Please submit the completed Health History Form by mailing, emailing or faxing to:

**Whether you are seen at the Warrenville, IL Clinic or any of our Outreach Clinics, please contact us at:**

Pfeiffer Medical Center  
3S721 West Street, Ste. 300  
Warrenville, IL 60555  
Phone: 630-505-0300  
Fax: 630-836-0667

**Electronic Communication:** If you would like to use email communication, please provide your email address. Please note that we cannot send private medical information by email due to privacy concerns. If the patient is a minor, please list the email address of the parent/legal guardian.

**Email Address:** _____________________@________________________ □ Patient □ Parent/Guardian

I would like email communication for:  
□ Appointment Reminders

**PLEASE NOTE:** WE ARE NOT A “COVERED ENTITY” UNDER MEDICARE GUIDELINES, AND CANNOT BILL MEDICARE FOR OUR SERVICES.

**PLEASE ALSO NOTE:** WE CANNOT ACCEPT PATIENTS WHO ARE PREGNANT.

**How did you hear about Pfeiffer Medical Center?**

□ Journey to a Cure by Emily Dillon □ FaceBook □ Are you a Former Patient? □ Yes □ No  
□ Family Member □ Friend □ Brochure □ If yes, Date last seen: ________________

□ Internet - if so:  
□ Google Search □ Google Advertisement  
□ Pfeiffer Medical Center website (www.hriptc.org)  
□ Print or Broadcast Media *(please provide details)*:

□ Presentation/Informational Seminar *(Location/Date):* ________________________________

□ Conference *(Location/Date):* ________________________________

□ Other: ____________________________________________

□ Professional Referral *(please provide specific information on the next page)*
PATIENT INFORMATION
* Required Information

* NAME:
  Last  First  M.I.

* ADDRESS:  ______________________________________
  Number  Street  Apt.
  City  State  Zip Code

Complete the parent information only if the patient is a minor.

Mother’s Name: _______________________
Father’s Name:  ______________________  or
Legal Guardian’s Name:____________________

EMERGENCY CONTACTS
1. NAME: ______________________________________
   PHONE: (____) ______-________

2. NAME: ______________________________________
   PHONE: (____) ______-________

GUARANTOR INFORMATION
* NAME: ______________________________________

* ADDRESS:
  Number  Street  Apt.
  City  State  Zip code

* Employer: ____________________________
* Employer Address: ______________________
  ______________________________________
* Employer Phone: (____) ______-________

* DATE OF BIRTH (DOB): _____/_____/_______
* PHONE: (____) ______-________

Does the Patient have:
*Federal Medicare  □ Yes  □ No
Federal Tricare Insurance  □ Yes  □ No
State Medicaid  □ Yes  □ No

Does the Patient have:

□ Parent  □ Legal Guardian  □ Spouse
□ Other: _______________________
□ Parent  □ Legal Guardian  □ Spouse
□ Other: _______________________

□ Parent  □ Legal Guardian*  □ Spouse
□ Other: _______________________
Home: (____) ______-________
Work (____) ______-________
Cell: (____) ______-________
*SS # ______-______-______
*DOB # ____/_____/_______

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EMAIL: __________________@_________________

Employer: ______________________________
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GUIDANCE RESPONSIBILITY: I understand that all professional services are charged to the patient, and are due and payable on the date that services are rendered unless other arrangements have been made with the financial counselor. I agree to pay all such charges in full immediately upon presentation of the appropriate statement.

Guarantor’s Signature ____________________________ DATE: ____________________________
**Medication Failures:**

**ALLERGIES/REACTIONS TO MEDICATIONS:** (rash, hives, swelling, shortness of breath)

**FOOD ALLERGIES AND SENSITIVITIES:**

**CURRENT PRESCRIPTIONS/OVER THE COUNTER MEDICATIONS/AND NUTRIENTS** (if need be add on another sheet)

<table>
<thead>
<tr>
<th>MEDICINE/Route</th>
<th>DOSE/How often</th>
<th>DATE STARTED</th>
<th>LAST TAKEN</th>
<th>RESPONSE</th>
<th>D/C’d (ofc. use)</th>
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**DO YOU SWALLOW PILLS?**

