Abundant Health Holistic Center
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PEDIATRIC INTAKE FORM

Child's Name: _____ Today's Date: _____
Date of Birth: _____ Height: _____ Weight: _____ ❒ Male ❒ Female Child's Age: _____
Grade Level: _____ Referred by:_____
Name and relation of individual who is filling out this form: _____
How did you hear about us? ❒ Friends ❒Family ❒ Website ❒Newspaper Yellow Pages: ❒ Sprint ❒ AT&T (BellSouth)
❒ Presentation ❒ Magazine ❒ Radio Other _____

How do you hope your child will benefit from care with us? Check all that apply:
Improvement of: ❒ Physical symptoms ❒ Emotional/mental symptoms ❒ Overall improved quality of life
❒ In the ability to respond to stress Other: _____

Has your child experienced any of the following health, treatment or healing modalities?
❒ Chiropractic ❒ Homeopathy ❒ Herbs ❒Massage❒ Craniosacral Therapy ❒ Emotional therapy/psychotherapy
❒ Acupuncture ❒Nutritional Counseling Therapy ❒ Light ❒ Music ❒ Dance ❒ Sound ❒Aromatherapy ❒Ayurvedic Medicine ❒ Reiki/Energy work Other:_____
If so, please describe:
When you went _____ for how long _____
What diagnoses have you been given: _____
How would you describe your experience? _____
Was it effective? Why/Why Not? _____

Contacts (in order of preference)

Name and relation to child:_____
Phone: (hm) _____ (wk)_____(cell) _____ Email _____
Address:_____

Name and relation to child:_____
Phone: (hm) _____ (wk)_____(cell) _____ Email _____
Address:_____

Whom does the child live with?_____

Child's Other Health Care Providers

Provider's name:_____ Phone: _____
Address (if available):_____

Provider's name:_____ Phone: _____
Address (if available):_____

Health and Development

of biological Brothers: _____ Sisters: _____ Place in the birth sequence #: ____Blended family siblings _____
How was the child's health in the first year? ❒Excellent ❒Very Good ❒Good ❒Fair ❒Poor ❒Unknown
Now? ❒Excellent ❒Very Good ❒Good ❒Fair ❒Poor ❒Unknown Compared to one year ago, how would you rate your child's general health now? ❒Excellent ❒Very Good ❒Good ❒Fair ❒Poor ❒Unknown
At what age did the child first: Sit up _____Crawl _____ Walk _____ Talk _____ Begin teething? _____
Were there any difficulties associated with teething? _____Fontanelles closing _____

Health Concerns

Name: _____

Does your child have any known contagious diseases at this time? ❒ No ❒ Yes _____
Does your child have any known life-threatening allergies? ❒ No ❒ Yes: _____

Please rank current & ongoing health problems you desire treatment for by priority and complete the symptoms:
1. Primary health concern: ❒ Mild ❒ Moderate ❒ Severe _____
_____
At what age / Date did this condition/illness begin:_____
What do you think might have caused this condition? (life trauma, surgery, drug reactions)
_____
Time of day/night it came on _____ The Onset was ❒Sudden ❒Gradual ❒Getting worse

Interferes with ❒Sleep ❒School ❒Play Worst thing about it _____

What does the pain/symptom feel like? ❒ Sharp ❒Dull ❒Ache ❒Pressure ❒Shooting ❒Radiating ❒Pulsating
Other _____ Did Grief or shock precede it? ❒Yes ❒No
What makes it **worse**? □ Heat □ Cold □ Activity □ Rest □ Emotions □ Stress □ Environment □ Other _____
What makes it **better**? □ Heat □ Cold □ Activity □ Rest □ Emotions □ Stress □ Environment □ Other _____
When does it happen? _____ What does it look like? _____
Do any other symptoms occur immediately before, during or after? _____
Do they tend to occur or become worse □daily □weekly □alternate days □ yearly □new □full moon □Barometer changes
Other _____ What has improved this condition? _____
What other (possibly unrelated) events occurred around the time the condition began?_____
_____
What, if any, medications or supplements have been used to treat this condition and what was their effectiveness?
_____
Other health concerns- Please describe complete details and what makes it better or worse as above:
2. ❒ Mild ❒ Mod ❒ Severe_____
_____
3. ❒ Mild ❒ Mod ❒ Severe_____
_____
4. ❒ Mild ❒ Mod ❒ Severe_____
_____

