PURSUING HEALTH

VIBRANT KIDS

PEDIATRICS

PRELIMINARY QUESTIONNAIRE FOR A PROSPECTIVE CONSULTATIVE PEDIATRIC PATIENT

Prospective Consultative Patient Questionnaire

We ask that you fill out this brief questionnaire before you schedule an appointment with our office. The purpose of this questionnaire is to determine if there is a good fit between your needs and our practice, and to determine starting points from which to prepare more detailed intake materials.

If after reviewing your responses on this questionnaire we determine our practice is likely to be able to help the patient you describe here, we will contact you to schedule the initial consultative appointment, and also send you a detailed historical questionnaire to complete before that appointment. Otherwise, we will provide you with referrals, if possible, to other practitioners.

Please understand that the completion of this brief questionnaire and a provider's reviewing it prior to the initial face-to-face appointment does not establish a doctor-patient relationship. If the patient has a severe or potentially life-threatening physical or emotional situation(s) arise while awaiting an appointment with our practice, you should seek medical care from a hospital emergency department or from the patient's primary care physician. Do not contact our office as we will not be able to provide any advice or care until that first face-to-face appointment.

Demographics

Patient

_____ _____ / _____ / _____

Patient's name Date of birth

_____ _____ lb _____ ft _____ in

Gender Weight Height

Mailing Address

_____

street 1

_____

street 2

_____ _____, _____

city state zip code

Prospective Consultative Patient Questionnaire

Vibrant Kids Pediatrics

Parent / Legal Guardian #1

_____ _____ / _____ / _____

Parent/guardian name Date of birth

_____ _____

phone number email

Relationship to patient: _____

Parent / Legal Guardian #2

_____ _____ / _____ / _____

Parent/guardian name Date of birth

_____ _____

phone number email

Relationship to patient: _____

If the patient is a minor or has a legal guardian, with whom does the patient live?

_____

If the parents/legal guardians listed above are *not* married, who has legal custody of the patient?

_____

Do *both* parents/legal guardians listed above have medical decision-making authority for the patient?

□ Yes □ No

If no, explain: _____

_____

Are *both* parents/legal guardians listed above supportive of alternate/integrative medical treatments?

□ Yes □ No

If no, explain: _____

_____

Are *both* parents/legal guardians listed above willing to either attend the first appointment or one attend and the other participate by phone or video call for at least 15-20 minutes during the initial visit?

□ Yes □ No

If no, explain: _____

_____

Referred by: _____

1. Concisely, what do you hope to achieve overall from your treatment in this practice?

2. Chief Complaint/Concerns

a. Please list and briefly describe the patient's top 3-5 concerns/symptoms/challenges in order of priority.

1)

2)

3)

4)

5)

b. Are there any specific types of treatments that you hope to incorporate in the patient's treatment?

c. Please list and briefly describe any integrative/holistic approaches that you already use to help the patient, e.g. herbal therapies, homeopathy, etc.

3. Readiness Assessment

Please rate by choosing on a scale from 5 (very willing) to 1 (not willing).

a. In order to achieve your health goals for the patient, how willing are you to:

i. Improve/change the patient's diet and water intake? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

ii. Give nutritional supplements to the patient 2-3 times per day? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

iii. Support the patient's lifestyle changes, e.g. sleep, exercise, relaxation? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

iv. Do lab testing, e.g. collecting urine and/or stool, blood draw? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

b. How willing are those closest to you to support/assist/help you make changes?
☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

c. Would anyone close to you be an obstacle to you as the patient gets well? ☐ Yes ☐ No

d. How certain/confident are you in your ability to make changes in the patient's diet, water consumption, exercise, supplements and lifestyle? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

e. If you are not very confident in your ability to make necessary changes or to get the help you need to make changes, what obstacles do you foresee?

_____

_____

4. Does the patient have a known or suspected genetic or chromosomal disorder, such as Downs Syndrome?

☐ Yes ☐ No

If yes, please indicate the condition (do not include genetic SNPs such as CBS, MTHFR or COMT variants):

_____

_____

5. Has the patient been diagnosed with a neurological condition other than a seizure disorder?

☐ Yes ☐ No

If yes, please specify the condition(s): _____

_____

6. Has the patient had any of the following recently?

Indicate R for recent (in the last 2 months) or P for past (more than 2 months) or both.

a. Thoughts of harming himself/herself ☐ No ☐ R ☐ P

b. Suicide attempts ☐ No ☐ R ☐ P

c. Thoughts of harming others ☐ No ☐ R ☐ P

d. Self-injurious behaviors (cutting, head-banging, etc.) ☐ No ☐ R ☐ P

e. Destructive behavior towards things or environments ☐ No ☐ R ☐ P

f. Aggressive behavior toward people or animals ☐ No ☐ R ☐ P

g. Alcohol abuse or dependence ☐ No ☐ R ☐ P

h. Recreational drug use ☐ No ☐ R ☐ P

i. Psychosis ☐ No ☐ R ☐ P

j. Periods of mania ☐ No ☐ R ☐ P

k. Eating disorder (purging, laxatives, etc.) ☐ No ☐ R ☐ P

If you marked recent or past to any of the issues above, please comment further below. Include dates the patient experienced symptoms and/or received treatments, and also indicate if the patient is currently under the care of a psychologist or psychiatrist.

_____

_____

_____

_____

_____

If not under the care of a psychologist or psychiatrist, please explain why: _____

_____

_____

7. Language

Do you speak English? ☐ Yes ☐ No

If no, will you have an interpreter available for all consultations and phone or video calls? ☐ Yes ☐ No

If the patient or family does not speak English, you will be required to bring a medical translator to all appointments.

Mail the completed questionnaire to:

Vibrant Kids Pediatrics
10 Market Square Way, Suite 100
Newnan, GA 30265