## Patient Contact Information

Current Date ____________ Patient Name ________________________________________

DOB ___________________ Gender of patient: M F

Home Address: ______________________________________________________________
STREET

______________________________________________________________________
CITY ST ZIP

Home Phone ( ) ________________________ Fax ( ) ________________________

Cell phone(s): Mom ( ) _________________ Dad ( ) ________________________

Email _____________________________________________________________________

Who lives in the house? ____________________________________________________

Who referred you? _________________________________________________________

## Parent or Legal Guardian Information

Marital Status: MARRIED / DIVORCED / OTHER

Mother's Legal Name ___________________ Father's Legal Name _________________

Mother's DOB _________________________ Father's DOB _______________________

Mother's Occupation ____________________ Father's Occupation _________________

Mother's Employer ______________________ Father's Employer __________________

Phone # ______________________________ Phone # ___________________________

Emergency contact (*other than parent*):_________________________________________

## Pharmacy Information

Name of preferred regular pharmacy ___________________________________________

Phone # ______________________________ Fax # ______________________________

Name of compounding pharmacy _______________________________________________

Phone # ______________________________ Fax # ______________________________



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## Initial Interview Form

**Appointment Date** ____________ **Patient's Age** _____**Height** ______**Weight** _____

**Medication Allergies:** __________________________________

**Genetic background (may check more than one):**
☐ **Caucasian** ( ☐ Northern European ☐ Mediterranean ☐ Ashkenazi Jewish**)**
☐ **African** ( ☐ African American ☐ West African ☐ East African )
☐ **Asian** ( ☐ East Asian ☐ South Asian/Indian ☐ Pacific Islander )
☐ **Hispanic** ☐ **Native American** ☐ **Other** ____________________

**Please list out your child's 3 greatest strengths:**

1. :

2. :

3. :

**Please list out your child's 3 greatest challenges (for example, speech, attention, etc):**

1. :

2. :

3. :

**What do you want to address during today's consult?**

**Does your child swallow pills or capsules?** Y N

| What medications (*not supplements*) are being taken: | |
|---|---|
| Drug: | Dose: |
| | |
| | |
| | |
| | |
| | |
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| What supplements are being taken? | |
|---|---|
| Supplement: | Dose: |
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**Dietary/Nutritional History:**

Breast fed? Y N If yes, for how long: ________ Formula? For how long? __________

Brand of formula? ____________________________ Begun at what age? ______________

Foods? Begun at what age? ________

First foods? (Please list)

Cow's milk? Y N

If yes, begun at what age? __________

Wheat products (bread, pasta etc.)? Y N

If yes, begun at what age? __________

Known allergies to food? (Please list including reaction)

Suspected sensitivities to foods? (Please list including reaction):

Food cravings? (Please list):

**Mark the most appropriate description below of your child's diet:**

____Mostly baby foods ____Mostly vegetarian (vegetables, fruits, grains, etc.) ____Mostly carbohydrates (bread, pasta, etc.) ____Mostly meat (beef, chicken, fish etc.)
____Mostly dairy (milk, cheese, etc.) ____Other, describe:

**Indicate the percentage of how your child's food is prepared (total should equal 100%):**

____ From scratch with whole natural foods
____ From scratch with prepared ingredients (canned/frozen/lunch meats/pasta with bottled sauce)
____ Heating up prepared meals (frozen pizza, frozen dinners, mac and cheese, canned soup etc.)
____ Meals prepared by strangers (fast food, restaurants, cafeteria etc.)

**Do you use a microwave oven to prepare food?** Y N



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**Food my child eats: (mark the appropriate column)**

| Food | Daily | 3-5 times per week | 1-3 times per week | Never or almost never | Used to eat in the past |
|---|---|---|---|---|---|
| Cookies | | | | | |
| Candy | | | | | |
| Sweet foods (desserts) | | | | | |
| Sweet drinks (soda, juices) | | | | | |
| Caffeine | | | | | |
| Artificial Sweeteners | | | | | |
| Chocolate | | | | | |
| Milk Whole | | | | | |
| 2% | | | | | |
| 1% | | | | | |
| Skim | | | | | |
| Cheese | | | | | |
| Ice Cream | | | | | |
| Fast Food | | | | | |
| Meat | | | | | |
| Pasta | | | | | |
| Bread White | | | | | |
| Wheat | | | | | |
| Fresh Veggies | | | | | |
| Fresh Fruit | | | | | |
| Fermented Foods (yogurt, kefir, pickles, kimchi etc.) | | | | | |

