Abundant Health Holistic Center
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PEDIATRIC INTAKE FORM

Child's Name: ____ Today's Date: ________________
Date of Birth: ___________ Height: _________ Weight: _________ ❒ Male ❒ Female Child's Age: ___________
Grade Level: ___________ Referred by:____
Name and relation of individual who is filling out this form: ______________________________________
How did you hear about us? ❒ Friends ❒Family ❒ Website ❒Newspaper Yellow Pages: ❒ Sprint ❒ AT&T (BellSouth)
❒ Presentation ❒ Magazine ❒ Radio Other ____

How do you hope your child will benefit from care with us? Check all that apply:
Improvement of: ❒ Physical symptoms ❒ Emotional/mental symptoms ❒ Overall improved quality of life
❒ In the ability to respond to stress Other: ____

Has your child experienced any of the following health, treatment or healing modalities?
❒ Chiropractic ❒ Homeopathy ❒ Herbs ❒Massage❒ Craniosacral Therapy ❒ Emotional therapy/psychotherapy
❒ Acupuncture ❒Nutritional Counseling Therapy ❒ Light ❒ Music ❒ Dance ❒ Sound ❒Aromatherapy ❒Ayurvedic Medicine ❒ Reiki/Energy work Other:____
If so, please describe:
When you went ______________________________________ for how long ____________________
What diagnoses have you been given: ____
How would you describe your experience? ____
Was it effective? Why/Why Not? ____

Contacts (in order of preference)

Name and relation to child:____
Phone: (hm) __________________ (wk)__________________(cell) ________________ Email ____________________
Address:____

Name and relation to child:____
Phone: (hm) __________________ (wk)__________________(cell) ________________ Email ____________________
Address:____

Whom does the child live with?____

Child's Other Health Care Providers

Provider's name:____ Phone: ________________________
Address (if available):____

Provider's name:____ Phone: ________________________
Address (if available):____

Health and Development

of biological Brothers: ______ Sisters: ______ Place in the birth sequence #: ____Blended family siblings __________
How was the child's health in the first year? ❒Excellent ❒Very Good ❒Good ❒Fair ❒Poor ❒Unknown
Now? ❒Excellent ❒Very Good ❒Good ❒Fair ❒Poor ❒Unknown Compared to one year ago, how would you rate your child's general health now? ❒Excellent ❒Very Good ❒Good ❒Fair ❒Poor ❒Unknown
At what age did the child first: Sit up _______Crawl ________ Walk _______ Talk _______ Begin teething? ________
Were there any difficulties associated with teething? __________________Fontanelles closing _______________

Health Concerns   Name: ___________________________________

Does your child have any known contagious diseases at this time? ❒ No ❒ Yes __________________________________
Does your child have any known life-threatening allergies? ❒ No ❒ Yes: ____

Please rank current & ongoing health problems you desire treatment for by priority and complete the symptoms:
1. Primary health concern: ❒ Mild ❒ Moderate ❒ Severe ____
____
At what age / Date did this condition/illness begin:____
What do you think might have caused this condition? (life trauma, surgery, drug reactions)
____
Time of day/night it came on _______________________________ The Onset was ❒Sudden ❒Gradual ❒Getting worse

Interferes with ❒Sleep ❒School ❒Play Worst thing about it ____

What does the pain/symptom feel like? ❒ Sharp ❒Dull ❒Ache ❒Pressure ❒Shooting ❒Radiating ❒Pulsating
Other ____ Did Grief or shock precede it? ❒Yes ❒No
What makes it **worse**? □ Heat □ Cold □ Activity □ Rest □ Emotions □ Stress □ Environment □ Other _______________
What makes it **better**? □ Heat □ Cold □ Activity □ Rest □ Emotions □ Stress □ Environment □ Other _______________
When does it happen? _________________________________ What does it look like? ___________________________
Do any other symptoms occur immediately before, during or after? ____
Do they tend to occur or become worse □daily □weekly □alternate days □ yearly □new □full moon □Barometer changes
Other _______________________________ What has improved this condition? __________________________________
What other (possibly unrelated) events occurred around the time the condition began?_______________________________
____
What, if any, medications or supplements have been used to treat this condition and what was their effectiveness?
____

