_\_ Age at first onset \_\_\_\_\_

Are your periods regular? Yes/No If not, explain: \_\_\_\_\_

Do you experience cramping? No Slight Moderate Severe

Do you experience clotting during your menstrual cycles? Yes / No

Do you have any PMS symptoms? Yes / No

If so, what kind? \_\_\_\_\_

Are you currently pregnant? Yes / No

Are you currently using birth control? Yes/No If yes, what kind? \_\_\_\_\_

Have you had a hysterectomy? Yes / No

If yes indicate complete or partial and year \_\_\_\_\_

Do you suffer from (circle all that applies) night sweats, hot flashes, memory loss

**MEN ONLY:**

Do you experience frequent urination? Yes / No If yes for how long \_\_\_\_\_

How many times do you get up at night to urinate? \_\_\_\_\_

Do you have strong urges to urinate with incomplete voiding Yes / No

What is your current energy level: Normal or Decreased If decreased, please explain:  
\_\_\_\_\_

Do you experience cold hands or feet Yes/No? If yes, for how long? \_\_\_\_\_

Have you had any prostate related issue? Yes / No If yes, please explain and give date of last prostate exam \_\_\_\_\_

**FAMILY HISTORY**

Marital Status: S/M/W Name of spouse \_\_\_\_\_

Describe health of spouse \_\_\_\_\_

Number of Children, if any \_\_\_\_\_

**Name of Parents/Siblings Age Sex Any physical conditions or concerns?**

\_\_\_\_\_ M / F \_\_\_\_\_

\_\_\_\_\_ M / F \_\_\_\_\_

\_\_\_\_\_ M / F \_\_\_\_\_

\_\_\_\_\_ M / F \_\_\_\_\_

Any family history of serious illnesses? Cancer/ Diabetes/ Heart Disease/ Other \_\_\_\_\_

**PRESENT COMPLAINTS**

List the 4 main health complaints you have in order of their importance to you (List the problem you would most like to get rid of below as #1, the second "worst" problem as #2, etc.):

1. \_\_\_\_\_  
First began how long ago? \_\_\_\_\_ How often does this bother you? \_\_\_\_\_  
What treatments have you tried? \_\_\_\_\_

Has this problem been getting better, worse or staying the same? \_\_\_\_\_

2. \_\_\_\_\_  
First began how long ago? \_\_\_\_\_ How often does this bother you? \_\_\_\_\_  
What treatments have you tried? \_\_\_\_\_

Has this problem been getting better, worse or staying the same? \_\_\_\_\_

3. \_\_\_\_\_  
First began how long ago? \_\_\_\_\_ How often does this bother you? \_\_\_\_\_  
What treatments have you tried? \_\_\_\_\_

Has this problem been getting better, worse or staying the same? \_\_\_\_\_

4. \_\_\_\_\_  
First began how long ago? \_\_\_\_\_ How often does this bother you? \_\_\_\_\_  
What treatments have you tried? \_\_\_\_\_

Has this problem been getting better, worse or staying the same? \_\_\_\_\_

OTHER COMPLAINTS OR PROBLEMS: (use separate sheet if needed)

\_\_\_\_\_  
\_\_\_\_\_

What is your present weight? \_\_\_\_\_ Are you ok with your weight? \_\_\_\_\_  
What is your ideal weight? \_\_\_\_\_ What time of day are you most tired? \_\_\_\_\_

Do you get depression, anxiety, worry, lack of concentration or memory problems? If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How many bowel movements do you currently have? Only indicate one of the following:

- \_\_\_\_\_ x per day
- \_\_\_\_\_ every other day
- \_\_\_\_\_ x per week

List any allergies or foods/substances you are sensitive to:

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**DRUGS, MEDICATIONS, SUPPLEMENTS**

Current **medications/prescription drugs** being taken, including “over the counter” medications:

(use a separate sheet if needed):

Drug: \_\_\_\_\_ Taken For: \_\_\_\_\_ How Long? \_\_\_\_\_ How Often? \_\_\_\_\_

Drug: \_\_\_\_\_ Taken For: \_\_\_\_\_ How Long? \_\_\_\_\_ How Often? \_\_\_\_\_

Drug: \_\_\_\_\_ Taken For: \_\_\_\_\_ How Long? \_\_\_\_\_ How Often? \_\_\_\_\_

Drug: \_\_\_\_\_ Taken For: \_\_\_\_\_ How Long? \_\_\_\_\_ How Often? \_\_\_\_\_

Drug: \_\_\_\_\_ Taken For: \_\_\_\_\_ How Long? \_\_\_\_\_ How Often? \_\_\_\_\_

Drug: \_\_\_\_\_ Taken For: \_\_\_\_\_ How Long? \_\_\_\_\_ How Often? \_\_\_\_\_

Are you currently under the care of a physician or other health care professional(s)? No/Yes

If Yes, Doctor's name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Any **nutritional supplements** (vitamins), herbs, tonics, homeopathic or other remedies you are taking \_\_\_\_\_

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Please list any additional information you would like the doctor to be aware

of: \_\_\_\_\_

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**DIET AND LIFESTYLE:**

HOW MUCH OF THE FOLLOWING DO YOU CONSUME PER WEEK?