Please list the foods and beverages normally consumed by your child for three typical days

| DAY 1 |
| --- |
| **Breakfast:** |
| **Morning snack:** |
| **Lunch:** |
| **Afternoon snack:** |
| **Dinner:** |
| **Other:** |
| **DAY 2** |
| **Breakfast:** |
| **Morning snack:** |
| **Lunch:** |
| **Afternoon snack:** |
| **Dinner:** |
| **Other:** |
| **DAY 3** |
| **Breakfast:** |
| **Morning snack:** |
| **Lunch:** |
| **Afternoon snack:** |
| **Dinner:** |
| **Other:** |

Is your child Gluten and/or Casein Free? Y N

Do you feel your is child eating adequate quantities and varieties of food? Y N

Please describe your child's STOOL pattern (Examples: daily, foul, large, mushy, etc.):

## ***GESTATIONAL HISTORY:***

| Gestation History | | | |
|---|---|---|---|
| Mother's Age at Birth | | Father's Age at Birth | |
| Total Number of Pregnancies | | Number of Miscarriages | |
| Pregnancy Number for This Child | | Number of Preterm Pregnancies | |
| Infertility treatment if any | | | |
| IVF Treatment if any | | | |

| Vaccinations in mom just before or during pregnancy | | | |
|---|---|---|---|
| Vaccination | Brand or serial number, if known | Age of Gestation in Weeks | Side Effects |
| Tetanus toxoid | | | |
| MMR | | | |
| Hepatitis A | | | |
| Hepatitis B | | | |
| Influenza (flu) | | | |
| Other: | | | |
| Other: | | | |

**Mark the most appropriate description below of the mom's diet during pregnancy:**
____ Vegan (NO meat, dairy or eggs) ____Vegetarian (vegetables, fruits, grains, dairy, eggs etc.) ____ Mostly carbohydrates (bread, pasta, etc.) ____Mostly meat ______ Mostly Seafood
____ Other:

**Indicate how mom's food was prepared during pregnancy (total should equal 100%):**
____ From scratch with whole natural foods
____ From scratch with prepared ingredients (canned/frozen/lunch meats/pasta with bottled sauce)
____ Heating up prepared meals (frozen pizza, frozen dinners, mac and cheese, canned soup etc.)
____ Meals prepared by strangers (fast food, restaurants, cafeteria etc.)

**Was the mother on birth control pills when pregnant and if so what type?**

**If yes to above, then what type and at what week gestation was it discontinued?**

**How many alcoholic beverages per week were consumed during pregnancy?**

**How many packs of cigarettes were smoked per day while pregnant with the child?**

**Any dental work during pregnancy?**

**How many amalgams/fillings did mom have during pregnancy?**

**Any occupational exposure to mercury or other toxins?**

**Did mom receive a Rhogam injection during pregnancy?**

**Was there normal prenatal care when pregnant?**

**How many ultrasounds during pregnancy?**

**Did mom have an amniocentesis?**

| **Birth History** | |
|---|---|
| Number of weeks gestation | |
| Was labor induced? | |
| Birth Weight | |
| Birth Length | |
| Birth Head Circumference | |
| Vaginal or C-section? | |
| Epidural in mom? | |
| Apgar Scores? | |

## *Early Life History of Child (up to 1 year old)*

| Feeding of the baby: | | | |
|---|---|---|---|
| | Percentage of Feeds Per Day | Ages in months when fed in this manner | Brand of Bottle and/or Formula and solid food |
| Breast fed | | | |
| Breast Milk in Bottle | | | |
| Formula | | | |
| Formula | | | |
| Formula | | | |
| Solids | | | |
| Solids | | | |
| Solids | | | |

**Food or Formula Allergies: ____________________________________________**

**Cow or milk intolerance in the first year of life: No   Yes**

**Any special diet in the first year of life?**

**Any pica (eating or chewing non-food items)?**

| Please indicate all places of residence & approximately when residence was build | | | |
|---|---|---|---|
| Type of Residence | Year Built | Zip code or city | Ages in months |
| Apartment: | | | |
| Private Home: | | | |

