

# Ingels Family Health

## New Patient Intake Form

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

*Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If there is anything you wish to bring to our attention that is not asked on this form, please note it in the **Comments Section**. Thank you.*

<b>Name:</b>		<b>Social Security Number:</b>	
<b>Address:</b>		<b>City/State/Zip:</b>	
<b>Home Phone:</b>	<b>Work Phone (mom / dad):</b>	<b>Cell Phone (mom / dad):</b>	
<b>Date of Birth:</b>	<b>Age:</b>	<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Height:</b> <b>Weight:</b>
<b>Parents/Guardians Names:</b>		<b>Town of Birth:</b>	
<b>Insurance Company</b>		<b>Policy #</b>	
<b>Pediatrician:</b>	<b>Phone:</b>	<b>Please tell us how you found out about this office:</b>	
<b>Emergency Contact Name:</b>	<b>Phone:</b>		
<b>Please list email if you would like to be notified of appointments, lab results, etc. :</b>			

**Diagnosis (Please circle):**

Autism      PDD-NOS      Asperger's      ADHD/ADD      Speech Delay      Dyspraxia

Other: \_\_\_\_\_

**Date you first noticed symptoms:** \_\_\_\_\_ **Date of diagnosis:** \_\_\_\_\_

**What symptoms did you first notice?** \_\_\_\_\_

**What symptoms are most bothersome today?** \_\_\_\_\_

**Services Received with dates (please circle):**

ABA \_\_\_\_\_ Speech Therapy \_\_\_\_\_ OT \_\_\_\_\_

PT \_\_\_\_\_ Sensory Integration \_\_\_\_\_ Other: \_\_\_\_\_

**Please list other healthcare providers you are working with:**

- 1. \_\_\_\_\_ Phone: \_\_\_\_\_
- 2. \_\_\_\_\_ Phone: \_\_\_\_\_
- 3. \_\_\_\_\_ Phone: \_\_\_\_\_

**Medications:** Please list all prescription and over-the-counter medications taken in past 2 years.

Name	Dose	Current	Date Discontinued	Adverse Reactions

**Drug Allergies** \_\_\_\_\_

**Supplements:** Please list all vitamins, minerals, herbs and other supplements taken in past 2 years.

Name	Dose	Current	Date Discontinued	Adverse Reactions

**Allergies:** Foods \_\_\_\_\_ Dust Mold Trees Grasses Weeds Others \_\_\_\_\_

**Hospitalizations and Traumas:** Please include surgeries, auto accidents, etc.

Type	Date	Complications

**Diet History:**

**Appetite:** Good Fair Poor

**Dietary Restrictions:** GFCF SCD Low Oxalate Body Ecology Others: \_\_\_\_\_

**Favorite foods:** \_\_\_\_\_ **Least Favorite Foods:** \_\_\_\_\_

**Thirst:** Not thirsty Thirsty for cold drinks Thirsty for warm drinks Thirsty for room temp drinks

**Do any foods make symptoms worse?** \_\_\_\_\_

**How does he/she feel after eating?** Better Worse No change

**Comments:**

\_\_\_\_\_

**Lifestyle History:**

What time does your child go to bed? \_\_\_\_\_ What time do they wake up? \_\_\_\_\_

Does your child wake in the night? Yes No If yes, what is he/she doing when they wake? \_\_\_\_\_

Does your child have any of the following problems during sleep? Nightmares Night terrors Talking  
Walking Bedwetting Restlessness (tossing/turning) Perspiring Other \_\_\_\_\_

How is your child's energy? Good Fair Poor Low stamina

What is his/her best time of day? Morning Afternoon Evening Specific time? \_\_\_\_\_

What kind of play does your child prefer? Self-play Parallel play Interaction with others None

**Past Medical History:**

Please circle if you have received any of the following vaccines: MMR DPT Hepatitis B Chicken pox

Hib (Hemophilus influenzae) Polio HPV (Gardasil) Pneumococcus Hepatitis A Typhoid

