Hirani Wellness Medical Center, Inc.
Karima Hirani MD, MPH

MEDICAL AND HEALTH HISTORY QUESTIONNAIRE
CHILD

- **Please complete this form prior to your visit. Bring it with you the day of your visit. Please do not mail it!**
- **This questionnaire is an important part of your visit. Accurate completion of this form will assure that you receive the best possible care in the time set aside for your visit.**
- **Please allow up to 60 minutes to complete this form. Please do not wait until the night before your visit.**

CONTACT INFORMATION

Home Phone	Mobile	Office	E-mail

CHILD'S INFORMATION

Name			Age	Sex	Birthdate	
Address			City		State	Zip
Height	Weight	Siblings and ages				
List those living in primary home (including pets)						
List those living in secondary home (including pets)						
Name and address of present physician(s)						
Who should we contact in case of emergency			Phone		Relationship	
Who may we thank for referring you			Travel time to office			

FINANCIAL AGREEMENT AND CONSENT

I claim full financial responsibility for all services rendered at Hirani Wellness. I understand that payment is required in full at the time of service. I certify the information provided in this questionnaire is correct to the best of my knowledge. I agree to notify Hirani Wellness of any changes with respect to the information provided in this questionnaire. I consent to medical evaluation and treatment by Dr. Hirani and the staff of Hirani Wellness. I have received a copy of Privacy Practices and consent to use and collection of personal and medical information described therein.

Signed **X** Date: Relationship to patient:

INSURANCE INFORMATION

Insurance company	
Address	
Phone	Group or policy number
Insured's name	

I hereby authorize the release of any medical information necessary in the processing of my claim. I also request payment to myself or to the party who provided care.

Signed **X** Date: Relationship to patient:

Name:_____

FATHER'S INFORMATION

Name			Age	Birthdate	Place of birth:	
Address			City		State	Zip
Home Phone	Mobile	Office		E-mail		
Profession	Current Health Problems					
Past Health Problems						
Hospitalizations						

❑ Depression ❑ Anxiety ❑ Psychotropic Medications ❑
❑ Psychosis ❑ Personality Disorder ❑ Mental or Emotional Illness ❑ Alcholism in father's family
❑ Bipolar ❑ Learning Disabilities ❑ Obsessive Compulsive Disorder ❑ Addition in father's family

Other comments:

MOTHER'S INFORMATION

Name			Age	Birthdate	Place of birth:	
Address			City		State	Zip
Home Phone	Mobile	Office		E-mail		
Profession	Current Health Problems					
Past Health Problems						
Hospitalizations						
Ever had a bad reaction to any medicine or nutrient?						
❑ Rh NEG?	❑ Amalgam fillings?	How many?	When placed?			

❑ Depression ❑ Anxiety ❑ Psychotropic Medications ❑
❑ Psychosis ❑ Personality Disorder ❑ Mental or Emotional Illness ❑ Alcholism in mother's family
❑ Bipolar ❑ Learning Disabilities ❑ Obsessive Compulsive Disorder ❑ Addition in mother's family

Other comments:

Name:_____

FAMILY HISTORY. Any history of dyslexia, autism, autoimmune disorder, ADHD, Down's, Alzheimer's or mental retardation in any relative on either side of family? Please describe in detail.

CHILD BIRTH HISTORY

Place of birth?	❑ C-Section	❑ Vaginal - Difficulty of labor?	
Condition at birth?	AGPAR score:	Weight?	Age at delivery?
Complications during pregnancy or delivery?			
Age at 1st vaccination?	What kind?	Reaction?	
Amalgams placed during pregnancy or breast feeding?	❑ Bottle fed	❑ Breast fed – How long?	
Injuries?	at what age?		
Fevers?	at what age?		
Infections?	at what age?		

CHILDHOOD ILLNESSES

❑ Colic	❑ Allergies	❑ Rheumatic fever	❑ German measles
❑ Eczema	❑ Bronchitis	❑ Recurrent colds	❑ Bedwetting
❑ Asthma	❑ Pneumonia	❑ Ear infections	❑ Tonsillectomy
❑ Polio	❑ Meningitis	❑ Thrush	❑ Persistent diaper rashes
❑ Learning disability	❑ Hyperactivity	❑ Surgery or ear tubes	❑ Other:

Other comments:

ANTIBIOTICS

Has your child ever been on frequent or prolonged antibiotic therapy such as Erythromycin, Penicillin, Tetracycline, Sulfa drugs, Flagyl, etc.?

IMMUNIZATIONS - Specify when, if known, and adverse reactions or changes in behavior:

Smallpox	Tetanus
Polio	Flu
Mumps	Measles
Pneumonia	Diphtheria
Pertussis	
Comments:	

Name:_____

SIEZURES Age of onset, type, accompanied by fever, timing re illnesses, injuries, vaccinations:

PRESCRIBED MEDICATIONS

Name of drug, dose and times
Present:

Past:

HOSPITALIZATIONS

List major hospitalizations. Please give dates, locations, diagnoses, lengths of hospital stays, and surgeries.

