



CHERYL LEUTHAEUSER, D.O
 4003 Broadview Rd.
 Richfield, OH 44286
www.integrativewellcare.com

Main 330-659-2320
 Cleveland 216-696-2320
 Toll Free 888-523-2320
drcheryl@integrativewellcare.com

PERSONAL INFORMATION (CHILD)

Note: Please bring a fairly recent picture of your child that we may keep plus a baby picture that we may look at and return.

Date Questionnaire Received / / Date of Initial Consultation / /

Above line is for office use only.

Child's Name: First Last Middle Initial

Parent(s) Name(s):

Address: Street City
 State Zip code Home Phone ()

Work Phone () Cell Phone ()

Email address Fax ()

Child's Age Birth Date: Month Day Year Child's Sex (Circle One) Female/Male

Social Security Number (optional)

Parent's Occupation(s)

Siblings: Name Sex (Circle One) Birth Date

	Male/Female	Month	Day	Year
	Male/Female	Month	Day	Year
	Male/Female	Month	Day	Year

HEALTH INSURANCE INFORMATION

Please note → We do not accept any health insurance. You are responsible for submitting your own claims.

Health Insurance ID/Group #

OTHER

Primary Care Physician Phone

City, State Fax

Your local Pharmacy Phone

City, State Fax

GENERAL

Referred by

Diagnoses or explanation given to you about your child. Date of diagnoses / /

Other problems to be addressed.



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PERSONAL INFORMATION (Continued)

Describe your child to me, including his/her history. Please be as detailed as possible.

When did you first notice your child's problem?

What did you first notice?

Was the onset of your child's problem sudden or gradual?

Was there any event or illness that you or others think brought on your child's symptoms?

Tell me your child's story.



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CHILD'S MEDICAL HISTORY

PRIMARY DOCTOR (S)

Name	Phone Numbers	City

**THERAPIST(S)
 Speech - Occupational - Physical - Other**

Name	Type of Therapist	Phone	City	Hours/Week

OTHER CARE-GIVERS

Name	Phone	City	Date of Evaluation

Specialist(s)

Naturopath(s)/Homeopath(s)

Nutritionist

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Other



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MEDICAL HISTORY (Continued)

Major surgeries – Please describe and give dates.

Surgery	Date(s)	Results

Major injuries – Please describe and give dates (broken bones, motor accidents, falls)

Injury	Date(s)	Results

Illnesses – Please list appropriate dates and any complications

Illness	Date(s)	Complications
Ear infections		
Sinus infections		
Bronchitis		
Pneumonia		
Thrush		
Chicken Pox		
Seizures		
Mono		
Other, Please list.		



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MEDICATIONS

Please bring your child's vaccine records to the appointment.

Previous supplements.

Current supplements.

Previous medications.

Current medications.

Please bring previous lab work to your child's appointment.

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PRENATAL HISTORY

Maternal age at delivery _____ years

Illnesses during pregnancy.

Medication(s) during pregnancy.

Other complications during pregnancy.

Complications during labor and delivery.

Mode of delivery (Circle one) C-Section/Vaginal? If C-Section, explain why.

If vaginal delivery, did you have forceps/vacuum?

Medication(s) during labor and delivery?

(Circle one) Full term/premature How many weeks? _____ weeks

Complications after delivery?

Medication(s) given to child during hospital stay?



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FAMILY HISTORY

List any allergies, major illnesses, genetic diseases or problems (such as digestive issues or mental health problems) for each family member of your child. **If any family members are deceased, please also list their age at death and cause.

Mother	
Father	
Siblings	
Maternal Grandparents	
Paternal Grandparents	
Others	

SOCIAL HISTORY

Who lives in the home with your child?

Parents (Circle one) married divorced separated

Are any children in your family adopted?

Pets in the house.

Caregivers besides parents.

List the people most important in your child's life.

Recent changes, losses, births, deaths, divorce, remarriage or moves.

Recent travel.

Child's response to these changes.

Is your child involved in any sports, music or other activities? Please describe.

How does your child interact with other children?

With adults.

What makes your child happy?

Sad?

Angry?

Stressed?

How do you as a parent deal with these emotions in your child?



