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.		

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			
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?	
(Circe one) Full term/premature	How many weeks? ____________ weeks
Complications after delivery?	
Medication(s) given to child during hospital stay?	

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DIETARY/NUTRITIONAL HISTORY

Breast-fed? Yes/No (Circle one). If yes, how long? ________________

Bottle-fed? Brand of formula ________________ Begun at what age? _______ For how long? ___________

Foods? Begun at what age? ______________ First foods? ____

Whole milk? Yes/No (Circle one) If yes, begun at what age? _______________

Known allergies to food? (Please list)

Food CRAVINGS? (Please list)

FOODS MY CHILD EATS – Place a √ in the appropriate column

Food	Daily	3–5 Times/Week	1-3 Times/Week	Never	Used to Eat
Cookies					
Candy					
Sweet foods					
Caffeine (soda, tea, etc.)					
Milk – Specify Type (e.g. cow's, rice, soy, etc. and whole, 2%, 1% or skim)					
Cheese					
Ice Cream					
Salty Foods					
Meat					
Pasta					
Bread – Specify Type (White, Wheat, Other)					

Check the most appropriate description below of your child's diet.

_______ Mostly baby foods
_______ Mostly carbohydrates (bread, pasta, etc.)
_______ Mostly dairy (milk, cheese, etc.)
_______ Mostly meat
_______ Mostly vegetarian (vegetables, fruits, grains, etc.)
_______ Other, Describe:

Describe your child's stool pattern (frequency, color, odor, consistency)

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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

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.
______ Perfumes/Cosmetics ______ Cleaning Products ______ Mold ______ Paint ______ 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 feet					
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.