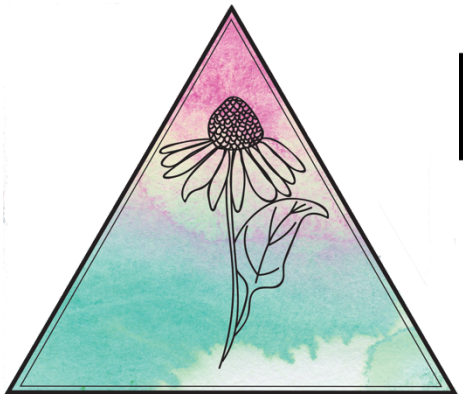

ENDOCRINE WELLNESS

Dr. Annette Kutz Schippel
1035 Junction Circle – Springfield, IL 62704
Phone (217) 370-5060 Fax (217) 210-0452
Email: endocrinewellness@gmail.com
www.endocrinewellnessgroup.com

Patient Information

Date: _____

Child's Full Name: _____ DOB: _____/_____/_____

Parent's Name(s): _____

Address, City, State, Zip: _____

Preferred Phone: _____ Atl. Phone: _____

Parent's Email: _____

Child's Sex: M F Age: _____ Height: _____ Weight: _____

Who is your child's primary care physician? _____

Are you seeing any other healthcare provider? _____

Who may we thank for referring you? _____

Billing Information: You must provide a credit/debit card number below or provide one at time of consultation.

Credit Card Type: Visa / MasterCard / Discover/Amex (please circle one)

CC #: _____ Expiration Date: _____ / _____

CVV: _____ Zip: _____

Consent to Treat

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son/daughter as the examining/treating doctor deems necessary. I understand and agree that I am personally responsible for payment of all these fees charged by this office for such care.

HIPAA – Notice of Privacy Policies

The notice of privacy practices describes how we may use and disclose your protected health information to carry out treatment, payment, or other healthcare operations. It also describes your rights to access and control your protected health information. "Protected health information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health. Please be advised that our office may deem it necessary to discuss your PHI with other treatment facilities, laboratories, or payment centers, among other reasons, with or without your consent. A full explanation of our rights and responsibilities as a healthcare facility and your rights as a patient, under HIPAA requirements, is available upon request.

Disclaimer

Please be advised that the nutritional and herbal programs that are administered by our office, and/or Dr. Annette Schippel are not intended as a primary therapy for any disease, but rather to provide nutritional and herbal support for normal body physiology and repair. Also be advised that any and all testing ordered by our office and/or Dr. Annette Kutz Schippel, whether it be by saliva, hair analysis and/or blood work is not used to treat or diagnose any disease. These types of testing simply offer guidance on how to use whole food supplements and herbs to support and balance the body, while dealing with imbalances.

Billing

We do not bill insurance for nutritional services, nor do we provide CPT or diagnosis codes for you to do so, as the nutritional work performed by Dr. Annette Kutz Schippel is not designed to diagnose or treat a disease. We would appreciate it if you were prepared to pay your consultation fee at the time of service.

Return Policy

Supplements must be in their original box/package. Boxes and bottles must be unopened. No expired products will be accepted. Any returns, for any reason are subject to a 20% restocking fee. No exceptions.

Please sign to confirm that you have read and understand the above information.

Patient Signature _____ Date _____

Thank you so much for taking the time to fill out this packet of information.
We look so forward to working with and getting to know you. We are dedicated to finding the best individual path for each of our patients.

Current Health Status/Concerns

Please provide us with current and ongoing problems

Problem	Date of Onset	Severity/Frequency	Treatment Approach	Success
Example: Headaches	May 2006	2 times per week	Acupuncture/Aspirin	Mild improvement

What diagnosis or explanation(s), if any, have been given to you for these concerns?

_____

_____

_____

When was the last time that your child felt well?_____

What seems to trigger his/her symptoms?_____

What seems to worsen his/her symptoms?_____

What seems to make him/her feel better?_____

What physician or other health care provider (including alternative or complimentary practitioners) have you seen for these conditions?_____

_____

_____

_____

Past Medical & Surgical History

If your child has experienced reoccurrence of an illness, please indicate when or how often under comments.

Illnesses	When /Onset	Comments
ADD/ADHD		
Anemia		
Asthma		
Bronchitis		
Cancer (specify type)		
Chicken Pox		
Chronic bacteria or fungal infection		
Congenital problems		
Constipation		
COVID		
Crohn's Disease or Ulcerative Colitis		
Diabetes (all types)		
Ear Infections (specify frequency)		
Epilepsy, convulsions, or seizures		
Fever blisters		
Hepatitis		
Herpes Lesions		
Hand-Foot-Mouth Disease		
Hyperactivity		
Influenza		
Irritable bowel (or chronic diarrhea)		
Jaundice		
Kidney stones		
Lyme		
Measles, Mumps, Rubella		
Mononucleosis or EBV		
Parasite Infection		
Pneumonia		
Ringworm		
RVS		
Sinusitis		
Thyroid disease (including Graves and Hashimoto's)		
Upset stomach, digestive problems		
Warts		