**Mattress brand/type used for child:**

**Estimate the number of antibiotic courses given to child in the first 2 years of life:**

## ***Developmental History***

**Is child right or left handed?**

**Has your child lost any skills (regression)?**

| Immunizations | | | | |
|---|---|---|---|---|
| ***Immunizations*** | ***# of times immunized*** | ***Thimerosal Containing Yes/No/Unknown*** | ***Complications*** | ***Premedication for Vaccine*** |
| Hepatitis B | | | | |
| Inactivated polio vaccine | | | | |
| MMR | | | | |
| Influenza | | | | |
| Meningococcal | | | | |
| Rotavirus | | | | |
| Diphtheria, Tetanus, Pertussis | | | | |
| Pneumococcal | | | | |
| Varicella | | | | |
| Hepatitis A | | | | |
| Other: | | | | |

**Did you notice a problems after vaccination? Please describe.**

## ***Child's Medical Disorders***

| Psychiatric disorders: | | | |
|---|---|---|---|
| Psychiatric disorders | When diagnosed | Severity | Duration of medication |
| Other (please specify): | | | |
| | | | |



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| Allergic disorders and treatment | | | |
|---|---|---|---|
| Allergic disorders | When diagnosed | Severity | Duration |
| Asthma | | | |
| Allergies | | | |
| Allergic rhinitis | | | |
| Seasonal allergies | | | |
| Eczema | | | |
| Food allergies | | | |
| Others (please specify) | | | |

| Gastrointestinal disorders: | | | |
|---|---|---|---|
| Gastrointestinal disorders | When diagnosed | Severity | Duration of medication |
| Other (please specify): | | | |
| | | | |

**Please list any other disorders your child may have?**

| Please list all treatments for the above disorders | | | |
|---|---|---|---|
| Medication | Dose | Duration of Treatment | Side effects |
| | | | |
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| Infectious diseases: | | | |
|---|---|---|---|
| Infectious disease | Data of First Infection | Date of Last Infection | Duration of medication |
| Sore throat | | | |
| Strep throat | | | |
| Ear infections | | | |
| RSV | | | |
| Others: | | | |

| Please list all treatments for the above disorders, including treatments for each and every infection. | | | |
|---|---|---|---|
| Medication | Dose | Duration of Treatment | Side effects |
| | | | |
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| Surgical procedures: | | | |
|---|---|---|---|
| Tonsillectomy | Adenoidectomy | | Ear tube placement |
| Appendix | Circumcision | | Hernia |
| Other: | | | |
| Name of anesthesia during surgery | Type and dose | Surgical Procedure | Side effects |
| | | | |
| | | | |



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| Biomedical or Complementary Therapies and Treatment | | | | |
|---|---|---|---|---|
| Alternative Therapies and Treatments | | | | |
| Treatment | Dose | Duration | Positive Effects | Adverse Effects |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| Travel History of Child | | | |
|---|---|---|---|
| Place travelled | Medications/ vaccinations needed | Age at that time | Illness or Side effects of medication |
| | | | |
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## ***Family History***

| Mark all the sleep disorders in the child's biological family: | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Mom | Dad | Sibling | Mom's parents | Dad's parents | Mom's siblings | Dad's siblings | Maternal cousin | Paternal cousin |
| Other: | | | | | | | | | |
| | | | | | | | | | |

| Mark all the developmental disorders in the child's biological family: | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Mom | Dad | Sibling | Mom's parents | Dad's parents | Mom's siblings | Dad's siblings | Maternal cousin | Paternal cousin |
| Other | | | | | | | | | |

| Mark all the neurological disorders in the child's biological family: | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Mom | Dad | Sibling | Mom's parents | Dad's parents | Mom's siblings | Dad's siblings | Maternal cousin | Paternal cousin |
| Other | | | | | | | | | |

| Mark all the inflammatory disorders in the child's biological family: | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Mom | Dad | Sibling | Mom's parents | Dad's parents | Mom's siblings | Dad's siblings | Maternal cousin | Paternal cousin |
| Allergies | | | | | | | | | |
| Asthma | | | | | | | | | |
| Psoriasis | | | | | | | | | |
| Hashimoto's thyroiditis | | | | | | | | | |
| Lupus | | | | | | | | | |
| Rheumatoid arthritis | | | | | | | | | |
| Autoimmune disorder, other | | | | | | | | | |

