

PURSUING HEALTH

VIBRANT KIDS

PEDIATRICS

PRELIMINARY QUESTIONNAIRE FOR A PROSPECTIVE PLATELET THERAPY PATIENT

Platelet Therapy Patient Questionnaire

We ask that you fill out this brief questionnaire before scheduling your initial regenerative platelet therapy evaluation with our office. When reviewed by our physician, we will contact you to schedule the evaluation.

Demographics

Patient

Patient's name

_____/_____/_____
Date of birth

Gender

Weight

lb

Height

ft

in

Mailing Address

street 1

street 2

city

state

zip code

Parent / Legal Guardian #1

Parent/guardian name

_____/_____/_____
Date of birth

phone number

email

Relationship to patient: _____



Platelet Therapy Patient Questionnaire

Vibrant Kids Pediatrics

Parent / Legal Guardian #2

Parent/guardian name

_____/_____/_____
Date of birth

phone number

email

Relationship to patient: _____

Current Medical History

Functional provider and/or referring provider: _____

Current diagnosis: _____

Current medications & supplements: _____

Special concerns: _____

Therapy:

OT PT Speech ABA

Other: _____

Prior labs: _____



Platelet Therapy Patient Questionnaire

Vibrant Kids Pediatrics

Birth History

Term? Yes No

Weeks: _____

Pregnancy complications? Yes No

If yes, please describe: _____

Vaccines (mom): Flu Tdap

Breast or bottle fed? Breast Bottle

Special formula or mom on special diet? _____

Jaundice? Yes No

Other problems? _____

Other medical history: _____

Motor Skills

Sat: _____ Crawled: _____

Walked: _____ Language: _____

Any regressions? _____



Platelet Therapy Patient Questionnaire

Vibrant Kids Pediatrics

Vaccines

Up to date? Yes No

Any reactions? Yes No

If yes, please describe: _____

Sleep

Easy to fall asleep Hard to go to sleep Difficulty staying asleep

Other: _____

Diet

Gluten free Dairy free Dye free

Other: _____

BMs

Regular Constipation Diarrhea

Other: _____

Social History

Lives with both parents Single parent Foster care

Siblings Pets

Other: _____

Family history: _____

Additional concerns: _____



Platelet Therapy Patient Questionnaire

Vibrant Kids Pediatrics

Environmental History

Home: Urban Suburban Rural

Water supply: City Well Filtered Other: _____

Heat: Electric Gas Other: _____

Mold exposure? Yes No

If yes, please describe: _____

Tick exposure? Yes No

If yes, please describe: _____