Other health concerns- Please describe complete details and what makes it better or worse as above:
2. ❒ Mild ❒ Mod ❒ Severe____
____
3. ❒ Mild ❒ Mod ❒ Severe____
____
4. ❒ Mild ❒ Mod ❒ Severe____
____

Environment

Are there any pets in the home? ❒ Yes ❒No If yes, what type and how many? _________________________________
How is the child's home heated? ________________________ Does anyone in the child's household smoke? ❒Yes ❒No
How would you describe the emotional climate of the child's home? ____
Are there any known environmental or chemical sensitivities (e.g., perfumes, detergents, odors, soaps, etc.)? ❒yes ❒no
Toxin Exposure Has the child ever lived near a refinery, polluted area or in a home with leaded paint? If so, what sort of pollution was s/he exposed to? ____
Has the child ever lived in a house that had new carpeting, paint, cabinets or any other refurbishing that seemed to affect their health at all? ____
Do you spray pesticides, herbicides or other chemicals around your home?____

Mental /Emotions □Normal □ Problem □ Recent change in Emotion

Predominant Emotion: □ Joy □ Fear □ Anger □Anxiety/Worry □Sadness □Shock □Grief **Below:** Check all that apply:

Child is:	**Emotionally**	**Has had**	**Poor memory for:**	**Dwells on:**
□ Outgoing □Extrovert	□Happy □Irritable □Sad	□Panic attacks	□Words □ Places	□Past disagreements
□ Introvert □Restless	□Grieving □Joyless	□Depression	□Where going	□Illness □Misfortune
□ Ambitious □Driven	□Fearful □Angry	□Anxiety	□ Doing □People	□School □Friends
□ Jealous □Dreamer	□Indifferent □Loathe Life	□Bad Temper	□Train of thought	□Suicide □Death
□Suspicious □Timid	□Impulsive □Moody	□Phobias	□ Omit letters words	□Future Events

Better **W**orse □B □W Thunderstorms □B □W Consolation □B □W Alone □B □W Crowds □B □W Contradiction
□Nervous □Difficult concentration Where is stress held in body? __________ How do they relax?__________________
How do they feel about school?_______________ Home life? _______________ Social life?______________________

Generalities **Name: ___________________________________**

❒Right ❒Left Handed. ❒Ambidextrous Blood Type________
Does the child tend to get sick the same season(s) year after year? ❒Yes ❒No Which one(s) ________________________
When ill or injured the side of the body most affected is: □Right □Left □Both □Right to Left □Left to Right □Don't Know
On injured/sick parts: □Better □Worse **Cold** □Better □Worse **Warm** □Better □Worse **Hot applications** □Don't know
Dislike: □ Tight Clothing □ Ties/Collars □ Belts Time Complaints usually come on___________ last until ____________

Usual Body Temperature _____**F** Chronic Fever**?** □Low □Hi □ Alternates daily or weekly (Tidal Fever)
□Feels cold easily □Cold hands □Cold feet □Feels Hot easily □Hot hands □Hot feet □Alternate feeling hot and cold
Prefer Thermostat set @ ______ Why? ____________ Wear most of the time a □Hat □Sweater □ Coat **Why**? ________
Sensitive to: □Cold □Hot □Humidity □Damp Conditions (House, Outdoors etc) □Dry climate □Light □Noise □ Sun
□ Drafts or Windy Conditions □ Uncovering □ Extreme temperature changes □ Weather changes (Barometer):
□Hot to Cold □AC to Summer Heat □Cool Nights w Hot Days □**Needs Fresh Air/Fan** □Closed room OK □It can be stuffy
Child is □Better □Worse **Outdoors** Why _________________ **Other** _____________________________________
Environment / Travel Do they like to travel? □ Y □ N Where to ____
Child is □Better □Worse **Mountains** □Better □Worse **Seashore** □Better □Worse **Desert Travel Often?** □Yes □No

