

STATE OF HEALTH HISTORY - MINOR

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	I like to be				
Name	called		Address _		Date
Phone	DOB		Age	Height	Weight
Parent or Guardian	oy/How did you hear a	near about us			
REASON FOR CARE (Write b	rief description)				
STRESSORS - Stresses from (daily living you are. o	or have b	een. exposed to.		
Check P (Past) and/or C (Current)		РС			TRESSORS IN LIFE RIGHT NOW
Large Physical (Accidents, trauma, surgery, electric sho difficult birth)					
Constant Physical (Repetit posture, limp)	tive Motion, poor				
Large Chemical: (Toxic Ex	posure)				
Constant Chemical: (Medicallergens, new home, pollution			_ Lis	ST TOP HEALTH ISSU	ES/GOALS
Large Mental/Emotional (F move/change in life, death of of danger, separation from lillness)	of relation, sense				
Constant Mental/Emotiona of sleep, negative attitude, s sustained concentration, rel- (parent/teacher/friends)	kipped meals,				
HABITS THAT EITHER CREA	TE EASE OR MORE	STRES	S IN YOUR BOD	Y	
Ease		rk "x" o	n line where y	ou are	StressDrink sodas / juice
Eat whole foods (fruits, veg, grain, meats),olive oil / butter, balanced diet					Eat refined/processed foods (crackers, sweets, canned),fried foods/ hydrolyzed fat, same foods a lot
Exercise / Play outside Stretch Wear supportive shoes					Sedentary / Play video games - TV Stay in same position for long time Wear cheap shoes with little support
Sleep thru night / sleep on					Hard to get to sleep, get up frequently
good bed D o what you enjoy					Do what you have to
Quality time w/ family/friend					Always involved with activities
B - 20					Negative thoughts / generally unhappy



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SYMPTOMS – Check if you are experiencing currently (C), or have experienced in the past (P).

Symptom	Р	С	Symptom	Р	С	Symptom	Р	С	Symptom	Р	С
Frequent infections			ADD/ADDH			Indigestion			Autism		
Allergies			Get up during night			Food sensitivities			Accident prone		
Fatigue			Irritated by bright light			Rash/itching			Joint swelling/pain		
Dizziness			Headaches			Anemia			Bone Pain		
Diabetes			Other brain issues			Hepatitis			Shin splints		
Eye/visual problems			Difficulty chewing/TMJ			Jaundice			Groin pulls		
Difficulty hearing			Mind "races"			Nausea/vomiting			Hip pain		
Ringing in ears			Difficulty balancing			Abdominal pain			Knee problems		
Nose bleeds			Numbness/tingling			Constipation			Foot problems		
Ear Infections			Muscle stiffness/pain			Change in bowel habits			Low back Pain		
Tubes in Ears			Muscle weakness			Change in appetite			Falls		
Sinus irritation			Difficulty breathing			Urinary			Shoulder/Arm/Hand		
						urgency/hesitancy/pain					
Hoarseness			Persistent cough			Flank/side pain			Suppressed Immune System		
Difficulty swallowing			Wheezing/asthma			Pelvic pain			Weight loss		
Easily irritated/difficulty focusing			Pulmonary issues			Yeast infections			Change in nails or skin		
Anxious or Depressed			Shortness of breath			Auto immune condition			Loss of flexibility		
Difficulty relaxing			Blood clotting issues			Strep infections			Pain in shoulder/neck		
List accidents, fall	s, fra	cture	es, sprains, strains	List	t hos	pitalizations/surgerie	s	List	t medications/ suppl	emen	ts

List accidents, falls, fractures, sprains, strains	List hospitalizations/surgeries	List medications/ supplements
Anything you would like to add?		
D-Ja Mataa.		
Dr's Notes:		