If you used to do this, write “past”.

Coffee (sugar? milk?) \_\_\_\_\_ Tea (sweet/un-sweet?) \_\_\_\_\_

Alcohol \_\_\_\_\_ Chocolate \_\_\_\_\_

Cigarettes \_\_\_\_\_ Laxatives \_\_\_\_\_

Diet Soda \_\_\_\_\_ Regular Soda \_\_\_\_\_

Chicken \_\_\_\_\_ Lunch Meat (cold cuts) \_\_\_\_\_

Red Meat \_\_\_\_\_ Pork \_\_\_\_\_

Milk \_\_\_\_\_ Peanuts \_\_\_\_\_

Artificial sweeteners \_\_\_\_\_ Recreational Drugs \_\_\_\_\_

How much water do you drink per day? \_\_\_\_\_

Do you drink Juices? If so, what types: \_\_\_\_\_

What types of hobbies/activities do you enjoy? \_\_\_\_\_

MAJOR LIFE CHANGES: (example: divorce, job loss, relocation, trauma/accidents, etc.)

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**CURRENT DIET INFORMATION**

Give some examples of *foods you eat currently*:

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Snacks \_\_\_\_\_

Dinner \_\_\_\_\_

Liquids \_\_\_\_\_

## INFORMED CONSENT FOR NUTRITIONAL COUNSELING

I hereby request and consent to Nutritional Counseling and other diagnostic procedures, including Ionic Foot Detoxification, Saliva Testing, or Nutritional Blood Testing (drawing complete off site) or physical therapy, on me (or on the patient named below, for whom I am legally responsible) by Dr. Bianca Kiovanni and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic. I have had an opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of nutritional counseling and other procedures. I understand that results are not guaranteed. I understand and am informed that, nutritional counseling is not intended to treat or cure any disease. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

**Probability of risks occurring:** The risks of complications due to nutritional counseling have been described as “rare.

**Other treatment options, which could be considered,** may include the following:

- ***Over-the-counter analgesics and/or prescription medication.*** The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- ***Medical care,*** typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- ***Hospitalization*** in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- ***Surgery*** in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

**Risks of remaining untreated:** Delay of treatment allows for a possible increase in severity and other degenerative changes. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult. I have read, or have had read to me, the above consent. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I have had the opportunity to discuss with the Doctor the nature and purpose of nutritional counseling and other procedures.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

**PATIENT NAME:** \_\_\_\_\_

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

To be completed by patient’s Parent/Legal Guardian if the patient is under legal guardianship or minor

**SIGNATURE OF PARENT/GUARDIAN:** \_\_\_\_\_

**RELATIONSHIP TO PATIENT:** \_\_\_\_\_

# Office Financial Policy

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325 Hammond Drive, Suite 201  
Atlanta, GA 30328  
(404)-256-0114

## RESPONSIBILITY OF BILL

I, \_\_\_\_\_, (referred to hereafter as "the undersigned") agree and understand that payment for any treatment/therapy/massage is due at the time of service, unless previous arrangements have been made. The undersigned hereby accepts full financial responsibility for charges and services rendered. I also agree that this obligation shall exist regardless of private contractual agreement between the undersigned and any insurance carrier, attorney, or third party not signing this agreement. Financial responsibility will also include charges for services not covered by insurance or for which payment is denied through any utilization review or pre-certification procedures. I also understand that if I suspend or terminate my care or treatment, the fees for services already rendered to me will be immediately due and payable. In the event of my payment default I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required for collection. I understand that this policy applies if I am signing for a minor and/or dependent.

## INSURANCE

If I have insurance all deductibles and co-payments are expected at the time of service or by an office approved, signed payment plan. (A "deductible" is a specific dollar amount that your health insurance company requires that you pay out-of-pocket each year before your health insurance plan begins to make payments to any doctor for your healthcare claims.) If I do not have health insurance, I understand payment is due at the time of service, or I have the option of creating an approved, affordable payment plan.

## RETURN CHECK POLICY

Each check that is returned to the office for insufficient funds will automatically be subject to a \$25.00 return check fee. Future payments must be made in guaranteed funds (cash, money order, debit card) and checks may not be accepted for a minimum period of six months.

## CANCELLED OR MISSED APPOINTMENTS

I understand that a \$20.00 fee may be assessed at the Doctor's discretion for any prior scheduled appointment that I fail to attend without 24 hours advance notice to reschedule or cancel.

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I have read or have had read to me, the above Office Financial Policy. I have also had the opportunity to ask any questions about its content, and by signing below I agree to this policy.

**PATIENT NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

To be completed by patient's Parent/Legal Guardian if the patient is under legal guardianship or minor

**SIGNATURE OF PARENT/GUARDIAN:** \_\_\_\_\_

**RELATIONSHIP TO PATIENT:** \_\_\_\_\_