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<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>DO YOU SWALLOW PILLS?</td>
<td>YES – NO</td>
</tr>
<tr>
<td>INTERESTED IN COMPOUNDING?</td>
<td>YES - NO</td>
</tr>
<tr>
<td>ANTIHISTAMINES IN PAST 3 MONTHS?</td>
<td>YES - NO</td>
</tr>
<tr>
<td>ALLERGY SHOTS/DROPS IN PAST 3 MONTHS?</td>
<td>YES - NO</td>
</tr>
<tr>
<td>TOTAL DAILY ZINC:</td>
<td></td>
</tr>
</tbody>
</table>

Patient Name: _____________________________________________ DOB: ____/____/______
HEALTH HISTORY FORM

Patient Medical History (check if applicable)

In the Past - or In the Past - or In the Past - or
Current Problem Current Problem Current Problem

☐ Acne ☐ Esophagitis ☐ Hypothyroidism
☐ Eczema ☐ Peptic Ulcer Disease ☐ Hyperthyroidism
☐ Psoriasis ☐ Gastro Esophageal Reflux ☐ Alzheimer’s Disease
☐ Allergic Rhinitis ☐ Colitis ☐ Parkinson’s Disease
☐ Chronic Sinusitis ☐ Irritable Bowel Syndrome ☐ Dementia
☐ Asthma ☐ Inflammatory Bowel Disease ☐ Seizure Disorder
☐ Arthritis/Rheumatoid/Lupus ☐ Gall Bladder Dysfunction ☐ Fibrocystic Breast Cancer
☐ Multiple Sclerosis ☐ Hepatitis ☐ Endometriosis
☐ Collagen Vascular Disease ☐ Liver Disease ☐ Fibroid Tumors
☐ Fibromyalgia ☐ Kidney Problems ☐ Polycystic Ovarian Disease
☐ Multiple Chemical Sensitivities ☐ Urinary Tract Infections ☐ PMS
☐ Heart Disease ☐ Benign Prostatic Hypertrophy ☐ Postpartum Depression
☐ Stroke ☐ Thush ☐ Menopause
☐ Hypertension ☐ Athlete’s Foot ☐ Glaucoma
☐ High Cholesterol/High Triglycerides ☐ Toe Nail Fungus/Fingernail ☐ Night-Blindness
☐ Diabetes ☐ Ring Worm ☐ Other: ______________
☐ Cancer ☐ Yeast Infections

Psychiatric History

Diagnosed - or Diagnosed - or Diagnosed - or
Symptoms or Suspected Symptoms or Suspected Symptoms or Suspected

☐ ADD ☐ Anxiety Disorders
☐ ADHD ☐ Generalized Anxiety Disorder
☐ Learning Disability ☐ Phobic Disorder
☐ PDD/Autism spectrum ☐ Panic Disorder
☐ Oppositional Defiant Disorder ☐ Obsessive Compulsive Disorder
☐ Conduct Disorder ☐ Post Traumatic Stress Disorder
☐ Behavior Disorder ☐ Acute Stress Disorder
☐ Tics/Tourettes

Mood Disorders
☐ Major Depressive Disorder
☐ Bipolar I Disorder
☐ Bipolar II Disorder
☐ Dysthmic Disorder
☐ Cyclothymic Disorder

Psychotic Disorders
☐ Schizophrenia
☐ Schizoaffective Disorders
☐ - Bipolar Type
☐ - Depressive Type
☐ Delusional Disorder
☐ Dissociative Disorder
☐ Dissociative Identity Disorder
☐ Dissociative Fugue Disorder

Eating Disorders
☐ Anorexia Nervosa
☐ Bulimia Nervosa
☐ PICA
☐ Obesity

Family History (Please indicate relatives using the key below. Other relatives may be listed if believed significant/relevant.)

☐ Patient is adopted, information is not available.