Environment

Are there any pets in the home? ❒ Yes ❒No If yes, what type and how many? _____
How is the child's home heated? _____ Does anyone in the child's household smoke? ❒Yes ❒No
How would you describe the emotional climate of the child's home? _____
Are there any known environmental or chemical sensitivities (e.g., perfumes, detergents, odors, soaps, etc.)? ❒yes ❒no
Toxin Exposure Has the child ever lived near a refinery, polluted area or in a home with leaded paint? If so, what sort of pollution was s/he exposed to? _____
Has the child ever lived in a house that had new carpeting, paint, cabinets or any other refurbishing that seemed to affect their health at all? _____
Do you spray pesticides, herbicides or other chemicals around your home?_____

Mental /Emotions □Normal □ Problem □ Recent change in Emotion

Predominant Emotion: □ Joy □ Fear □ Anger □Anxiety/Worry □Sadness □Shock □Grief **Below:** Check all that apply:

Child is:	**Emotionally**	**Has had**	**Poor memory for:**	**Dwells on:**
□ Outgoing □Extrovert	□Happy □Irritable □Sad	□Panic attacks	□Words □ Places	□Past disagreements
□ Introvert □Restless	□Grieving □Joyless	□Depression	□Where going	□Illness □Misfortune
□ Ambitious □Driven	□Fearful □Angry	□Anxiety	□ Doing □People	□School □Friends
□ Jealous □Dreamer	□Indifferent □Loathe Life	□Bad Temper	□Train of thought	□Suicide □Death
□Suspicious □Timid	□Impulsive □Moody	□Phobias	□ Omit letters words	□Future Events

Better **W**orse □B □W Thunderstorms □B □W Consolation □B □W Alone □B □W Crowds □B □W Contradiction
□Nervous □Difficult concentration Where is stress held in body? _____ How do they relax?_____
How do they feel about school?_____ Home life? _____ Social life?_____

Generalities **Name:** _____

❒Right ❒Left Handed. ❒Ambidextrous Blood Type_____
Does the child tend to get sick the same season(s) year after year? ❒Yes ❒No Which one(s) _____
When ill or injured the side of the body most affected is: □Right □Left □Both □Right to Left □Left to Right □Don't Know
On injured/sick parts: □Better □Worse **Cold** □Better □Worse **Warm** □Better □Worse **Hot applications** □Don't know
Dislike: □ Tight Clothing □ Ties/Collars □ Belts Time Complaints usually come on_____ last until _____

Usual Body Temperature **_____F** Chronic Fever**?** □Low □Hi □ Alternates daily or weekly (Tidal Fever)
□Feels cold easily □Cold hands □Cold feet □Feels Hot easily □Hot hands □Hot feet □Alternate feeling hot and cold
Prefer Thermostat set @ _____ Why? _____ Wear most of the time a □Hat □Sweater □ Coat **Why**? _____
Sensitive to: □Cold □Hot □Humidity □Damp Conditions (House, Outdoors etc) □Dry climate □Light □Noise □ Sun
□ Drafts or Windy Conditions □ Uncovering □ Extreme temperature changes □ Weather changes (Barometer):
□Hot to Cold □AC to Summer Heat □Cool Nights w Hot Days □**Needs Fresh Air/Fan** □Closed room OK □It can be stuffy
Child is □Better □Worse **Outdoors** Why _____ **Other** _____
Environment / Travel Do they like to travel? □ Y □ N Where to _____
Child is □Better □Worse **Mountains** □Better □Worse **Seashore** □Better □Worse **Desert Travel Often?** □Yes □No

Dietary History

What is the approximate weight of your child? _____Has there been any recent weight gain or weight loss? □Yes □No
Please describe the child's eating habits (e.g., ❒good appetite, ❒picky eater, ❒Sneaking/hoarding food): _____
Are you satisfied with your child's diet the way that it is now? Why or why not? _____

Aversions/Dislikes: _____ Cravings whether eaten or not? _____
Comfort Foods _____ Food Allergies or Intolerances_____
Does the child have any dietary restrictions (vegetarian/vegan, religious, junk food etc.)?_____

Describe the child's usual diet on a typical day:
Breakfast: _____ Lunch: _____
Dinner: _____ Snacks: _____