Dietary History

What is the approximate weight of your child? ________Has there been any recent weight gain or weight loss? □Yes □No
Please describe the child's eating habits (e.g., ❒good appetite, ❒picky eater, ❒Sneaking/hoarding food): ____________
Are you satisfied with your child's diet the way that it is now? Why or why not? _____________________________________

Aversions/Dislikes: ____________________________ Cravings whether eaten or not? _____________________________
Comfort Foods _______________________________ Food Allergies or Intolerances_____________________________
Does the child have any dietary restrictions (vegetarian/vegan, religious, junk food etc.)?___________________________

Describe the child's usual diet on a typical day:
Breakfast: ____ Lunch: ____
Dinner: ____ Snacks: _______________________________________

Thirst □Increased □Decreased □Always Thirsty □Thirsty w No Desire to Drink □No Thirst. **Prefer** □Freq Small Sips
□ Large Sips □Gulps **Usually prefer drinks** □Hot □Warm □Room Temp □Cold □Iced or □Lots of Ice □ Chews Ice
Cups/Glasses: Water _____ Tea _____ Soda ______ Juices____ Coffee _____Prefers to drink ____________________

How many x day do they have: Meat ______ Veggies ______Dairy ______ (□milk □cheese □yogurt □ice cream) _____ Soy _____
Fish _____ Chicken _____ Caffeine ______ Artificial Sugar ____ Diet Soda ____ Sugar/Sweets ____Processed Foods ________
Soy Rice or Almond Milk ____ non-edible things like ❒dirt ❒blanket fuzz ❒chalk ❒glue other ___________________________
Consumes ❒Sugar ❒Aspartame ❒Splenda ❒Diet Products ❒Fat free products ❒Stevia ❒Xylitol other _____________
each of these tastes **in order of preference Craves:** Sweet ____Salty ____ Sour ____ Spicy ___Smoked___ Bitter ___
Avoids: Sweet ___Salty ___Sour __ Spicy ___Smoked ___ Bitter ____

How was the infant fed? ❒Breast fed ❒ Formula (❒milk ❒soy ❒rice ❒goat milk Other: ________________________
How long was the infant fed this way? ______________ Any reactions to what they were being fed? ________________
What foods were introduced before 6 months? (Please list the approximate month that each food was introduced, as well as any reactions that may have occurred). ____
What foods were introduced between 6 and 12 months? Were there any reactions to these foods? ___________________
____
Did the child ever experience Colic? ❒Yes ❒No If yes, how severe was the colic? ❒Mild ❒Moderate ❒Severe

Currently; Frequency of bowel movements:_____ x/day or _____ x/week Any pain when passing stool? ❒Yes ❒No
Frequency of Urination _______x Day ______ Night Odor ________________# of wet Diapers Day ______ Night _____
Do any of your child's bowel/Urine habits concern you? ____

Medical History Name: ___________________________________

If you are unsure of any of the terminology please put a question mark beside the word.

Has the child ever experienced any of the following illnesses? ❒ Rubella ❒ Mumps ❒ Measles ❒ Chickenpox ❒ Scarlet Fever ❒ Polio ❒ Rheumatic Fever ❒ Strep throat ❒ Tonsilitis ❒ Meningitis ❒ Convulsions ❒ Seizures ❒Diabetes ❒Heart trouble ❒Cancer ❒Autism ❒ADD ❒Cerebral Palsy ❒ Enlarged adenoids Other:___________
times your child has had ❒Antibiotics _____ Steroids ________ Did/Does the child take probiotics? ❒Yes ❒No

