Please submit the completed Health History Form by mailing / 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. 300A
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
☐ General announcements of new services, programs, upcoming events, research and Marketing.

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 Treatment Center?

☐ CNBC ☐ Reuters ☐ 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 Treatment Center website (www.hriptc.org)

☐ Yahoo advertisement ☐ Other website: _____

☐ Print or Broadcast Media *(please provide details)*:

☐Autism File ☐Chicago Parent ☐Chicago Special Parent ☐Other: _____

☐ Presentation/Informational Seminar *(Location/Date)*: _____

☐ Conference *(Location/Date)*: _____

☐ Other:_____

☐ Professional Referral *(please provide specific information on the next page)*

Pfeiffer Medical Center

HEALTH HISTORY FORM **Page** B

PATIENT INFORMATION

*** Required Information**

*NAME: _____
Last First M.I.

*ADDRESS: _____
Number Street Apt.

_____
City State Zip Code

*DATE OF BIRTH (DOB): _____/_____/_____

GENDER: ☐ Male ☐ Female

AGE: _____ WEIGHT: _____ lbs.

*PHONE: (____) _____-_____

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

Mother's Name: _____

Father's Name: _____ *or*

Legal Guardian's Name:_____

Does the Patient have:

*Federal Medicare ☐ Yes ☐ No

Federal Tricare Insurance ☐ Yes ☐ No

State Medicaid ☐ Yes ☐ No

EMERGENCY CONTACTS

1. NAME: _____ ☐ Parent ☐ Legal Guardian ☐ Spouse

   PHONE: (____) _____-_____ ☐ Other: _____

2. NAME: _____ ☐ Parent ☐ Legal Guardian ☐ Spouse

   PHONE: (____) _____-_____ ☐ Other: _____

GUARANTOR INFORMATION

NAME: _____ ☐ Parent ☐ Legal Guardian ☐ Spouse ☐ Other: _____

*ADDRESS: _____
Number Street Apt.

_____
City State Zip code

Home: (_ ____) _____-_____
Work (_____) _____-_____
Cell: (_____) _____-_____
*SS # ____-_____-_____
*DOB # _____/_____/_____

EMAIL: _____@_____

*Employer: _____
*Employer Address: _____

_____

*Employer Phone: (_____) _____-_____

PROFESSIONAL REFERRAL:

NAME: _____

PROF. TITLE:_____

Address:_____

_____

Phone: (_____) _____-_____

***If Legal Guardian, please include documents showing legal guardianship with this form.**

FINANCIAL 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: _____

HEALTH HISTORY FORM

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

CURRENT PRESCRIPTIONS/OVER THE COUNTER MEDICATIONS/ NON PFEIFFER NUTRIENTS

MEDICINE/Route	DOSE/How often	DATE STARTED	LAST TAKEN	RESPONSE	D/C'd *(ofc. use)*	***RN*** *INITIALS/* ***Date***
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						

MEDICATION FAILURES:

RN SIGNATURE:_____ Date: _____

DO YOU SWALLOW PILLS ?	**YES – NO**
INTERESTED IN COMPOUNDING?	**YES - NO**
ANTIHISTAMINES IN PAST 3 MONTHS?	**YES - NO**
ALLERGY SHOTS/DROPS IN PAST 3 MONTHS?	**YES - NO**
TOTAL DAILY ZINC:_____	

Patient Name: _____ DOB: ____/____/_____

Patient Medical History (check if applicable)

In the Past - or
⇩ *Current Problem*

☐ ☐ Acne
☐ ☐ Eczema
☐ ☐ Psoriasis

☐ ☐ Allergic Rhinitis
☐ ☐ Chronic Sinusitis
☐ ☐ Asthma
☐ ☐ Arthritis/Rheumatoid/Lupus
☐ ☐ Chronic Fatigue Syndrome
☐ ☐ Multiple Sclerosis
☐ ☐ Collagen Vascular Disease
☐ ☐ Fibromyalgia
☐ ☐ Multiple Chemical Sensitivities

☐ ☐ Heart Disease
☐ ☐ Stroke
☐ ☐ Hypertension
☐ ☐ High Cholesterol/High Triglycerides
☐ ☐ Diabetes
☐ ☐ Cancer

In the Past - or
⇩ *Current Problem*

☐ ☐ Esophagitis
☐ ☐ Peptic Ulcer Disease
☐ ☐ Gastro Esophageal Reflux
☐ ☐ Pancreatitis
☐ ☐ Colitis
☐ ☐ Irritable Bowel Syndrome
☐ ☐ Inflammatory Bowel Disease
☐ ☐ Gall Bladder Dysfunction