Thirst □Increased □Decreased □Always Thirsty □Thirsty w No Desire to Drink □No Thirst. **Prefer** □Freq Small Sips
□ Large Sips □Gulps **Usually prefer drinks** □Hot □Warm □Room Temp □Cold □Iced or □Lots of Ice □ Chews Ice
Cups/Glasses: Water _____ Tea _____ Soda _____ Juices____ Coffee _____Prefers to drink _____

How many x day do they have: Meat _____ Veggies _____Dairy _____ (□milk □cheese □yogurt □ice cream) _____ Soy _____
Fish _____ Chicken _____ Caffeine _____ Artificial Sugar ____ Diet Soda ____ Sugar/Sweets ____Processed Foods _____
Soy Rice or Almond Milk ____ non-edible things like ❒dirt ❒blanket fuzz ❒chalk ❒glue other _____
Consumes ❒Sugar ❒Aspartame ❒Splenda ❒Diet Products ❒Fat free products ❒Stevia ❒Xylitol other _____
each of these tastes **in order of preference Craves:** Sweet ____Salty ____ Sour ____ Spicy ___Smoked___ Bitter ___
Avoids: Sweet ___Salty ___Sour __ Spicy ___Smoked ___ Bitter ____

How was the infant fed? ❒Breast fed ❒ Formula (❒milk ❒soy ❒rice ❒goat milk Other: _____
How long was the infant fed this way? _____ Any reactions to what they were being fed? _____
What foods were introduced before 6 months? (Please list the approximate month that each food was introduced, as well as any reactions that may have occurred). _____
What foods were introduced between 6 and 12 months? Were there any reactions to these foods? _____
_____
Did the child ever experience Colic? ❒Yes ❒No If yes, how severe was the colic? ❒Mild ❒Moderate ❒Severe

Currently; Frequency of bowel movements:_____ x/day or _____ x/week Any pain when passing stool? ❒Yes ❒No
Frequency of Urination _____x Day _____ Night Odor _____# of wet Diapers Day _____ Night _____
Do any of your child's bowel/Urine habits concern you? _____

Medical History

Name: _____

If you are unsure of any of the terminology please put a question mark beside the word.

Has the child ever experienced any of the following illnesses? ❒ Rubella ❒ Mumps ❒ Measles ❒ Chickenpox
❒ Scarlet Fever ❒ Polio ❒ Rheumatic Fever ❒ Strep throat ❒ Tonsilitis ❒ Meningitis ❒ Convulsions ❒ Seizures
❒Diabetes ❒Heart trouble ❒Cancer ❒Autism ❒ADD ❒Cerebral Palsy ❒ Enlarged adenoids Other:_____
times your child has had ❒Antibiotics _____ Steroids _____ Did/Does the child take probiotics? ❒Yes ❒No

Has the child ever experienced any of the following conditions?
❒Frequent colds ❒Ear infections- how many and how often? _____ Treated with _____
❒Diaper Rash ❒Cradle Cap ❒Cold sores ❒Thrush ❒Atopic Dermatitis ❒Eczema ❒Psoriases ❒Impetigo ❒Head lice
❒Asthma ❒Sinusitis ❒Bronchitis ❒Pneumonia ❒Croup ❒ Whooping Cough ❒Breathing Problems
❒Digestion problems ❒ Diarrhea ❒ Constipation ❒Colic ❒Urinary tract infection ❒Trouble with bedwetting
❒ High fevers ❒ Heat or cold intolerance ❒Thyroid problems
❒Appendicitis ❒Ruptures/hernias ❒Conjunctivitis (pink eye) ❒Chronic Bruising ❒Chronic nose bleeds
❒Orthopedic problem ❒Joint ❒ Backache ❒Arm ❒Leg ❒Neck ❒Walking problem ❒Muscle jerking ❒Scoliosis
❒Growing Pains ❒Neuritis ❒Neuralgia ❒ Fractures – where _____
❒Hyperactivity ❒Difficulty concentrating ❒Restlessness ❒Headaches ❒ Learning problems

Has the child received any or all of the following vaccinations? ❒ Current on western schedule? ❒Yes ❒No
❒ Hepatitis ❒ DPT ❒ MMR ❒ HIB ❒ Polio ❒ TB ❒ Flu ❒ Smallpox ❒ Pneumovaccine ❒ Chickenpox
❒ Other: _____Were there any adverse reactions to, or chronic illness, following vaccination? ❒Yes ❒No
Describe _____

