Fitness Genome Tayebjee Chiropractic Neurology Center
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Welcome to Fitness Genome Tayebjee Chiropractic Neurology Center. Carefully complete all of the following health history questionnaires. The accuracy of your answers will help us better diagnose and treat your child's conditions. Thank you for your patience with what may appear to be some duplication in questions in different areas. Each questionnaire has been carefully designed to identify your child's specific condition.

Patient Name: ____________________________ Age: _______ DOB: _____/_____/______
Patient Guardian/Representative: ____
Handed: ❑ Right ❑ Left ❑ Ambidextrous
Gender:❑ Female ❑ Male SSN: _____/_____/______
Street address: ____ Unit/APT: _______
City: ___________________________ State: _____________ ZIP: ______________________
Home Phone: _____________________________ Cell Phone: __________________________
Email address: ____
Number of Siblings: _____ Name and Ages: ____
How did you hear about Fitness Genome and/or Dr. Nisreen?__________________________
Emergency Contact Information: Contact Name: _____________________________________
Phone: (_____)___________________ Alternate Phone: (_____)___________________
Relationship to Patient: ____
Primary Pediatrician: Name: ____
Clinic Name: ____
Street Address: ____
City: __________________________ State: ________________ ZIP:_______________________
Primary Pharmacy: Name: ____
Street Address: ____
City: __________________________ State: ________________ ZIP:_______________________
Primary Chiropractor: Name: ____
Clinic Name: ____
Street Address: ____
City: __________________________ State: ________________ ZIP:_______________________
When? _______________________________ How long were you under care?______________
Primary Language Spoken: ____

Have you consulted or do you regularly consult any of the following providers? (Check all that apply.)

❑ Medical Physician	❑Acupuncturist	❑Massage Therapist	❑Energy Healer
❑Naturopath	❑Homeopath	❑Psychotherapist	❑Dentist

Quality of Life Rank: Please rate your child's current quality of life.

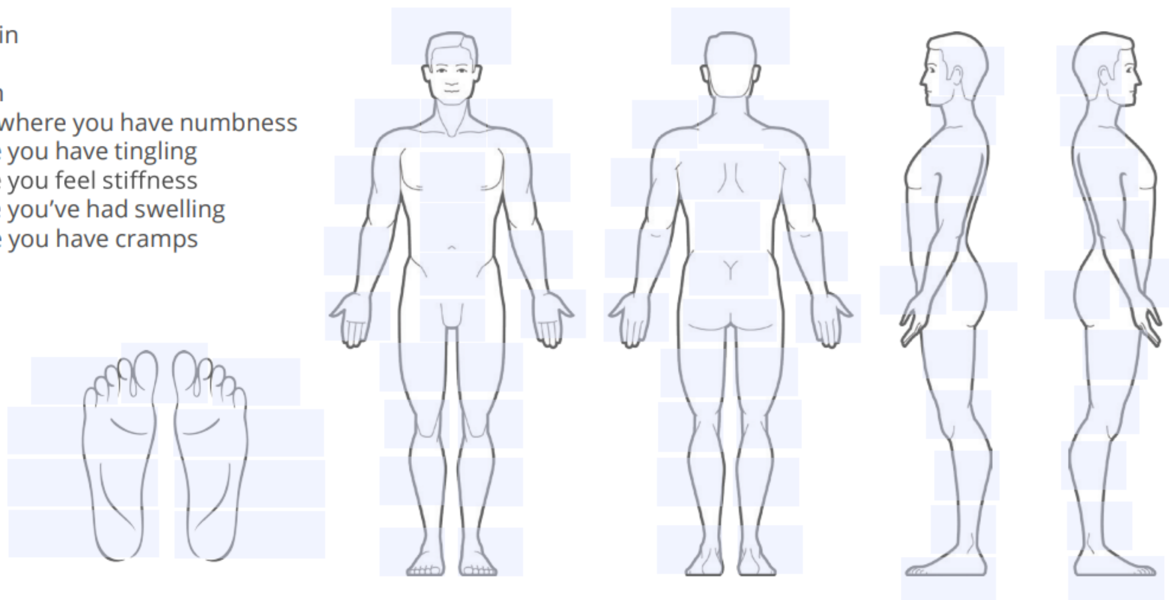
Poor 1 2 3 4 5 6 7 8 9 10 Excellent

What are the 3 greatest concerns about your child's present state of health?