Whooping Cough		
Yeast Infections or Thrust		
Other (describe)		

Injuries	When	Comments
Back injury		
Broken bones or fractures (describe)		
Head injury or Concussion		
Neck injury		
Other (describe)		

Diagnostic Studies	When	Comments
Biopsy (specify location)		
Blood Tests		
CAT Scan		
MRI		
X-Ray (Please indicate type)		
Other (describe)		

Surgeries	When	Comments
Appendectomy		
Dental Surgery		
Gall Bladder		
Hernia		
Tonsillectomy		
Tubes in Ears		
Other (describe)		

Hospitalizations

Where Hospitalized	When	Reason

Medications

Prescription Drug Usage

Is your child presently receiving any medications? Yes____ No_____

List all medications your child is currently on. Include over the counter non-prescription drugs.

Medication Name	Date started	Date stopped	Dosage

List all vitamins, minerals, and any nutritional supplements that your child is taking now.

Type	Date Started	Date Stopped	Dosage

Is your son/daughter allergic to any medication, vitamin, mineral, or other nutritional supplement?
Yes___ No ___

If yes, please list:_____

_____

Childhood History

Please answer to the best of your knowledge.

	Yes	No	Don't Know	Comment
Was your child a full-term baby?				
A premature birth? ('preemie')				
Breast fed?				
Bottle fed?				

When pregnant, did your child's mother:

Smoke tobacco?				
Use recreational drugs?				
Drink alcohol?				
Use estrogen?				
Other prescription or non-prescription medications?				

As a baby, how was your child fed? *(Please circle BREAST or FORMULA)*
BREAST How long? _____
FORMULA What kind? _____ How long? _____

Immunization History

Please indicate if you have been vaccinated against any of the following diseases:	Yes	No	Don't Know	Comment (Any know adverse reactions)
Smallpox				
DTaP (Diphtheria, Tetanus, Pertussis)				
Polio (oral or injected)				
Hepatitis (specify type)				
MMR (Mumps, Measles, Rubella)				
Typhoid				
Cholera				
Influenza (Flu Shot)				
RSV				
HPV				
COVID (specify number of doses and maker)				

Has your child been vaccinated recently (past 6-8 months)? Yes_____ No_____

If your child has experienced ear infections, in which ear do your child's earaches/infections usually occur? Right____ Left____ Both_____

Were your child's earaches/infections generally treated with antibiotics? Yes____ No_____

Does your child have high absence from school? Yes___ No___

If yes, why? _____

To your knowledge, has your child ever been exposed to toxic metals in school or at home? YES NO

If yes, indicate which:

☐ Lead ☐ Arsenic ☐ Aluminum ☐ Cadmium ☐ Mercury

Milestones

Please indicate the most complex skill that your child can perform in each section. In each section, the tasks are arranged in order of increasing developmental age.

Gross Motor Skills

□ Able to hold head up momentarily
□ Head & shoulders can support by forearms
□ Infant can be pulled into a sitting position by hands
□ Sits unsupported in the upright position
□ Head and shoulders can be supported by arms
□ Rolls from prone to supine positions
□ Crawls
□ Stands holding furniture
□ Walks with someone holding onto one hand
□ Walks unassisted
□ Runs
□ Negotiates stairs placing 2 feet on each step
□ Climbs stairs using one foot on each step
□ Walks downstairs with one foot on each step
□ Hops on one foot

Social Skills

□ Smiles
□ Reaches for familiar objects
□ Plays with hands
□ Plays with feet
□ Clearly shows joy and pleasure
□ Feeds self with fingers
□ Plays peek-a-boo
□ Understands yes and no

Fine Motors Skills

□ Primitive grasp reflex present
□ Holds & shakes an object in the hand
□ Grasps objects independently
□ Moves an object from one hand to the other
□ Self-feeding, can hold and eat without assistance
□ Checks objects by placing in the mouth
□ Picks up objects with thumbs and index finger
□ Turns 2 to 3 pages of a book at a time
□ Builds a tower containing at least 5 blocks
□ Builds a tower containing at least 10 blocks

Communication Skills

□ Makes cooing sound
□ Laughs
□ Uses one syllable words such as "da"
□ Uses 2-to-3 word vocabulary
□ Uses 2-ro03 word phrases

Adaptive Skills

□ Feed from a cup unassisted
□ Holds own bottle
□ Feeds self with utensils
□ Able to identify and match some colors
□ Copies a circle
□ Copies a cross

Diet & Eating Habits

Is your child's diet high in:	Yes	No	Don't Know	Comment
Sugar? (Sweets, Candy, Cookies, etc.)				
Soda?				
Fast food, pre-packaged foods, artificial sweeteners?				
Milk, cheeses, other dairy products?				
Meat, vegetables, & potato diet?				
Vegetarian diet?				
Diet high in white breads?				