ALLERGIES TO MEDICATIONS AND NUTRIENTS

Name of drug or nutrient and type of reaction

OTHER ALLERGIES AND SENSITIVITIES

Foods, Pollens, Animals, Chemicals, etc.

HAS YOUR CHILD HAD A DISORDER SINCE BIRTH? OR LATER ONSET? Please describe the development of the problem

TOILET AND STOOL PATTERNS

Please describe color, frequency, consistency and odor

SLEEP PATTERNS

Current: ❑ Restful ❑ Restless ❑ Nightmares

Past: ❑ Restful ❑ Restless ❑ Nightmares

Name:_____

TRAVEL

Has your child ever traveled out of the country?	Had traveler's diarrhea?
Been treated for parasites?	Been tested for intestinal parasites?

PREVIOUS LAB WORK

❑ Organic Acids	❑ Stool Analysis	❑ Urinary Peptides
❑ Immune Function Test	❑ Fatty Acid Analysis	❑ Heavy Metal Studies
❑ Amino Acids	❑ Vitamin and Mineral Levels	❑ Hair Analysis
❑ 24 Hour EEG	❑ neuroSPECT	❑

Other Comments:

PLEASE BRING PREVIOUS LAB RESULTS

DO YOU HAVE A PERSONAL OPINION WHY YOUR CHILD IS DEVELOPMENTALLY DELAYED?

PLEASE GIVE ANY OTHER INFORMATION THAT WOULD BE HELPFUL IN EVALUATING YOUR CHILD

Name:_____

PLEASE DESCRIBE GENERAL DEVELOPMENT				
Any history of physical or sexual abuse?				
❑ Amalgam fillings?	How many?	When placed?		
Age walking began?	Age speech began?	Age started daycare?		
Chromosomal studies:	EEG:	MRI:		
Academic performance?				
Learning disorders and delays?				
Disruptive and anti-social behavior in public?				
Has your child been given any diagnosis or need special schooling?				
Teacher comments or reactions?				
Describe general personality?				
❑ Mood swings	❑ Temper tantrums	❑ Inconsolable crying spells	❑ Hyperactive	❑ Hypoactive
❑ Makes friends easy	❑ Keeps friends:	❑ Right handed	❑ Left handed	
Relation to adults?				
Relation to other children?				
Relation to animals?				
Closest personal bond?				
Imagination pattern?				
Imaginary friends?				
Motor development?				
Eye contact?				
Affection?	Sense of humor?			
Alertness?				
Favorite activities?				
Repetitiousness?				
Favorite object?	Favorite activities?			
Fear of dark, water, strangers, etc. Unusual fears, phobias, or attachments:				
Reaction to change?				
Self-sufficiency?				

Name:_____

DIET SURVEY

Please take the time to answer these questions specifically and concisely.

Specify what foods and beverages your child normally consumes during a typical day (Please be specific):		
	Weekdays	**Weekends**
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		

Name:_____

EATING HABITS

	Frequent	Often	Occasional	Seldom	Never
Eat at restaurants	❑	❑	❑	❑	❑
Eat at fast food restaurants	❑	❑	❑	❑	❑
Pastries, cookies, candies, ice cream, sweets	❑	❑	❑	❑	❑
Add sugar to coffee, tea, cereals, other foods	❑	❑	❑	❑	❑
Colas or other soft drinks	❑	❑	❑	❑	❑
Instant breakfasts, pop tarts, doughnuts, muffins	❑	❑	❑	❑	❑
Cold breakfast cereals	❑	❑	❑	❑	❑
Caffeine drinks (coffee, tea, cola, chocolate)	❑	❑	❑	❑	❑
Deep fried foods	❑	❑	❑	❑	❑
Margarine of any type	❑	❑	❑	❑	❑
Whole grain hot cereals (oatmeal, wheatena, etc)	❑	❑	❑	❑	❑
Meat (beef, veal, pork, ham, lamb, liver)	❑	❑	❑	❑	❑
Chicken or turkey (❑ regular ❑ free range)	❑	❑	❑	❑	❑
Fresh fish	❑	❑	❑	❑	❑
Processed meat (bologna, turkey roll, sausage, etc)	❑	❑	❑	❑	❑
Fresh raw fruit	❑	❑	❑	❑	❑
Salads	❑	❑	❑	❑	❑
Whole grains or whole grain breads	❑	❑	❑	❑	❑
White bread or white flour products	❑	❑	❑	❑	❑
Beans and legumes (lentil, kidney, chickpea, etc)	❑	❑	❑	❑	❑
Yogurt (❑ whole ❑ lowfat ❑ plain ❑ flavored)	❑	❑	❑	❑	❑
Milk (❑ whole ❑ lowfat ❑ skim)	❑	❑	❑	❑	❑
Cheese	❑	❑	❑	❑	❑
Eggs (❑ regular ❑ free range)	❑	❑	❑	❑	❑
Salt	❑	❑	❑	❑	❑
Herbs, fresh and dried, or spices	❑	❑	❑	❑	❑
Drink adequate water (❑ tap ❑ filtered ❑ bottled)	❑	❑	❑	❑	❑
Eat if excessively bored or depressed	❑	❑	❑	❑	❑
Swallow food before chewing well	❑	❑	❑	❑	❑
Hurried or rushed meals	❑	❑	❑	❑	❑
Adequate fiber or roughage in diet	❑	❑	❑	❑	❑
Artificial sweeteners (saccharin, Nutrasweet, etc)	❑	❑	❑	❑	❑
Shop at health food stores	❑	❑	❑	❑	❑
Number of glasses of water per day					