1. ________________ 2. ________________ 3. ________________

Please label any areas where you are experiencing the following symptoms:

"//" stabbing pain
"B" for burning pain
"D" for dull pain
"A" for aching pain
"N" on or in areas where you have numbness
"T" in areas where you have tingling
"St" in areas where you feel stiffness
"Sw" in areas where you've had swelling
"C" In areas where you have cramps
"W" for weakness
"Tr" for tremor



What are activities or responsibilities are being or have been affected by the above issues?

____

What are your goals for your child's care?

1. ________________ 2. ________________ 3. _______________

Have you seen anyone else for this condition? _____ If yes, who? _____________________

Has your child lost missed school because of this condition? _____ If yes, how many?_______

How long has this problem been present? ____

What do you think is causing/triggering your child's present condition?

____

Has you child had any diagnostic testing for this condition? (Describe testing/imaging/lab and dates)____

Indicate any other symptoms you may think may be important: _________________________

Do you now or have you ever suffered from:

- ❑ Headaches
- ❑ Neck pain
- ❑ Upper back pain
- ❑ Midback pain
- ❑ Low back pain
- ❑ Shoulder pain
- ❑ Arm pain
- ❑ Wrist pain
- ❑ Hand pain
- ❑ Upper leg pain
- ❑ Hip pain
- ❑ Knee pain
- ❑ Ankle/foot pain
- ❑ Jaw pain
- ❑ Joint swelling
- ❑ Muscle Aches
- ❑ Numbness/tingling
- ❑ Fatigue
- ❑ Vision problems
- ❑ Ringing in the ears
- ❑ Memory problems
- ❑ Cognitive challenges
- ❑ Brain Fog
- ❑ Concentration difficulties
- ❑ Slow mental development
- ❑ Difficulty Sleeping
- ❑ Restlessness
- ❑ Hyperactivity
- ❑ ADD/ADHD
- ❑ Broken Bones ________
- ❑Scoliosis
- ❑ Dizziness
- ❑ Arrhythmia
- ❑ Colic
- ❑ Abdominal pain
- ❑ Asthma
- ❑ Digestive disorder or troubles
- ❑ Constipation
- ❑ Sinus pain/Congestion
- ❑ Anxiety
- ❑ Low Energy
- ❑ Constipation
- ❑ Diarrhea
- ❑ Allergies
- ❑ Skin Irritations
- ❑ Bedwetting
- ❑ Sensitivity to Light
- ❑ Acne
- ❑ Ear infections
- ❑ Tire Easily
- ❑ Frequent colds
- ❑ Cold/Tingling/ Numbness in Hands/Feet
- ❑ Muscle Aches
- ❑ Recurrent Fever
- ❑Frequent cravings
- ❑ Irritability
- ❑ Depression
- ❑ Mood Swings
- ❑ Temper Tantrums
- ❑ Frequent Colds
- ❑ Epilepsy
- ❑ Dermatitis/Eczema
- ❑ Rash
- ❑ Concussion
- ❑ Slow physical development
- ❑ Loss of balance
- ❑ Muscular incoordination
- ❑ Loss of concentraion
- ❑ Anemia
- ❑ Food aversions
- ❑ Sports injury
- ❑ Other: ________________

Medication List

Medications (Include over-the-counter medications)	Dose (e.g. Strength, # of pills or drops)	Route (e.g. by mouth, inhaled or transdermal)	Frequency (how often)

Supplements/Herbals

Supplement/herbal Name	Dose (e.g. Strength, # of pills or drops)	Route (e.g. by mouth, inhaled or transdermal)	Frequency (how often)

Physical Stressors:

Has your child ever had any accidents, traumas or injuries (including notable childhood injuries and car accidents): (Dates & Description)

____

Has your child ever had any operations/surgeries and/or hospitalizations? (Dates)

____

Has your child ever had any fractures/broken bones or dislocations? (Dates)

____

Has your child ever had any major illness: (Dates):

____

Has your child ever suffered a head injury or concussion? Did he/she lose consciousness? How long?

____

Chemical Stressors:

Please rate you child's CONSUMPTION for each (1=never, 5 = high)

Water

❏1 ❏2 ❏3 ❏4 ❏5

Dairy

❏1 ❏2 ❏3 ❏4 ❏5

Processed Foods

❏1 ❏2 ❏3 ❏4 ❏5

Sugary Drinks

❏1 ❏2 ❏3 ❏4 ❏5

Sugar

❏1 ❏2 ❏3 ❏4 ❏5

Gluten

❏1 ❏2 ❏3 ❏4 ❏5

Artificial Sweeteners

❏1 ❏2 ❏3 ❏4 ❏5

Fast Foods

❏1 ❏2 ❏3 ❏4 ❏5

How would you describe your child's diet?