Has the child ever been hospitalized? ❒Yes ❒No If yes, for what reason? _____
How long was the child in the hospital or under care? _____
_____

Please list any medications and/ or supplements the child is currently taking: _____
_____
_____

Has your child been to see the dentist? ❒yes ❒no Describe any dental work done: _____
Describe your child's daily oral hygiene practice: _____
Has your child had their vision checked? ❒yes ❒no Describe any vision problems: _____

Sleep Patterns

What time does the child usually go to bed? _____ usually wakes in the morning? _____
Does the child nap during the day? ❒Yes ❒No If yes, what time(s) do they nap? _____
Do they sleep straight through the night? ❒Yes ❒No Do they wake up looking/acting refreshed? ❒Yes ❒No
Do they have any recurring dreams or nightmares? ❒Yes ❒No How often do they have nightmares? _____
Doesn't remember dreams ❒Yes ❒No Dream Themes _____
Sleep position going to sleep _____ Waking up _____
Does the child have any problems associated with sleeping? ❒yes ❒no Bedwetting ❒yes ❒no
If yes, what kind of trouble do they have (e.g., trouble falling asleep, trouble waking up, etc.)? _____
_____
Perspires during sleep? ❒Yes ❒No Where _____Odor _____
Drools during sleep? ❒Yes ❒No How much _____
Any other issue? _____

Social Patterns **Name:** _____

Is the child in: □school □home school □daycare □home care □other: _____
How would you describe the child's behavior at daycare/school? _____
How would you describe the child's behavior at home? _____
Does this differ greatly from behavior at home? ❒Yes ❒No How _____
What makes your child angry? _____
Do they have any difficulties expressing anger? ❒Yes ❒No Other emotions? ❒Yes ❒No _____
Do they experience uncontrollable rage? ❒Yes ❒No explain _____
What makes your child sad? _____
Does he/she cry when sad? □Yes □No explain _____
Does he/she now have or ever had a problem with: ❒Biting❒Hitting❒Stealing ❒Fire setting ❒Temper tantrums ❒Lying
List any major experiences of grief or loss in your child's life _____
What fears does your child have? _____
How does your child react when afraid? _____
When sick what is the child's behavior? _____
What are the child's interests and favorite activities? _____
What, if any, recreational activities are the child involved in? _____
How would you describe the child's temperament/personality? _____
Is there anything that you would want to change? _____
Does the child exercise regularly? ❒Yes ❒No How much and how often do they exercise?
_____
How much television does the child watch? _____ hours a day/week. Computer _____ hours a day/week
How often does the child read (not for school), **or** How often does someone read to the child?
❒ Daily ❒ Several times a week ❒Weekly ❒ Less than weekly
Is your family life stressful? ❒Yes ❒No Is your child's life stressful? ❒Yes ❒No
If yes, please identify the factors that contribute to the stressful situation(s) and explain: _____
_____
Can you think of any other habit/activity that has a positive or negative effect on your child's health? ❒Yes ❒No
Explain: _____

Family History

Please indicate if a close relative (parent, grandparent, sibling) has had any of the following:
❒ I don't know the family medical history

Condition	Relative	Condition	Relative
❒ Allergies		❒ Seizures	
❒ Anemia		❒ Stroke	
❒ Arthritis		❒ Diabetes	
❒ Asthma		❒ Eczema	
❒ Birth Defects		❒ Glaucoma	
❒ Bleeding Disorder		❒ Kidney Disease	
❒ Cancer		❒ Psoriasis	
❒ Hay Fever		❒ Depression	
❒ High Blood Pressure		❒ Tuberculosis	
❒ Juvenile Arthritis		❒ Mental Illness	
❒ Other: _____	_____	❒ Other: _____	

Name: _____ Next to each individual listed below, please put an "L" for living or "D" for deceased, as well as present age or age at the time of death. Please indicate if the family member suffered from any diseases such as cancer, high blood pressure, heart attack, stroke, diabetes, skin disorders, depression, mental disease, asthma, allergies or arthritis.