Has the child ever experienced any of the following conditions?
❒Frequent colds ❒Ear infections- how many and how often? _________________ Treated with ___________________
❒Diaper Rash ❒Cradle Cap ❒Cold sores ❒Thrush ❒Atopic Dermatitis ❒Eczema ❒Psoriases ❒Impetigo ❒Head lice
❒Asthma ❒Sinusitis ❒Bronchitis ❒Pneumonia ❒Croup ❒ Whooping Cough ❒Breathing Problems
❒Digestion problems ❒ Diarrhea ❒ Constipation ❒Colic ❒Urinary tract infection ❒Trouble with bedwetting
❒ High fevers ❒ Heat or cold intolerance ❒Thyroid problems
❒Appendicitis ❒Ruptures/hernias ❒Conjunctivitis (pink eye) ❒Chronic Bruising ❒Chronic nose bleeds
❒Orthopedic problem ❒Joint ❒ Backache ❒Arm ❒Leg ❒Neck ❒Walking problem ❒Muscle jerking ❒Scoliosis
❒Growing Pains ❒Neuritis ❒Neuralgia ❒ Fractures – where ____
❒Hyperactivity ❒Difficulty concentrating ❒Restlessness ❒Headaches ❒ Learning problems

Has the child received any or all of the following vaccinations? ❒ Current on western schedule? ❒Yes ❒No
❒ Hepatitis ❒ DPT ❒ MMR ❒ HIB ❒ Polio ❒ TB ❒ Flu ❒ Smallpox ❒ Pneumovaccine ❒ Chickenpox
❒ Other: ___________Were there any adverse reactions to, or chronic illness, following vaccination? ❒Yes ❒No
Describe ____

Has the child ever been hospitalized? ❒Yes ❒No If yes, for what reason? ___________________________________
How long was the child in the hospital or under care? ____
____

Please list any medications and/ or supplements the child is currently taking: __________________________________
____
____

Has your child been to see the dentist? ❒yes ❒no Describe any dental work done: _______________________________
Describe your child's daily oral hygiene practice: ____
Has your child had their vision checked? ❒yes ❒no Describe any vision problems: ______________________________

Sleep Patterns

What time does the child usually go to bed? _____________ usually wakes in the morning? _______________________
Does the child nap during the day? ❒Yes ❒No If yes, what time(s) do they nap? _________________________________
Do they sleep straight through the night? ❒Yes ❒No Do they wake up looking/acting refreshed? ❒Yes ❒No
Do they have any recurring dreams or nightmares? ❒Yes ❒No How often do they have nightmares? ________________
Doesn't remember dreams ❒Yes ❒No Dream Themes ____
Sleep position going to sleep ______________________________ Waking up ____________________________________
Does the child have any problems associated with sleeping? ❒yes ❒no Bedwetting ❒yes ❒no
If yes, what kind of trouble do they have (e.g., trouble falling asleep, trouble waking up, etc.)? ______________________
____
Perspires during sleep? ❒Yes ❒No Where ______________________________________Odor ______________________
Drools during sleep? ❒Yes ❒No How much ____
Any other issue? ____

Social Patterns **Name:** ___________________________________

Is the child in: ☐school ☐home school ☐daycare ☐home care ☐other: ___________________________________
How would you describe the child's behavior at daycare/school? ____
How would you describe the child's behavior at home? ____
Does this differ greatly from behavior at home? ❒Yes ❒No How ____
What makes your child angry? ____
Do they have any difficulties expressing anger? ❒Yes ❒No Other emotions? ❒Yes ❒No ________________________
Do they experience uncontrollable rage? ❒Yes ❒No explain ____
What makes your child sad? ____
Does he/she cry when sad? ☐Yes ☐No explain ____
Does he/she now have or ever had a problem with: ❒Biting❒Hitting❒Stealing ❒Fire setting ❒Temper tantrums ❒Lying
List any major experiences of grief or loss in your child's life ____
What fears does your child have? ____
How does your child react when afraid? ____
When sick what is the child's behavior? ____
What are the child's interests and favorite activities? ____
What, if any, recreational activities are the child involved in? ____
How would you describe the child's temperament/personality? ____
Is there anything that you would want to change? ____
Does the child exercise regularly? ❒Yes ❒No How much and how often do they exercise?
____
How much television does the child watch? _________ hours a day/week. Computer _________ hours a day/week
How often does the child read (not for school), **or** How often does someone read to the child?
❒ Daily ❒ Several times a week ❒Weekly ❒ Less than weekly
Is your family life stressful? ❒Yes ❒No Is your child's life stressful? ❒Yes ❒No
If yes, please identify the factors that contribute to the stressful situation(s) and explain: ____________________________
____
Can you think of any other habit/activity that has a positive or negative effect on your child's health? ❒Yes ❒No
Explain: ____