Yellow fever Meningitis Flu (Influenza virus) Other \_\_\_\_\_

Adverse Reactions \_\_\_\_\_

**Have you ever had any of the following illnesses?**

Allergies	Y	N	Eye disorders	Y	N	Mental disorders	Y	N
Anemia	Y	N	Fibromyalgia	Y	N	Mononucleosis	Y	N
Asthma/Bronchitis	Y	N	Heart murmur	Y	N	MCS	Y	N
Bone or joint disorders	Y	N	Hepatitis	Y	N	Muscle disease	Y	N
Cancers, leukemia, lymphoma	Y	N	Herpes	Y	N	Neurological disease	Y	N
Celiac disease/Gluten intol.	Y	N	High blood pressure	Y	N	Psychiatric disease	Y	N
Chronic fatigue	Y	N	Hypoglycemia	Y	N	Sinus infections	Y	N
Crohn's disease	Y	N	IBS	Y	N	Skin problems (eczema)	Y	N
Depression	Y	N	Kidney/Bladder problems	Y	N	Thyroid disorders	Y	N
Diabetes	Y	N	Liver disease	Y	N	Other:	Y	N

**Family Medical History:**

Mother: Living: Age \_\_\_\_\_ Deceased: Age \_\_\_\_\_ Health Issues \_\_\_\_\_

Father: Living: Age \_\_\_\_\_ Deceased: Age \_\_\_\_\_ Health Issues \_\_\_\_\_

Siblings (Bro/Sis): Living: Age \_\_\_\_\_ Deceased: Age \_\_\_\_\_ Health Issues \_\_\_\_\_

Siblings (Bro/Sis): Living: Age \_\_\_\_\_ Deceased: Age \_\_\_\_\_ Health Issues \_\_\_\_\_

Siblings (Bro/Sis): Living: Age \_\_\_\_\_ Deceased: Age \_\_\_\_\_ Health Issues \_\_\_\_\_

Siblings (Bro/Sis): Living: Age \_\_\_\_\_ Deceased: Age \_\_\_\_\_ Health Issues \_\_\_\_\_

Maternal Grandmother: Living: Age \_\_\_\_\_ Deceased: Age \_\_\_\_\_ Health Issues \_\_\_\_\_

Maternal Grandfather: Living: Age \_\_\_\_\_ Deceased: Age \_\_\_\_\_ Health Issues \_\_\_\_\_

Paternal Grandmother: Living: Age \_\_\_\_\_ Deceased: Age \_\_\_\_\_ Health Issues \_\_\_\_\_

Paternal Grandfather: Living: Age \_\_\_\_\_ Deceased: Age \_\_\_\_\_ Health Issues \_\_\_\_\_

**HEAD & FACE**

- Headaches  
Location \_\_\_\_\_
- Throbbing / Burning/ Sharp / Ache
- Constant / Intermittent
- Dull / Severe
- Frequent / Irregular
- Worse with menstrual cycle
- Worse in Winter/Spring/Summer/Fall
- Worse in hot/cold weather
- Worse night time/daytime
- Aggravated by smells
- Migraines
- Dizziness
- Facial pain
- Poor memory
- Cloudy thinking
- Poor Concentration
- Confusion
- Other \_\_\_\_\_

**EYES**

- Poor vision / glasses
- Night blindness
- Blind field
- Spots in front of eyes
- Eye pain
- Eye strain
- Eyes dry/itchy
- Excessive tearing
- Sensitive to light
- Other \_\_\_\_\_

**EARS**

- Poor Hearing
- Ringing in ears
- Recurrent earaches/infections
- Eruption in/around ears
- Sensitive to noise
- Itchy ears
- Drainage from ears
- Other \_\_\_\_\_

**NOSE**

- Frequent colds
- Sinus congestion
- Sinusitis
- Nose bleeds
- Post nasal drip
- Nasal discharge
- Loss of smell
- Sensitive to smells
- Itchy nose
- Sneezing
- Other \_\_\_\_\_

**MOUTH**

- Gum sores/bleeding
- Dental decay
- Grinding teeth
- Canker sores
- Jaw clicking
- Unusual tastes
- Bad breath
- Other

**THROAT**

- Recurrent sore throat
- Hoarseness
- Difficulty swallowing
- Lump in throat
- Cough chronic/seasonal
- Itchy throat
- Other

**RESPIRATORY**

- Chronic cough  
Dry          Productive
- Coughing blood
- Asthma/wheezing
- Short of breath with exertion
- Short of breath without exertion
- Short of breath when lying down
- Phlegm
- Chronic bronchitis/pneumonia
- Difficulty breathing