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ENVIRONMENTAL HISTORY

Do you, your child, or any family members practice any relaxation/stress management techniques?																
LOCATION ___ City ___ Suburban ___ Wooded ___ Farm ___ Other _____																
WATER ___ City ___ Well If you have a purification system, please describe _____																
Type of HEAT ___ Electric ___ Gas ___ Oil ___ Other _____																
Do you live near ___ Power lines ___ Woods ___ Industrial areas ___ Water → Type (ocean, swamp, etc.) _____																
Does your home have a lot of ___ Dust ___ Mold ___ Down/Feather items (pillows, stuffed animals, etc.)																
Are there specific areas in your home that you suspect have issues? Please describe																
Describe your child's bedroom (Check appropriate response)																
Bedding: ___ Synthetic ___ Down ___ Feather ___ Mattress cover ___ Crib ___ Junior Bed ___ Adult Bed																
Flooring ___ Wall-to-Wall Carpet ___ Area rug ___ Wood ___ Glued down ___ Synthetic Pad																
Window Treatment ___ Shades ___ Blinds ___ Thin curtain ___ Thick curtain ___ Valence ___ Other, Please describe																
Other items in room including furniture, toys, stuffed animals?																
Flooring in other rooms:																
Child's bathroom?																
Living room?																
Family room?																
Is your child sensitive to or bothered by any of the following? Please check where appropriate and list specific products where possible.																
<table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">_____ Perfumes/Cosmetics</td> <td style="width: 33%;">_____ Cleaning Products</td> <td style="width: 33%;">_____ Mold</td> <td style="width: 33%;">_____ Paint</td> </tr> <tr> <td>_____ Pollens/Grasses</td> <td>_____ Soaps</td> <td>_____ Animals (dander)</td> <td></td> </tr> <tr> <td>_____ Detergents</td> <td>_____ Dust</td> <td>_____ Gasoline</td> <td></td> </tr> <tr> <td colspan="4">_____ Other, Please describe _____</td> </tr> </table>	_____ Perfumes/Cosmetics	_____ Cleaning Products	_____ Mold	_____ Paint	_____ Pollens/Grasses	_____ Soaps	_____ Animals (dander)		_____ Detergents	_____ Dust	_____ Gasoline		_____ Other, Please describe _____			
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_____ Pollens/Grasses	_____ Soaps	_____ Animals (dander)														
_____ Detergents	_____ Dust	_____ Gasoline														
_____ Other, Please describe _____																
Please list known allergies.																



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THERAPIES AND DIETS

Please indicate therapies and diets you have used and/or are using.

Now	Past	Diets	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments
		Gluten Free							
		Casein Free							
		Yeast Free							
		High Protein/Low Carb							
		Salicylate Free							
		Low Phenolics							
		IgG reactive food avoidance							
		Specific Carbohydrate Diet							
		Feingold							
		Low oxalate							
		Other							



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SIGNS AND SYMPTOMS

Please check any signs/symptoms your child may demonstrate and note duration and details if appropriate.

Description	Mild	Mod	Severe	Duration	Unique Details
Stimming (repetitive actions or movements)					
Head banging					
Aggressiveness (biting, kicking, biting others)					
Mood swings					
Irritability/tantrums					
Fears/anxieties					
Hyperactivity					
Inability to concentrate/focus					
Impulsive					
Seizures					
Poor coordination					
Sensitive to crowds					
Recurrent/chronic fever					
Flushing					
Difficulty falling to sleep					
Night waking					
Nightmares					
Bed wetting/soiling					
Headache					
Dark circles/puffiness under eyes					
Congestion					
Dripping nose					
Earaches					
Sore throats					
Cough					
Wheezing					
Canker sores					
Diarrhea					



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SIGNS AND SYMPTOMS (Continued)

Constipation					
Bloating					
Passing gas					
Belching					
Food craving					
Mucous/blood in stool					
Eczema					
Hives					
Acne					
Seborrhea (cradle cap)					
Sensitivity to insect bites					
Cracking/peeling hands					
Cracking/peeling fees					
Reflux					
Persistent colic					

Describe any other symptoms you would like me to know about your child.

List any other history, pertinent thoughts or questions that you want to address.