| Mark all the psychiatric disorders in the child's biological family: | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Mom | Dad | Sibling | Mom's parents | Dad's parents | Mom's siblings | Dad's siblings | Maternal cousin | Paternal cousin |
| Other | | | | | | | | | |

| Mark all the gastrointestinal disorders in the child's biological family: | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Mom | Dad | Sibling | Mom's parents | Dad's parents | Mom's siblings | Dad's siblings | Maternal cousin | Paternal cousin |
| Other | | | | | | | | | |

| Mark all the other disorders in the child's biological family: | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Mom | Dad | Sibling | Mom's parents | Dad's parents | Mom's siblings | Dad's siblings | Maternal cousin | Paternal cousin |
| Other | | | | | | | | | |

***Please list anything else you may think is helpful for Dr. Nikogosian to know:***

# General Office Policies

***Please review carefully. Sign and date.***

- *Patient Responsibility:* You are encouraged to ask questions on any health-related topic and to take an active role in your health-care.
- *Confidentiality:* Information revealed during office visits is confidential. Your record and the information contained within it will not be disclosed to others unless you direct us to do so in writing. Exceptions to this confidentiality include disclosure of the intent to harm yourself or others and subpoena from specific government agencies (as outlined in the HIPAA Privacy Rule).
- *Treatment Plan:* Each treatment plan and/or procedure possesses both risks and benefits. You are encouraged to ask questions if you would like additional information. Although your plan will be thoroughly researched and customized to your individual personal goals and health status, no guarantees can be assured regarding the outcomes of treatment plan(s) or procedure(s).
- *Office Visits:* Office visits are billed at $200.00 per hour. The first office visit is $400.00 and is typically 2 hours long. This length may vary. If a longer visit is necessary, you will notified of this prior to your appointment. Subsequent follow-up visits are a minimum of 30 minutes. There is no refund for services provided. You may be eligible for out-of-network insurance reimbursement or tax deduction for medical services.
- *Insurance:* We do not accept any insurance. All fees are settled directly between patient and provider. At the patient's request, we will provide you with the necessary forms and diagnostic codes needed for you to submit an out-of-network claim to your insurance. Please note that we are are not Medicare providers and are opted out of the Medicare program. Our services can not be submitted to Medicare for reimbursement.
- *Payment:* We accept cash, money orders and most major credit cards. Checks are not accepted.
- *Cancellation policy:* When an appointment is scheduled, time is reserved especially for you and no one else. Since our appointments are much longer than standard office visits, cancellations are significant interruptions to the Clinic. Thus, a minimum of 3 days' notice is required for cancellations of new patient visits and 1 day notice for existing patients. There will be a 100% office visit charge for "no-shows" or late cancellations.

- *Specialty Laboratory Testing:* Our clinic frequently uses specialty testing. These are usually an out-of-pocket expense. Occasionally, there is some insurance coverage. We will guide you through identifying the costs associated with your testing.

- *Treatment Plan Questions:* We encourage patients to call or e-mail with questions regarding their treatment plan. If there is a need for longer discussion regarding new symptoms or new concerns, then we recommend you schedule an additional follow-up appointment. Questions that require longer than 5-minute responses fit this scenario. Additionally, if it has been longer than 8 weeks since your last appointment, schedule an appointment rather than email.

- *Emergencies and after-hours care:* The Clinic is not a primary care clinic - we offer consultative services only. **You must have a primary care doctor with whom you can consult in the event of an emergency or urgent problem.** If you notice an adverse effect from one of the components of your Clinic treatment plan, you should discontinue it then email or call the Clinic during normal business hours. If you have a serious health problem that requires immediate attention, you should call your other doctors(s), call 911, or have someone take you to the nearest hospital emergency room.

- Please email us at info@swfunctionalmedicine.com for any questions regarding this policy.

I agree to all terms and conditions of these General Office Policies.

Signature: Date:

______________________________________________________________

I agree to allow Armen E. Nikogosian, MD to use or to describe my anonymous medical history and laboratory data for educational purposes in lectures, blogs, case reports, and other publications that are communicated to other professionals, but may include members of the public. This medical history and laboratory data might include photographs and/or other images of parts of my body other than my face (nutrition/physical exam findings only). Armen E. Nikogosian, MD will never publish any information that uses my name or that identifies me as the source of any of the information, data, or images that it publishes. If you **do not** wish to participate, initial here:______