**CARDIOVASCULAR**

- High blood pressure
- Low blood pressure
- Fainting
- Chest tightness
- Chest pain
- Heart palpitations
- Irregular heartbeat
- Rapid heartbeat
- Cold hands/feet
- Overall cold body temperature
- Overall warm body temperature
- Swelling of hands / ankles
- Other

**GASTROINTESTINAL**

- Excess thirst
- Never thirsty
- Excess appetite
- Never hungry
- Weight gain sudden/chronic
- Weight loss sudden/chronic

- Food cravings
- Food aversions
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Blood in stool
- Undigested food in stool
- Urgent bowel movements
- Hemorrhoids
- Belching / Gas
- Heartburn
- Abdominal pain Stomach/Intestines
- Abdominal bloating
- Other

**URINATION**

- Frequent
- Urgent
- Difficult
- Painful
- Scanty
- Blood in urine
- Incontinence
- Kidney stones
- Wake at night to void
- Other

**MUSCULOSKELETAL**

- Neck stiff/pain
- Shoulder stiff/pain
- Back ache/stiff/pain
- Elbow stiff/pain
- Hand/wrist stiff/pain
- Hip pain
- Knee stiff/pain
- Foot/ankle stiff/pain
- Muscle aches
- Muscle weakness
- Muscle cramps
- Stiff joints
- Swollen joints
- Arthritis
- Bursitis
- Other

**NEUROLOGICAL**

- Nervousness
- Tremors
- Convulsions
- Numbness/Tingling
- Nerve pain/Neuralgia
- Seizures
- Learning disabled
- Other

**SKIN and HAIR**

- Rashes  
Where? \_\_\_\_\_
- Itching
- Ulcerations
- Eczema  
Where? \_\_\_\_\_
- Hives
- Pimples
- Loss of hair
- Hair dry
- Hair oily
- Skin dry
- Skin oily
- Nails soft
- Nails brittle
- Excess sweat  
Where \_\_\_\_\_
- Rarely sweat
- Night sweat
- Flushing
- Bruise easily
- Other \_\_\_\_\_

**ENERGY**

- Sudden energy drop
- Fatigue on arising
- Fatigue after meals
- Fatigue without exertion
- Fatigue all the time
- Hyperactivity at night
- Hyperactivity during day
- Restlessness
- Lethargy
- Other \_\_\_\_\_

**EMOTION**

- Easily susceptible to stress
- Apathetic
- Mood swings
- Anxiety
- Panic attacks
- Bad temper
- Angry
- Irritable
- Manic
- Depressed
- Sad
- Pensive
- Difficulty making decisions
- Fearful
- Repress emotions
- Predominant emotion \_\_\_\_\_
- Other \_\_\_\_\_

**ENVIRONMENT**

- Pets: dog/cat/other \_\_\_\_\_
- Age of home \_\_\_\_\_
- Type of heat: oil/gas/electric
- Type of flooring carpet/wood/pergo/  
ceramic/linoleum/other
- Recent remodeling
- Basement finished/unfinished
- Water damage Yes No
- Exposure to pesticides(chemlawn)/  
herbicides
- Brand of cleaning products  
\_\_\_\_\_  
\_\_\_\_\_

**INFECTIONS**

- Lyme disease
- Babesia
- Bartonella
- Mycoplasma pneumoniae
- Chlamydia pneumoniae
- Candida
- Chronic Strep throat
- PANDAS
- Herpes simplex
- Varicella zoster (Shingles/Chicken  
pox)
- Epstein-Barr virus (mono)
- HIV
- CMV
- Anaplasma (Ehrlichiosis)
- Parvovirus B19
- Toxoplasma
- Giardia
- Worms
- Valley fever (Coccidioides)
- Rocky Mountain Spotted Fever
- Malaria
- Yellow fever
- Dengue fever
- Other \_\_\_\_\_

**SOCIAL**

- Interacts well with others
- Interacts poorly with others
- Engages mostly in self play
- Engages mostly in parallel play
- Engages in interactive play
- Tends to be a leader
- Tends to be a follower
- Likes quiet activities like reading
- Likes physical activities like sports
- Follows commands as directed
- Cannot follow commands
- Receptive language  
Good Fair Poor
- Expressive language  
Good Fair Poor

Comments (please tell us any other problems you would like to discuss):