JODY SHEVINS, ND

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Greetings,

It is extremely helpful to have you prepare some information before your first appointment. This ensures that our visit is as thorough and useful as possible. These forms include a questionnaire, diet diary, disclosures and consent forms. Please complete all four pages of the questionnaire, especially the history. You can fill out the diet diary for any 3 days in a row between now and your appointment.

Thank you for putting your time into this preparation and please remember to bring them with you to your appointment.

If you need to cancel your appointment, please call at least 24 hours in advance. Barring emergencies, there will be a charge for missed first appointments not cancelled at least a day ahead.

Payment is expected at the time of your visit. We accept cash, check or credit card.

I look forward to meeting with you.

Sincerely,

Jody K. Shevins, ND

dr.shevins@gmail.com

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Child's Name _____

Address_____ Date_____ Gender_____

City _____State____ Zip_____ Date of Birth _____

Home Phone_____ Name of parents _____

Work Phone _____ _____

Cell Phone _____ Email address_____

Indicate any ailments which have affected your relatives. Do/did they have the same ailments as you? Possible ailments: AIDS, alcoholism, allergies, arthritis, asthma, cancer, diabetes, drug addiction, epilepsy, frequent colds, gonorrhea, gout, heart problems, mental illness, neurological problems obesity, pleurisy, pneumonia, skin problems, syphilis, thyroid problems, tuberculosis, ulcers, warts.

RELATIVE	AGE	AGE AT DEATH	AILMENTS
MOTHER			
FATHER			
SISTERS			
BROTHERS			
MATERNAL GRANDMOTHER			
MATERNAL GRANDFATHER			
MATERNAL AUNT/UNCLE			
PATERNAL GRANDMOTHER			
PATERNAL GRANDFATHER			
PATERNAL AUNT/UNCLE			

Referred by _____

What would you like cured? *Please be brief*. Details will be reviewed during your consultation.

Describe any significant stresses, illnesses or medications during this child's pregnancy.

Briefly describe this child's birth including any medications or interventions.

Did/does this child nurse? Yes/no. If so for how long? Any particular difficulties?

If not, what type of formula was used?

What vaccines were given and were there any reactions?

If child is male, was he circumcised? Yes/no. Please describe any complications if relevant.

At what age did your child: walk_____ first teeth_____ talk_____

Girls: If menses have begun, what was her age at first period? Any concerns?

Your Child's Health/Life History

Please write a brief timeline of your child's life. Beginning with birth, list major illnesses, injuries, hospitalizations, significant turning points or major events in their life. Also include any major use of medications or recreational drugs. Keep it simple, we will go into detail as needed.

DIET DIARY

Please list everything that your child eats, drinks or takes for three consecutive days. If your child is nursing, please list mother's dietary intake as well.

DAY ONE DAY TWO DAY THREE

Please list all supplements, herbs and medications that the child and nursing mother are taking.