Relationship	L/D	Age	Diseases Suffered/ Cause of Death
Mother			
Father			
Maternal Grandfather			
Maternal Grandmother			
Paternal Grandfather			
Paternal Grandmother			
Sister(s)			
Brother(s)			
Maternal Aunts			
Maternal Uncles			
Paternal Aunts			
Paternal Uncles			

Do either of the parents of the child have a chronic illness? □Yes □No If yes, please describe: _____

Prenatal Health and History

What was the health of the parents at the time of conception? ❒ The child was adopted at age _____
Mother ❒Poor ❒Fair ❒Good ❒Excellent ❒Unknown **Father:** ❒Poor ❒Fair ❒Good ❒Excellent ❒Unknown
What was the health of the mother during pregnancy? ❒Poor ❒Fair ❒Good ❒Excellent ❒Unknown
What was the emotional state of the mother during pregnancy? ❒Poor ❒Fair ❒Good ❒Excellent ❒Unknown
What was the mother's first thought upon finding out she was pregnant? _____
What was the father's first thought upon finding out she was pregnant? _____
How was the mother's diet during pregnancy? ❒Poor ❒Fair ❒Good ❒Excellent ❒Unknown
Did the mother receive medical care during pregnancy? ❒Yes ❒No ❒Unknown
Mother's age at the time of the child's birth?_____# previous pregnancies _____ and births _____
What was the mother's occupation during pregnancy? _____

Did the mother experience any of the following during pregnancy?
❒Bleeding ❒High blood pressure ❒Nausea ❒Vomiting ❒ Diabetes ❒Physical or ❒ Emotional trauma
❒Thyroid problems ❒ Accident ❒ Illness ❒ Other Explain: _____

Did the mother use any of the following during pregnancy? ❒ Tobacco ❒ Alcohol ❒ Recreational drugs_____
❒ Prescription medications: ❒ Over-the-counter medications: ❒ Vitamins and/or supplements: ❒ Other: _____

Were any of the following interventions used pre/during pregnancy? ❒Fertility treatments ❒ Ultrasound❒Amniocentesis
❒ Chorionic Villi Sampling ❒ Triple Screen ❒ Maternal Serum Screening ❒ Vacuum extraction ❒ Other: _____

Birth History

Term length: ❒ Pre-term (37 weeks or less) ❒Full-term (38-42 weeks) ❒ Post-term (42 weeks +) _____ weeks
Location of birth: ❒ Hospital ❒ Home ❒ Birthing Center ❒ Other: _____
Birth: ❒ Vaginal ❒ C-section Types of Intervention:❒ Induced labor ❒ Use of forceps ❒ Epidural/Anesthesia
❒Episiotomy ❒Other: _____Were there any complications during delivery (e.g., breech delivery)? _____
Length of labor: _____ Weight of infant at birth: ___lbs __ oz. Inches ___ APGAR score (0 to 10): 1minute _____
2 minutes _____ 5 minutes: _____ Was the infant alert and responsive within twelve hours of delivery?❒Yes ❒No
Did the child experience any of the following at or shortly after birth? ❒ Merconium ❒ Cyanosis (blue)
❒ Jaundice (yellow) ❒ Rashes ❒ Seizures ❒ Birth injuries: ❒ Infections: _____
❒ Difficulties with feeding: ❒Latching on ❒Inability to suck ❒ Birth defects: _____
❒ Other: _____

Name: _____

Is there anything that you feel is important that has not been covered?

_____

_____

_____

_____

_____

_____

_____

If you have a teenager please continue to fill out the Adolescent form after this page.

Thank you for taking the time to fill in this information. It would be a good idea to keep a copy of this info and to give it to the child when they become an adult so they will know their history.

Leave Blank
Finger Nails: □Brittle □Thin □Thick, □Ridges V H □ Pitting □White Flecks □ Spoon Shaped □Moons □Yellow □Fungus □Hangnails □Fissures Color: □Blue, □Pale, □Pink, □Red, □Yellow, □White, Healthy Looking Y N Hands/Fingers □ Calloused
Toenails: □Brittle □Thin, □Thick, □Ridges V H □Pitting, □White Flecks, □Spoon Shaped, □Moons, □Yellow □Fungus □Hangnails □Fissures □Ingrown toenail Color: □Blue □Pale □Pink □Red □Yellow □White □Healthy Looking □Soles/Toes Calloused

