

Please submit the completed Health History Form by mailing / faxing to:

Whether you are seen at the Warrenville, IL Clinic, Judson Center in Royal Oak, MI or any of our Outreach Clinics, please contact us at:

Pfeiffer Treatment 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*)



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:

EMERGENCY CONTACTS

1. NAME: PHONE:
2. NAME: PHONE:

GUARANTOR INFORMATION

*NAME:
*ADDRESS: Number Street Apt. City State Zip code
EMAIL: @

*Employer:
*Employer Address:
*Employer Phone:

*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

Parent Legal Guardian Spouse
Other:
Parent Legal Guardian Spouse
Other:

Parent Legal Guardian Spouse
Other:
Home:
Work:
Cell:
*SS #
*DOB #

PROFESSIONAL REFERRAL:

NAME:
PROF. TITLE:
Address:
Phone:

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:

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	REASON / 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: _____

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: ____/____/____

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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!

How many alcoholic drinks do you consume? _____ per day / week / month

History of past use : _____

Describe any illegal drug use in the last year:

Do you use tobacco? _____ Frequency? _____

History of past use: _____

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

Past Treatment & Response:

Hospitalizations – Dates & Reason

Surgeries – Dates & Reason

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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
- Ovarian cysts
- Hysterectomy
- Other: _____
- Post Partum Depression
- Irregular Periods
- Menopause
- Endometriosis
- Fibrocystic Breast Cancer

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: _____

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*)

<u>Sweets</u>	Low	Avg.	High	<u>Carbohydrates</u> ¹	Low	Avg.	High
<u>Protein</u>	Low	Avg.	High	<u>Fruit</u>	Low	Avg.	High
<u>Dairy</u>	Low	Avg.	High	<u>Vegetables</u>	Low	Avg.	High

Main Beverage: _____ Amount per day: _____

Caffeine: _____ per day/week Hypoglycemic symptoms²

Pica³ Aversion to breakfast Picky eater

Bowel movements / Stooling

Frequency: _____ per _____

Character of stools:

Constipation Diarrhea Encopresis⁴ 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

Enuresis⁵ 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

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Cognitive / Executive Functions

- Problem staying on task Impulsivity Problems with memory
- Poor organization Sequencing⁶ 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 pain⁷ 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

Brain Health

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 Family/Friend History
 Thoughts Plan Preparation Intent
 ----- Past Current

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

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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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 occupation⁸ / hobby⁹:

Immunizations (note reaction or regression)

Water source¹⁰:

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:

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