❏Mostly whole, organic foods ❏Pretty average ❏High in processed/fast foods

Do you have any special dietary restrictions? ______ What type? ____________________

Allergies, Does your child have any food, seasonal or environmental allergies: ______________

What kind? ____

How often do they occur?____

Is your child vaccinated? ________ If yes, did you have an adverse reaction? ______________

Has your child been exposed to any of the following on a regular basis, (past or present)?

Toxic chemicals, Radiation, Second hand smoke, Chemotherapy, Drug therapy ____________

If yes, please list: ____

Emotional Stressors:
It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has experienced any of the emotional stresses below:

Childhood Trauma Y N	Loss of loved one Y N
School Y N	Abuse Y N
Lifestyle change Y. N	Parents divorce Y N

Has your child had any strong emotional stressors either recently, or that has an effect on his/her daily life?
____
Please list any other emotional stresses your child may be experiencing (anxiety, nervousness, depression, etc.)____

Exercise Frequency:
❑1-2x/week ❑3-5x/week ❑Daily ❑Never
What types of exercise do your child perform?____
What are your child's hobbies? ____
Do your child currently play any sports? ____

Pregnancy & Fertility History:
Any fertility issues?__________ If yes, please explain: ______________________________
Did mother smoke?__________ If yes, please explain: _______________________________
Did mother consume alcohol? _______ If yes, please explain: ____
Was mother ill? ______ If yes, please explain: ____
Please explain any notable episodes of mental or physical stress during your pregnancy:
____
Please explain any other concerns or notable remarks about your child's conception or pregnancy:
____
Did you have ultrasounds during pregnancy? ❑Yes ❑No If yes, how many and which months?_____________

Labor & Delivery History
Child birth was:
❑Medicated vaginal birth ❑Un-medicated vaginal birth ❑Scheduled cesarean ❑Emergency cesarean
How many weeks was your child born?____________________________
Child birth was: ❑Hospital ❑Birthing Center ❑At home ❑Other _____________________
Please check any applicable interventions or complications:
❑Breech ❑Induction ❑Pain Medication ❑Epidural ❑Episiotomy ❑Vacuum extraction ❑Forceps ❑Other
Please describe any other concerns or notable remarks about your child's labor and/or delivery:
____
Child's birth weight and height: ____
APGAR Score (if known): ____

Growth & Development History

Is/was your child breastfed? ❑Yes ❑No If yes, how long? ___________________________

Any difficulty with breastfeeding? ❑Yes ❑No If yes, explain: ______________________________

Did they every use formula? ❑Yes ❑No If yes, what age & what type: ___________________

Did your child ever suffer from colic, reflux, or constipation as an infant? ❑Yes ❑No

If yes, please explain: ____

Did/does your child frequently arch their neck/back, feel stiff, or bend their head? ❑Yes ❑No

If yes, please explain: ____

At what age did the child:

❑Hold their head up: __________________ ❑Sit on their own: __________________

❑Teethe: ____________________________ ❑Crawl: ___________________________

❑Walk: _____________________________ ❑Talk: ____________________________

❑Begin cow's milk: __________________ ❑Begin solid foods: ________________

Has your child received any antibiotics? ❑Yes ❑No If yes, how many times and list reason(s):

____

How many hours of sleeping per night: ____

Any night terrors or difficulty sleeping? ❑Yes ❑No

Behavioral, social or emotional issues? ❑Yes ❑No If yes, please explain: __________________________

How many hours per day does your child spend watching a TV, computer, tablet, phone, etc.? ______________

Patient Authorization:

Thank you for taking the time to fill out this health history questionnaire. This information is important to the doctor obtaining an accurate clinical picture. Please sign below authorizing that the information in this form has been read and filled out completely and accurately to the best of your understanding and you agree to allow this office to examine your child for further evaluation.

_______________________________________ ___________________________

Patient's (or guardian's) signature Date

_______________________________________ ___________________________

Patient's (or guardian's) printed name Date

Privacy Act:

I consent to the use of my child's protected health information by Dr. Nisreen Tayebjee DC for the purpose of analyzing, assessing and providing treatment recommendations to my child, obtaining payment for my health care bills or conduct health care operations. HIPAA Compliance. Furthermore, I understand that the information in this form is considered confidential and for use by your doctor at Fitness Genome Tayebjee Chiropractic Neurology Center.