DIETS

	Very Good	Good	No response	Bad	Very Bad	Don't Know	Bad, then Good	Doing Now
Gluten Free	❑	❑	❑	❑	❑	❑	❑	❑
Casein Free	❑	❑	❑	❑	❑	❑	❑	❑
Yeast Free	❑	❑	❑	❑	❑	❑	❑	❑
High Protein / Low Carbohydrate	❑	❑	❑	❑	❑	❑	❑	❑
Feingold	❑	❑	❑	❑	❑	❑	❑	❑
Salicylate Free	❑	❑	❑	❑	❑	❑	❑	❑
Low Phenolics Diet	❑	❑	❑	❑	❑	❑	❑	❑
IgG reactive food avoidance diet	❑	❑	❑	❑	❑	❑	❑	❑
Other:	❑	❑	❑	❑	❑	❑	❑	❑
Other:	❑	❑	❑	❑	❑	❑	❑	❑
Other:	❑	❑	❑	❑	❑	❑	❑	❑

Name:_____

MEDICATION OR SUPPLEMENT

	Good	No response	Bad	Don't Know	Bad, then Good	Doing Now	Comments
Amino Acid Mix	❑	❑	❑	❑	❑	❑	
Deanol	❑	❑	❑	❑	❑	❑	
DMG	❑	❑	❑	❑	❑	❑	
TMG	❑	❑	❑	❑	❑	❑	
Glutamine	❑	❑	❑	❑	❑	❑	
SAMe	❑	❑	❑	❑	❑	❑	
Tryptophan	❑	❑	❑	❑	❑	❑	
Tyrosine	❑	❑	❑	❑	❑	❑	
Calcium	❑	❑	❑	❑	❑	❑	
Magnesium	❑	❑	❑	❑	❑	❑	
Manganese	❑	❑	❑	❑	❑	❑	
Selenium	❑	❑	❑	❑	❑	❑	
Zinc	❑	❑	❑	❑	❑	❑	
Human Growth Factor	❑	❑	❑	❑	❑	❑	
IV Immune Globulin	❑	❑	❑	❑	❑	❑	
Oral Immune Globulin	❑	❑	❑	❑	❑	❑	
Kutapressin	❑	❑	❑	❑	❑	❑	
Secretin IV	❑	❑	❑	❑	❑	❑	
Secretin transdermal	❑	❑	❑	❑	❑	❑	
Steroids	❑	❑	❑	❑	❑	❑	
TTFD	❑	❑	❑	❑	❑	❑	
DHA rich oils	❑	❑	❑	❑	❑	❑	
EPA rich oils	❑	❑	❑	❑	❑	❑	
Omega 6 rich oils	❑	❑	❑	❑	❑	❑	
Cod Liver Oil	❑	❑	❑	❑	❑	❑	
Flax Oil	❑	❑	❑	❑	❑	❑	
Alka Gold	❑	❑	❑	❑	❑	❑	
Carbatrol	❑	❑	❑	❑	❑	❑	
Tranxene	❑	❑	❑	❑	❑	❑	
Famvir	❑	❑	❑	❑	❑	❑	
Valtrex	❑	❑	❑	❑	❑	❑	
Zovirax	❑	❑	❑	❑	❑	❑	
Diflucan	❑	❑	❑	❑	❑	❑	
Nystatin	❑	❑	❑	❑	❑	❑	
B12 injections	❑	❑	❑	❑	❑	❑	
Glutathione IV	❑	❑	❑	❑	❑	❑	
Glutathione Oral	❑	❑	❑	❑	❑	❑	
Other:	❑	❑	❑	❑	❑	❑	
Other:	❑	❑	❑	❑	❑	❑	
Other:	❑	❑	❑	❑	❑	❑	
Other:	❑	❑	❑	❑	❑	❑	

Name:_____

NUTRIENT SUPPLEMENTS

If your child is taking vitamins, minerals or other supplements, please list them below. Be sure to indicate the dose in milligrams or units, the brand, and the number of times taken per day. Try to bring the label of any multiple or combination formulas.

Supplement	Brand	Dose	# times per day