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
4575 Weaver Parkway
Warrenville, IL 60555-4039
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

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:____________________

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

GENDER: ☐ Male ☐ Female

AGE: ________ WEIGHT: ________ lbs.

*PHONE: (____) _______-___________

Does the Patient have:

*Federal Medicare ☐ Yes ☐ No

Federal Tricare Insurance ☐ Yes ☐ No

State Medicaid ☐ Yes ☐ No

** **Please include a copy of your insurance card.**

EMERGENCY CONTACTS

1. NAME: ______________________________ ☐ Parent ☐ Legal Guardian ☐ Spouse
   PHONE: (____) _____-_______ ☐ Other: ____________________
2. NAME: ______________________________ ☐ Parent ☐ Legal Guardian ☐ Spouse
   PHONE: (____) _____-_______ ☐ Other: ____________________

GUARANTOR INFORMATION

*NAME: ______________________________

*ADDRESS: ______________________________
Number Street Apt.

____
City State Zip code

EMAIL: ________________@________________

☐ Parent ☐ Legal Guardian* ☐ Spouse
☐ Other: ____________________
Home: (_ ____) _______-_________
Work (______) _______-_________
Cell: (______) _______-_________
*SS # _____-________-_______
*DOB # _____/______/______

Insurance Group # ____________________ **Insurance Policy #** ________________

*****Please include a copy of the front and back of your insurance card with this form.**

*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: ____/____/______

Pfeiffer Medical Center

HEALTH HISTORY FORM

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: ____

Patient Name: ____ DOB: ____/____/______

Pfeiffer Medical Center

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: ________________

Office use only

---

[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:*

Office use only

[6] Problems putting things in order, planning

[7] Brain, face, neck, shoulder

Patient Name: ____ DOB: ____/____/______

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

Office use only

Patient Name: ____ DOB: ____/____/______

DEVELOPMENTAL ADDENDUM

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

office use only

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

HEALTH HISTORY FORM

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:

Phone Number: ____

Office use only

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: ______________________________________

Patient Name: ____ DOB: ____/____/______