Family History

Please indicate if a close relative (parent, grandparent, sibling) has had any of the following:
❒ I don't know the family medical history

Condition	Relative	Condition	Relative
❒ Allergies		❒ Seizures	
❒ Anemia		❒ Stroke	
❒ Arthritis		❒ Diabetes	
❒ Asthma		❒ Eczema	
❒ Birth Defects		❒ Glaucoma	
❒ Bleeding Disorder		❒ Kidney Disease	
❒ Cancer		❒ Psoriasis	
❒ Hay Fever		❒ Depression	
❒ High Blood Pressure		❒ Tuberculosis	
❒ Juvenile Arthritis		❒ Mental Illness	
❒ Other: ____________________	________________________	❒ Other: ____________________	

Name: ______________________________________ Next to each individual listed below, please put an "L" for living or "D" for deceased, as well as present age or age at the time of death. Please indicate if the family member suffered from any diseases such as cancer, high blood pressure, heart attack, stroke, diabetes, skin disorders, depression, mental disease, asthma, allergies or arthritis.

Relationship	**L/D**	**Age**	**Diseases Suffered/ Cause of Death**
Mother			
Father			
Maternal Grandfather			
Maternal Grandmother			
Paternal Grandfather			
Paternal Grandmother			
Sister(s)			
Brother(s)			
Maternal Aunts			
Maternal Uncles			
Paternal Aunts			
Paternal Uncles			

Do either of the parents of the child have a chronic illness? ☐Yes ☐No If yes, please describe: ____________________________

Prenatal Health and History

What was the health of the parents at the time of conception? ❒ The child was adopted at age ______________________
Mother ❒Poor ❒Fair ❒Good ❒Excellent ❒Unknown **Father:** ❒Poor ❒Fair ❒Good ❒Excellent ❒Unknown
What was the health of the mother during pregnancy? ❒Poor ❒Fair ❒Good ❒Excellent ❒Unknown
What was the emotional state of the mother during pregnancy? ❒Poor ❒Fair ❒Good ❒Excellent ❒Unknown
What was the mother's first thought upon finding out she was pregnant? ____
What was the father's first thought upon finding out she was pregnant? ____
How was the mother's diet during pregnancy? ❒Poor ❒Fair ❒Good ❒Excellent ❒Unknown
Did the mother receive medical care during pregnancy? ❒Yes ❒No ❒Unknown
Mother's age at the time of the child's birth?_________# previous pregnancies __________ and births _____________
What was the mother's occupation during pregnancy? ____

Did the mother experience any of the following during pregnancy?
❒Bleeding ❒High blood pressure ❒Nausea ❒Vomiting ❒ Diabetes ❒Physical or ❒ Emotional trauma
❒Thyroid problems ❒ Accident ❒ Illness ❒ Other Explain: ____

Did the mother use any of the following during pregnancy? ❒ Tobacco ❒ Alcohol ❒ Recreational drugs______________
❒ Prescription medications: ❒ Over-the-counter medications: ❒ Vitamins and/or supplements: ❒ Other: _____________

Were any of the following interventions used pre/during pregnancy? ❒Fertility treatments ❒ Ultrasound❒Amniocentesis
❒ Chorionic Villi Sampling ❒ Triple Screen ❒ Maternal Serum Screening ❒ Vacuum extraction ❒ Other: ___________