Are there foods that your child must avoid because they give him/her symptoms? Yes___ No___
If yes, please explain: (Example: milk – diarrhea)_____
_____
_____

Does your child have symptoms ***immediately after*** eating, such as belching, bloating, sneezing, hives, etc.? Yes___ No____

If yes, are these symptoms associated with any particular food or supplement? Yes___ No____

If yes, please name the food or supplement and symptom(s). _____
_____

Do you feel that your son/daughter has ***delayed*** symptoms after eating certain foods, such as rash, fatigue, muscle aches, sinus congestion, etc.? (Symptoms may not be evident for 24 hours or more) Yes___ No____

Does he/she feel **worse** when eating a lot of:

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ Other_____

Does he/she feel **better** when eating a lot of:

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other_____

Does your child have an aversion to certain foods? Yes _____ No _____
If yes, what food(s) _____
_____

Experience chronic exposure to secondhand smoke in your home? Yes___ No___

Please complete the following chart as it relates to your child's bowel movements:

Frequency	√	**Color**	√
More than 3x/day		Medium brown consistently	
1-3x/ day		Very dark or black	
4-6x/week		Greenish color	
2-3x/week		Blood is visible	
1 or fewer x/week		Varies a lot	
		Dark brown consistently	
Consistency	√	Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often floats			
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose but not watery			
Alternating between hard and loose			

Urinary Frequency or Bladder Habits

When was your child toilet trained? _____

Did your child wet the bed after being toilet trained? Yes____ No____

If yes, for how long? _____ Any treatment given? Yes____ No____

If yes, what kind? _____

Sleep

How well does your child sleep?

□Well □ Trouble falling asleep □ Trouble staying asleep □ Insomnia

What is the average number of hours your child most often sleeps each night? _____

When your child wakes in the morning does he/she still feel tired? Yes____ No____

If yes, how often? _____

Do you keep your child's room completely dark at night? Yes____ No____

Does your child take naps? Yes___ No____

How often would you say your child has nightmares, if at all? NEVER SOMETIMES OFTEN

Exercise (Ages 4 years old and up)

Does your child get physical activity regularly? Yes____ No____

Please list what type of physical activity and/or sport that your child participates in:

_____

_____

_____

Emotional Status (Ages 4 years and up)

Does your child seem happy overall? Yes____ No____

Overly sensitive without good cause (i.e. overtired, hungry)? Yes____ No _____

Have extreme mood swings or extreme bursts of anger? Yes____ No _____

Does your child seem to have a lot of friends? Yes____ No____

Is your child bullied at school or by a family member? Yes____ No____

How does your child seem to cope with stress? (ex. Read, play video games, listen to music)_____

_____

Family Health History

Please indicate current and past family history to the best of your knowledge

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age (if still living)									
Age at death (if deceased)									
Heart Attack									
Stroke									
Uterine Cancer									
Colon Cancer									
Breast Cancer									
Ovarian Cancer									
Prostate Cancer									
Skin Cancer									
ADD/ADHD									
ALS or other Motor Neuron Diseases									
Alzheimer's									

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Anemia									
Anxiety									
Arthritis									
Asthma									
Autism									
Autoimmune Diseases									
Bipolar Disease									
Bladder disease									
Blood clotting problems									
Celiac disease									
Dementia									
Depression									
Diabetes									
Eczema									
Emphysema									
Environmental Sensitivities									
Epilepsy									
Flu									
Genetic Disorders									
Glaucoma									
Headache									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)									
Inflammatory Bowel Disease									
Insomnia									
Irritable Bowel Syndrome									
Kidney disease									
Multiple Sclerosis									
Nervous breakdown									
Obesity									

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Osteoporosis									
Other									
Parkinson's									
Pneumonia/Bronchitis									
Psoriasis									
Psychiatric disorders									
Schizophrenia									
Sleep Apnea									
Smoking addiction									
Substance abuse (such as alcoholism)									
Ulcers									

Is there anything that you would like to discuss with the doctor today that you feel was not covered on this form? Yes_____ No_____
Comments _____
_____
_____

Readiness Assessment

Circle the number that best fits on a scale of 1 (not willing) to 5 (very willing).

To improve your health, how willing are you to:

Significantly modify your diet	1	2	3	4	5
Take nutritional supplements every day	1	2	3	4	5
Keep a record of everything you eat each day	1	2	3	4	5
Modify your lifestyle (e.g., work, sleep habits etc.)	1	2	3	4	5
Practice relaxation techniques	1	2	3	4	5
Engage in regular exercise	1	2	3	4	5
Have periodic lab tests to assess progress	1	2	3	4	5

Thank you for taking the time to complete this health history medical questionnaire. The information derived from all of these forms will provide invaluable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms alone.

We look forward to helping you achieve lifelong health and wellbeing.

Yours in Health,

Dr. Annette Kutz Schippel