ADD/ADHD ☐ Thyroid ☐ Bipolar ☐ Arthritis ☐__________
Violence ☐ Ulcers ☐ Alcohol/Drug Abuse ☐ Diabetes ☐__________
Panic Attacks ☐ Heart Disease ☐ Suicide Attempt ☐ Kidney Problems ☐__________
Asthma ☐ Stroke ☐ Depression ☐ Cancer ☐__________
Early Senility ☐ Hypertension ☐ Schizophrenia ☐ Psoriasis ☐__________
Alzheimer’s ☐

KEY:  M =Mother  MGM = Maternal Grandmother  MGF = Maternal Grandfather  MA/MU = Maternal Aunt/Uncle  S =Sister
F = Father  PGM = Paternal Grandmother  PGF = Paternal Grandfather  PA/PU = Paternal Aunt/Uncle  B =Brother

Other: __________________________________________________________________________

Patient Name: ___________________________________________  DOB: _____/_____/______
HEALTH HISTORY FORM

Chief Complaint: List the symptoms or problems you would like the Pfeiffer Treatment Center to address, #1 being most important:
1.
2.
3.
4.
5.
6.
7.

Are you pregnant? □ Yes □ No □ N/A
Are you breastfeeding? □ Yes □ No □ N/A

WE CANNOT ACCEPT PATIENTS WHO ARE PREGNANT!

All *starred* items must be filled in

*How many alcoholic drinks do you consume?
None______________ Per day/ week/ month  -----------------------------
Past abuse?_____________________________________________________

*Any illegal drug use in year?_____________________________________
None______________ Per day/week/Month___________________________
Past abuse?_____________________________________________________

Do you use tobacco?_________ Per day/week/month__________________

List all Current Therapies (OT ,PT, Speech ,ABA, Psychiatrist, Therapist, Other):

Past Treatment & Response:

Hospitalizations – Dates & Reason

Surgeries – Dates & Reason

Office Use Only:

Patient Name: ____________________________________________

DOB: ____/____/_____
Physical Health
Please note problems /diagnoses in the following areas, including dates of diagnoses:

Skin / Hair:

Ear, Nose, Throat:

Digestive / GI:

Last Dental Visit/Status: ____________________________________________

Heart / Circulatory / Cholesterol:

Respiratory: (Allergies/Asthma/Other)

Endocrine (thyroid, diabetes, etc.):

Liver:

Kidney / Urinary:

Neurologic:

Head Injuries (dates, was there loss of consciousness?)

Reproductive:

Female History:
Age at first period _____
Number of pregnancies: ____  Miscarriages/abortions:  ____  Births:  ____
☐ PMS  ☐ Post Partum Depression
☐ Ovarian cysts  ☐ Irregular Periods  ☐ Endometriosis
☐ Hysterectomy  ☐ Menopause  ☐ Fibrocystic Breast Cancer
☐ Other: ___________________________________________________________________

Last Menstrual Period: ________________________________________________
History of Yeast Infections: ____________________________________________

Immune (cancer, Lupus, AIDS, ALS, etc.):

Sensory (vision, hearing, taste, smell, touch):

Last Primary Physician Visit: ____________________________
Last Vision Exam: ______________  Last Hearing Exam: ________________

Patient Name: __________________________________________  DOB: ____/____/____
Patient Name: ________________________________
DOB: ____/____/______

**Diet:**
- ☐ Regular
- ☐ Casein Free
- ☐ Gluten Free
- ☐ Vegetarian
- ☐ Feingold
- ☐ Body Ecology
- ☐ Specific Carbohydrate
- ☐ Low Salt
- ☐ Mediterranean
- ☐ Other: ________________________________

Response to current diet: ________________________________

How long on current diet: ________________________________

Number of meals per day: _____

Number of snacks: ______

Appetite: ____________________

Cravings: ____________________

Rate the intake of the foods below (circle)

<table>
<thead>
<tr>
<th>Category</th>
<th>Low</th>
<th>Avg.</th>
<th>High</th>
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</thead>
<tbody>
<tr>
<td>Sweets</td>
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<tr>
<td>Protein</td>
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</tr>
<tr>
<td>Dairy</td>
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<tr>
<td>Carbohydrates</td>
<td>1</td>
<td>Low</td>
<td>Avg.</td>
</tr>
<tr>
<td>Fruit</td>
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<td></td>
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<tr>
<td>Vegetables</td>
<td>Low</td>
<td>Avg.</td>
<td>High</td>
</tr>
</tbody>
</table>