_______________________________________ ___________________________

Patient's (or guardian's) signature Date

_______________________________________ ___________________________

Patient's (or guardian's) printed name Date

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always

Category I

Feeling that bowels do not empty completely 0 1 2 3
Lower abdominal pain relieved by passing stool or gas 0 1 2 3
Alternating constipation and diarrhea 0 1 2 3
Diarrhea 0 1 2 3
Constipation 0 1 2 3
Hard, dry, or small stool 0 1 2 3
Coated tongue or "fuzzy" debris on tongue 0 1 2 3
Pass large amount of foul-smelling gas 0 1 2 3
More than 3 bowel movements daily 0 1 2 3
Use laxatives frequently 0 1 2 3

Category II

Increasing frequency of food reactions 0 1 2 3
Unpredictable food reactions 0 1 2 3
Aches, pains, and swelling throughout the body 0 1 2 3
Unpredictable abdominal swelling 0 1 2 3
Frequent bloating and distention after eating 0 1 2 3

Category III

Intolerance to smells Intolerance to jewelry 0 1 2 3
Intolerance to shampoo, lotion, detergents, etc 0 1 2 3
Multiple smell and chemical sensitivities 0 1 2 3
Constant skin outbreaks 0 1 2 3

Category IV

Excessive belching, burping, or bloating 0 1 2 3
Gas immediately following a meal 0 1 2 3
Offensive breath 0 1 2 3
Difficult bowel movements 0 1 2 3
Sense of fullness during and after meals 0 1 2 3
Difficulty digesting proteins and meats; undigested food found in stools 0 1 2 3

Category V

Stomach pain, burning, or aching 1-4 hours after eating 0 1 2 3
Use of antacids 0 1 2 3
Feel hungry an hour or two after eating 0 1 2 3
Heartburn when lying down or bending forward 0 1 2 3
Temporary relief by using antacids, food, milk, or carbonated beverages 0 1 2 3
Digestive problems subside with rest and relaxation 0 1 2 3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine 0 1 2 3

Category VI

Difficulty digesting roughage and fiber 0 1 2 3
Indigestion and fullness last 2-4 hours after eating 0 1 2 3
Pain, tenderness, soreness on left side under rib cage 0 1 2 3
Excessive passage of gas 0 1 2 3
Nausea and/or vomiting 0 1 2 3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed 0 1 2 3
Frequent loss of appetite 0 1 2 3

Category VII

Abdominal distention after consumption of fiber, starches, and sugar 0 1 2 3
Abdominal distention after certain probiotic or natural supplements 0 1 2 3
Decreased gastrointestinal motility, constipation 0 1 2 3
Increased gastrointestinal motility, diarrhea 0 1 2 3
Alternating constipation and diarrhea 0 1 2 3
Suspicion of nutritional malabsorption 0 1 2 3
Frequent use of antacid medication 0 1 2 3

Category VIII

Greasy or high-fat foods cause distress 0 1 2 3
Lower bowel gas or bloating several hours after eating 0 1 2 3
Bitter metallic taste in mouth, especially in the morning 0 1 2 3
Burpy, fishy taste after consuming fish oils 0 1 2 3
Unexplained itchy skin 0 1 2 3
Yellowish cast to eyes 0 1 2 3
Stool color alternates from clay colored to normal brown 0 1 2 3
Reddened skin, especially palms 0 1 2 3
Dry or flaky skin and/or hair 0 1 2 3
History of gallbladder attacks or stones 0 1 2 3
Have you had your gallbladder removed? *YES NO*

Category IX

Acne and unhealthy skin 0 1 2 3
Excessive hair loss 0 1 2 3
Overall sense of bloating 0 1 2 3
Bodily swelling for no reason 0 1 2 3
Hormone imbalances 0 1 2 3
Weight gain 0 1 2 3
Poor bowel function 0 1 2 3
Excessively foul-smelling sweat 0 1 2 3

Category X

Crave sweets during the day 0 1 2 3
Irritable if meals are missed 0 1 2 3
Depend on coffee to keep going/get started 0 1 2 3
Get light-headed if meals are missed 0 1 2 3
Eating relieves fatigue 0 1 2 3
Feel shaky, jittery, or have tremors 0 1 2 3
Agitated, easily upset, nervous 0 1 2 3
Poor memory, forgetful between meals 0 1 2 3
Blurred vision 0 1 2 3