☐ ☐ Hepatitis
☐ ☐ Liver Disease
☐ ☐ Kidney Problems
☐ ☐ Urinary Tract Infections
☐ ☐ Benign Prostatic Hypertrophy

☐ ☐ Thrush
☐ ☐ Athlete's Foot
☐ ☐ Toe Nail Fungus/Fingernail
☐ ☐ Ring Worm
☐ ☐ Yeast Infections

In the Past - or
⇩ *Current Problem*

☐ ☐ Hypothyroidism
☐ ☐ Hyperthyroidism

☐ ☐ Alzheimer's Disease
☐ ☐ Parkinson's Disease
☐ ☐ Dementia
☐ ☐ Seizure Disorder

☐ ☐ Fibrocystic Breast Cancer
☐ ☐ Endometriosis
☐ ☐ Fibroid Tumors
☐ ☐ Polycystic Ovarian Disease
☐ ☐ PMS
☐ ☐ Postpartum Depression
☐ ☐ Menopause

☐ ☐ Glaucoma
☐ ☐ Night-Blindness
☐ ☐ Other: _____

Psychiatric History

Diagnosed - or
⇩ *Symptoms or Suspected*

☐ ☐ ADD
☐ ☐ ADHD
☐ ☐ Learning Disability
☐ ☐ PDD/Autism spectrum
☐ ☐ Oppositional Defiant Disorder
☐ ☐ Conduct Disorder
☐ ☐ Behavior Disorder
☐ ☐ Tics/Tourettes

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

Diagnosed - or
⇩ *Symptoms or Suspected*

Anxiety Disorders
☐ ☐ Generalized Anxiety Disorder
☐ ☐ Phobic Disorder
☐ ☐ Panic Disorder
☐ ☐ Obsessive Compulsive Disorder
☐ ☐ Post Traumatic Stress Disorder
☐ ☐ Acute Stress Disorder

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

Diagnosed - or
⇩ *Symptoms or Suspected*

Psychotic Disorders
☐ ☐ Schizophrenia
☐ ☐ Schizoaffective Disorders
☐ ☐ - Bipolar Type
☐ ☐ - Depressive Type
☐ ☐ Delusional Disorder

☐ ☐ Dissociative Disorder
☐ ☐ Dissociative Identity Disorder
☐ ☐ Dissociative Fugue Disorder

Other
☐ ☐ _____
☐ ☐ _____

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: _____

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 llegal 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: ____/____/_____

HEALTH HISTORY FORM

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: _____

Office use only

Patient Name: _____ DOB: ____/____/_____

HEALTH HISTORY FORM

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)*

Sweets	Low	Avg.	High	Carbohydrates[1]	Low	Avg.	High
Protein	Low	Avg.	High	Fruit	Low	Avg.	High
Dairy	Low	Avg.	High	Vegetables	Low	Avg.	High

Main Beverage: _____ Amount per day: _____

Caffeine: _____ per day/week ☐ Hypoglycemic symptoms[2]

☐ Pica[3] ☐ Aversion to breakfast ☐ Picky eater

Bowel movements / Stooling

Frequency: _____ per _____

Character of stools:

☐ Constipation ☐ Diarrhea ☐ Encopresis[4] ☐ 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[5] ☐ Sleep Apnea ☐ Restless Legs Other: _____

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[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

Patient Name: _____ DOB: ____/____/_____

Cognitive / Executive Functions

☐ Problem staying on task ☐ Impulsivity ☐ Problems with memory
☐ Poor organization ☐ Sequencing[6] ☐ 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 Position: _____
Time there: _____ ☐ Student ☐ Homemaker ☐ N/A
☐ Retired ☐ Disabled ☐ Unemployed

Sensory:
Sensitivities: ☐ Light ☐ Sound ☐ Odors ☐ Tactile *(clothing)*
☐ Ringing in the ears
☐ Upper body pain[7] ☐ Back pain ☐ Joint pain
Headaches: ☐ Tension/muscle ☐ Migraine Frequency: _____
Pain tolerance: ☐ High ☐ Avg. ☐ Low

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:*

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[6] Problems putting things in order, planning

[7] Brain, face, neck, shoulder

HEALTH HISTORY FORM

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

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Patient Name: _____ DOB: ____/____/_____

DEVELOPMENTAL ADDENDUM

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

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Mother's health during pregnancy

Mother's age at patient's birth: _____

Dental work:

RhoGam:

Immunizations:

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.

Birth events: ☐ 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:
_____

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