Main Beverage: _______________

Amount per day: _______________

Caffeine: ______ per day/week

☐ Hypoglycemic symptoms

☐ Pica

☐ Aversion to breakfast

☐ Picky eater

**Bowel movements / Stooling**

Frequency: _____ per ________

Character of stools:
- ☐ Constipation
- ☐ Diarrhea
- ☐ Encopresis
- ☐ Excess gas
- ☐ Stomach aches
- ☐ Posturing

**Gut Treatment**

Tests done: ________________________________

Treatment: ________________________________

Effectiveness: ________________________________

**Immune Function**

Immunizations current?
- ☐ Yes
- ☐ No

Adults 65 yrs & older: Pneumonia vaccine?
- ☐ Yes
- ☐ No

Reactions/Regressions related to immunizations:

- ☐ Frequent colds/infections
- ☐ Environmental allergies/rhinitis
- ☐ Chemical Sensitivities
- ☐ Other:

Frequency of Antibiotic Use: ________________

**Sleep**

Time to Bed: ________________

Time Awake: ________________

Difficulty:
- ☐ Falling asleep
- ☐ Staying asleep
- ☐ Waking
- ☐ Nightmares
- ☐ Dream recall:
- ☐ None
- ☐ Dull
- ☐ Vivid
- ☐ Enuresis
- ☐ Sleep Apnea
- ☐ Restless Legs
- ☐ Other: ____________________

---

1 Simple carbohydrates such as bread, pasta, breakfast cereals, etc.
2 Drowsy after meals, shakiness/dizziness, irritability when hungry, craving sweets, etc.
3 An abnormal craving or appetite for nonfood substances, such as dirt, paint, or clay.
4 Accidental soiling of undergarments
5 Bedwetting
### Cognitive / Executive Functions

- [ ] Problem staying on task
- [ ] Impulsivity
- [ ] Problems with memory
- [ ] Poor organization
- [ ] Sequencing
- [ ] Foggy brained
- [ ] Hyper behavior / fidgety
- [ ] Distractible
- [ ] Racing thoughts
- [ ] Problems with focus / concentration
- [ ] Loses things frequently

**Motivation:**

- [ ] None
- [ ] Low
- [ ] Normal
- [ ] High

**Highest grade completed:**

**Performance / Grades:**

**Learning Disabilities (LD) identified:**

**Accommodations / School Setting:**

**Employment:**

- [ ] Full time
- [ ] Part time
- [ ] N/A
- [ ] Student
- [ ] Homemaker
- [ ] Retired
- [ ] Disabled
- [ ] Unemployed

**Time there:**

**Social Development**

- Lives with whom (include ages)?
  - [ ] Seeks Interaction
  - [ ] Isolates
  - [ ] Alienates
  - [ ] Makes poor choices
  - [ ] Parallel play
  - [ ] Poor eye contact
  - [ ] Divergent Gaze
  - [ ] Misses social cues

  **If Child:**
  - [ ] Prefers younger playmates
  - [ ] Prefers older playmates

**Notes:**

**Personality and Behavior:** *Briefly describe:*

---

6 Problems putting things in order, planning

7 Brain, face, neck, shoulder
**Brain Health**  *Star* questions must be answered.

Describe Typical Response to Stress:

Describe Temper:

**Anger Management:**
- ☐ Argues
- ☐ Verbal tantrums
- ☐ Destroys property
- ☐ Threats
- ☐ Aggressive to others
- ☐ Intentional harm

Frequency of Anger Outbursts: _________________________________

Intensity & Duration of Anger: _________________________________

**Behavior:** ☐ Oppositional Defiant ☐ Self Harm Behaviors:

Anxiety disorders (OCD, Panic, Nervousness, Worry) _____________________________

Depressive Disorders: ________________________________________________

*Suicide Risk*  ☐ History of Attempt, Dates of Attempts_____________________  

*Treatment___________________________________________________________

*Past history of ideation, plan or intent____________________________________

*In past 6 months  ☐ Thoughts  ☐ Plan  ☐ Preparation  ☐ Intent  

*Are you under a Psychiatrist’s care?______________________________________

If answer is yes to suicidal ideation in past 6 months, Psychiatrist is necessary.

