

KIDS Intake Questionnaire							
All questions contained in the questionnaire are strictly confidential and will become part of your medical record.							
Name (Last, First, M.I.):				Today's Date:			
Surgeries (what & when)				Hospitalizations (what & when)			
Girls Only							
Last Menstrual Cycle							
Family History							
Relative:		Diseases (with age of onset):				If deceased (list age & cause):	
Mother:							
Father:							
Siblings:							
Screening							
Recent Illness Y/N, date		Please list any history of STDs:					
Bleeding/ Blood clotting disorders?		Developmental delays/autism/ ADHD		Last thyroid Ultrasound (and results):			
Other tests:							



Allergies (include medications, supplements, food and substances)	
Allergen	Reaction

[illegible]

List Current Doctors or Health Care Providers	

Current Health Complaints	
#1	
#2	
#3	

Current Symptoms (please check yes or no)	
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Diarrhea: yes ☐ no ☐

Constipation: yes ☐ no ☐

Brittle Hair/Nails: yes ☐ no ☐

Fatigue: yes ☐ no ☐

Asthma: yes ☐ no ☐

Breathing prob: yes ☐ no ☐

Irritability: yes ☐ no ☐

Snoring: yes ☐ no ☐

Weight Gain/Loss: yes ☐ no ☐

Anxiety/Depress: yes ☐ no ☐

Headaches: yes ☐ no ☐

Vision problems: yes ☐ no ☐

Exercise yes ☐ no ☐

intolerance:

Hypoglycemic: yes ☐ no ☐

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How did you hear about Roots Medical? _____

I testify that the information above is the truth to the best of my knowledge.

Patient's Signature: _____ Date: _____

Patient's Guardians Signature: _____ Date: _____