Only if we have discussed it or you desire to look at diet for health reasons on the following page, you will find a Diet Diary. Please list, in the spaces provided, every food item that the child puts into their mouth (excluding gum, but inclusive of EVERY OTHER food item) for at least a 7 day period. Please take note of any physical symptom or sensitivities that they may experience during this exercise and note them in the 'notes' section provided.
If at any time, you have questions or concerns, please feel free to contact the office by phone at (352) 365-4325

Adolescent Developmental History

Name: _____ Gender: _____ Age: ____ Date of birth: _____

Age of: puberty: _____ Period: _____ Breast development: _____ Voice change: _____ Pubic Hair _____
Any complications/ symptoms experienced at puberty? _____
Were there any issues that affected your development (e.g., physical abuse, inadequate nutrition, neglect, etc.):
_____

_____

SOCIAL HISTORY

Do you have a best friend? ❒Yes ❒No How many close friends do you have? _____

Are your relationships ❒ strong or ❒ superficial? ❒Explain _____

What activities do you participate in regularly with your friends? _____

EDUCATION

Type of school: _____ Grade: _____special ed? (e.g. gifted program) ❒Yes ❒No

If yes, describe: _____

Have you ever been held back in school? ❒Yes ❒No If yes, describe: _____

What grades do you usually receive in school? _____How do you feel about school? _____

What school activities do you become involved in?_____

INTERESTS/ ACTIVITIES Do you have a part time job? ❒Yes ❒No
Describe special areas of interest or hobbies (e.g. art, reading, music, sports, organizations – scout, etc.)
_____
What is your current **stress level** on a scale of 1 to 10? (10 being the worst stress you've ever had)_____

What is your current **energy level** on a scale of 1 to 10? (10 being the most energy you've ever had)_____

What are your future goals?_____

RECREATIONAL DRUGS

Do you use ❒Yes ❒No have a problem with alcohol or drugs? ❒Yes ❒No If yes, describe: _____
Do you smoke? ❒Yes ❒No Age started _____ If yes how many cigarettes per day do you smoke?_____

SEXUALITY
Are you currently in an intimate relationship? ❒Yes ❒No For how long?_____
Are or have you ever been sexually active? ❒Yes ❒No If yes, at what age did you become active _____
What form of birth control are you using? _____
What is your sexual orientation? (e.g. Hetero/Homosexual)_____
Have you ever been sexually abused? ❒Yes ❒No Explain _____

Girls Only
Typical length of menses (days) _____**Typical length of cycle** from 1st day to 1st day of menses _____
Bleeding □Regular □Irregular □In-between Spotting. **#Tampons/ Pads** per day _____ Per night _____
□Heavy Flow □ Scanty Flow **Painful Periods** □ Before □ Middle □ End □ After □Want pressure □No pressure **Menses Color:** □Pale □Bright □Dark □Purple □Red □Brown **@:** Start _____Middle _____ End _____ □ **Clots** □Hot Flashes □ #Miscarriages _____ □ # Abortions _____
Emotion Around Period □ Normal □ Abnormal □ Crying □ Depressed □ Irritability □ Anger □ Sadness
□Other _____
Describe any symptoms that you experience before/during and/or after your period □ breast tenderness □ cramps □ bloating □ Nausea/Vomiting □ fatigue □ food cravings etc _____
Other _____
Vaginal Discharge □ Normal □ Abnormal Color _____ Consistency _____ Smell _____
□ Fibroids □ Cysts □ Other
Breast □ Lumps □ Tenderness □ Heaviness □ Comes and goes with cycle □ Fibroids □ Cysts
Nipple □ Discharge color _____ □ Deviation Other _____
□ Cancer _____□ **Hormone Use** Type _____How Long _____
Anything else?
_____
_____
_____
_____
_____
_____
_____
_____

Boys Only

Desire for sex □ Aversion □ Low □Excessive **Masturbation** □Excessive explain _____
Pain □ Yes □ No where and describe: _____
□Want pressure □No pressure □Swelling or Lumps (where) _____
□**Itchin**g where and describe: _____
Penis □Blood □Mucous □Discharge (color) _____ □Abnormal Erections □ Seminal discharge color _____
□Warts □Rashes □Spots □Nocturnal Emissions □ STD □Complaint or problem with intercourse?
_____
Anything else?
_____
_____
_____
_____
_____
_____
_____

Diet Diary

	Breakfast	Lunch	Dinner	Snacks	Notes