Category XI

Fatigue after meals 0 1 2 3
Crave sweets during the day 0 1 2 3
Eating sweets does not relieve cravings for sugar 0 1 2 3
Must have sweets after meals 0 1 2 3
Waist girth is equal or larger than hip girth 0 1 2 3
Frequent urination 0 1 2 3
Increased thirst and appetite 0 1 2 3
Difficulty losing weight 0 1 2 3

Category XII

Cannot stay asleep	0 1 2 3
Crave salt	0 1 2 3
Slow starter in the morning	0 1 2 3
Afternoon fatigue	0 1 2 3
Dizziness when standing up quickly	0 1 2 3
Afternoon headaches	0 1 2 3
Headaches with exertion or stress	0 1 2 3
Weak nails	0 1 2 3

Category XIII

Cannot fall asleep	0 1 2 3
Perspire easily	0 1 2 3
Under a high amount of stress	0 1 2 3
Weight gain when under stress	0 1 2 3
Wake up tired even after 6 or more hours of sleep	0 1 2 3
Excessive perspiration or perspiration with little or no activity	0 1 2 3

Category XIV

Edema and swelling in ankles and wrists	0 1 2 3
Muscle cramping	0 1 2 3
Poor muscle endurance	0 1 2 3
Frequent urination	0 1 2 3
Frequent thirst	0 1 2 3
Crave salt	0 1 2 3
Abnormal sweating from minimal activity	0 1 2 3
Alteration in bowel regularity	0 1 2 3
Inability to hold breath for long periods	0 1 2 3
Shallow, rapid breathing	0 1 2 3

Category XV

Tired/sluggish	0 1 2 3
Feel cold—hands, feet, all over	0 1 2 3
Require excessive amounts of sleep to function properly	0 1 2 3
Increase in weight even with low-calorie diet	0 1 2 3
Gain weight easily	0 1 2 3
Difficult, infrequent bowel movements	0 1 2 3
Depression/lack of motivation	0 1 2 3
Morning headaches that wear off as the day progresses	0 1 2 3
Outer third of eyebrow thins	0 1 2 3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0 1 2 3
Dryness of skin and/or scalp	0 1 2 3
Mental sluggishness	0 1 2 3

Category XVI

Heart palpitations	0 1 2 3
Inward trembling	0 1 2 3
Increased pulse even at rest	0 1 2 3
Nervous and emotional Insomnia	0 1 2 3
Night sweats	0 1 2 3
Difficulty gaining weight	0 1 2 3

Category XVII (Males Only)

Urination difficulty or dribbling	0 1 2 3
Frequent urination	0 1 2 3
Pain inside of legs or heels	0 1 2 3
Feeling of incomplete bowel emptying	0 1 2 3
Leg twitching at night	0 1 2 3

Category XVIII (Males Only)

Decreased libido	0 1 2 3
Decreased number of spontaneous morning erections	0 1 2 3
Decreased fullness of erections	0 1 2 3
Difficulty maintaining morning erections	0 1 2 3
Spells of mental fatigue Inability to concentrate	0 1 2 3
Episodes of depression	0 1 2 3
Muscle soreness	0 1 2 3
Decreased physical stamina	0 1 2 3
Unexplained weight gain	0 1 2 3
Increase in fat distribution around chest and hips	0 1 2 3
Sweating attacks	0 1 2 3
More emotional than in the past	0 1 2 3

Category XIX (Menstruating Females Only)

Perimenopausal	0 1 2 3
Alternating menstrual cycle lengths	0 1 2 3
Extended menstrual cycle (greater than 32 days)	0 1 2 3
Shortened menstrual cycle (less than 24 days)	0 1 2 3
Pain and cramping during periods	0 1 2 3
Scanty blood flow	0 1 2 3
Heavy blood flow	0 1 2 3
Breast pain and swelling during menses	0 1 2 3
Pelvic pain during menses	0 1 2 3
Irritable and depressed during menses	0 1 2 3
Acne	0 1 2 3
Facial hair growth	0 1 2 3
Hair loss/thinning	0 1 2 3

Category XX (Menopausal Females Only)

How many years have you been menopausal?	_____ *Years*
Since menopause, do you ever have uterine bleeding?	*YES NO*
Hot flashes	0 1 2 3
Mental fogginess	0 1 2 3
Disinterest in sex	0 1 2 3
Mood swings	0 1 2 3
Depression	0 1 2 3
Painful intercourse	0 1 2 3
Shrinking breasts	0 1 2 3
Facial hair growth	0 1 2 3
Acne	0 1 2 3
Increased vaginal pain, dryness, or itching	0 1 2 3