**This is SERIOUS! If you can check current Plan, Preparation or Intent, contact your family / friend / mental health professional immediately, or call 911.**

Has there ever been a Psychiatric Evaluation? Yes___ No___

Please list dates and diagnosis:

Dementia / Degenerative disorders/ Memory Impairment:

Eating disorders:

Bipolar Disorder:

Predominant Mood: ________________________________

Psychotic disorders:
- ☐ Hallucinations: ☐ Auditory ☐ Visual ☐ Tactile
- ☐ Disordered Thoughts ☐ Delusions ☐ Other: ☐ Paranoia

Seizure disorders:

Tics / Tourette’s: ☐ Clumsiness / accident prone

Patient Name: __________________________________________________________ DOB: ____/____/______
# Developmental Addendum

*Complete this section only for developmental disorders such as Autism Spectrum Disorders (ASD), Pervasive (and other) Developmental Disorders, etc.*

<table>
<thead>
<tr>
<th>Mother’s health during pregnancy</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother’s age at patient’s birth: _____</td>
<td></td>
</tr>
<tr>
<td>Dental work:</td>
<td></td>
</tr>
<tr>
<td>RhoGam:</td>
<td></td>
</tr>
<tr>
<td>Immunizations:</td>
<td></td>
</tr>
</tbody>
</table>

### Note type, amount and frequency

| Alcohol use: |  |
| Tobacco use: |  |
| Illicit drug use: |  |

Medications, Supplements, Herbs used:

| Mood disorders: |  |
| Significant Illnesses: |  |
|☐ High blood pressure / Preeclampsia☐ Toxemia☐ Gestational diabetes |  |

Preterm labor @ ____ weeks

### Neonatal Health

|☐ Low birth weight – Birth weight: _____lbs. _____ oz. |  |
|☐ Cord around neck☐ Emergency C-section |  |
|☐ Forceps use☐ Vacuum use☐ Fetal distress |  |
|☐ Preterm delivery @ ____ weeks☐ Other delivery problems: |  |

|☐ Jaundice☐ Oxygen after birth☐ Ear infections☐ Colic |  |
|☐ Antibiotics☐ Formula intolerance |  |

|☐ Skin problems: |  |

### Potential toxic exposures

|☐ Home built before 1978 |  |
|☐ Second hand smoke |  |
|☐ Parent or family occupation ⁸ / hobby ⁹: |  |
|☐ Immunizations (note reaction or regression) |  |

Water source ¹⁰:

---

⁸ Work with lead or other heavy metals, Lead/brass/bronze melting/ refining/ manufacturing, Rubber/plastic manufacturing, Painting, Demolition, Construction, Battery manufacture/recycling, Radiator manufacturing/repair, Soldering, Steel welding/cutting

⁹ Glazed pottery, Stained glass, Painting, Firearms (shooting, reloading), Lead figurines, Antique toys, etc.

¹⁰ Note if bottled, tap, well, filtered, softened, tested
**Developmental History**

Gross motor development:

Fine motor development:

Sensory Integration:

- [ ] Repetitive behaviors:
- [ ] Disruptive behaviors:

Plays with toys appropriately?  

- [ ] Yes  
- [ ] No

**Language development**

- [ ] Early  
- [ ] Normal  
- [ ] Late

- [ ] Regressed – at what age? ______

**Language functioning:**

- [ ] None  
- [ ] Words  
- [ ] Sentences

- [ ] Repetitive  
- [ ] Processing deficits
- [ ] Echolalia  
- [ ] Scripting

- [ ] Able to understand / follow directions

Notes:

---

**Other:** Please note anything of concern not entered above, or give additional information if needed.

---

**Name of Current Primary Care Physician:** ____________________________

**Phone Number:** ____________________________

**Name of Current Psychiatrist:** ____________________________

**Phone Number:** ____________________________

**Name of Current Therapist:** ____________________________

**Phone Number:** ____________________________

---

**Patient Name:** ________________________________________  

**DOB:** ____/____/______

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**Office use only**