Birth History

Term length: ❒ Pre-term (37 weeks or less) ❒Full-term (38-42 weeks) ❒ Post-term (42 weeks +) __________ weeks
Location of birth: ❒ Hospital ❒ Home ❒ Birthing Center ❒ Other: ____
Birth: ❒ Vaginal ❒ C-section Types of Intervention:❒ Induced labor ❒ Use of forceps ❒ Epidural/Anesthesia
❒Episiotomy ❒Other: _________Were there any complications during delivery (e.g., breech delivery)? _____________
Length of labor: ______ Weight of infant at birth: ___lbs __ oz. Inches ___ APGAR score (0 to 10): 1minute _______
2 minutes _______ 5 minutes: _______ Was the infant alert and responsive within twelve hours of delivery?❒Yes ❒No
Did the child experience any of the following at or shortly after birth? ❒ Merconium ❒ Cyanosis (blue)
❒ Jaundice (yellow) ❒ Rashes ❒ Seizures ❒ Birth injuries: ❒ Infections: _____________________________________
❒ Difficulties with feeding: ❒Latching on ❒Inability to suck ❒ Birth defects: _____________________________________
❒ Other: ____

Name: ___________________________________

Is there anything that you feel is important that has not been covered?

____

____

____

____

____

____

____

If you have a teenager please continue to fill out the Adolescent form after this page.

Thank you for taking the time to fill in this information. It would be a good idea to keep a copy of this info and to give it to the child when they become an adult so they will know their history.

Leave Blank
Finger Nails: □Brittle □Thin □Thick, □Ridges V H □ Pitting □White Flecks □ Spoon Shaped □Moons □Yellow □Fungus □Hangnails □Fissures Color: □Blue, □Pale, □Pink, □Red, □Yellow, □White, Healthy Looking Y N Hands/Fingers □ Calloused
Toenails: □Brittle □Thin, □Thick, □Ridges V H □Pitting, □White Flecks, □Spoon Shaped, □Moons, □Yellow □Fungus □Hangnails □Fissures □Ingrown toenail Color: □Blue □Pale □Pink □Red □Yellow □White □Healthy Looking □Soles/Toes Calloused

Only if we have discussed it or you desire to look at diet for health reasons on the following page, you will find a Diet Diary. Please list, in the spaces provided, every food item that the child puts into their mouth (excluding gum, but inclusive of EVERY OTHER food item) for at least a 7 day period. Please take note of any physical symptom or sensitivities that they may experience during this exercise and note them in the 'notes' section provided.
If at any time, you have questions or concerns, please feel free to contact the office by phone at (352) 365-4325

Adolescent Developmental History

Name: ____________________________________ Gender: _______ Age: ____ Date of birth: _____________

Age of: puberty: ______ Period: ______ Breast development: ______ Voice change: ______ Pubic Hair _____
Any complications/ symptoms experienced at puberty? ____
Were there any issues that affected your development (e.g., physical abuse, inadequate nutrition, neglect, etc.):
____

____

SOCIAL HISTORY

Do you have a best friend? ❒Yes ❒No How many close friends do you have? ________

Are your relationships ❒ strong or ❒ superficial? ❒Explain ____

What activities do you participate in regularly with your friends? ____

EDUCATION

Type of school: ___________________________ Grade: ________special ed? (e.g. gifted program) ❒Yes ❒No

If yes, describe: ____

Have you ever been held back in school? ❒Yes ❒No If yes, describe: ____

What grades do you usually receive in school? _______How do you feel about school? ____________________________

What school activities do you become involved in?____

INTERESTS/ ACTIVITIES Do you have a part time job? ❒Yes ❒No
Describe special areas of interest or hobbies (e.g. art, reading, music, sports, organizations – scout, etc.)
____
What is your current **stress level** on a scale of 1 to 10? (10 being the worst stress you've ever had)____________________

What is your current **energy level** on a scale of 1 to 10? (10 being the most energy you've ever had)__________________

What are your future goals?____

RECREATIONAL DRUGS

Do you use ❒Yes ❒No have a problem with alcohol or drugs? ❒Yes ❒No If yes, describe: _____________________
Do you smoke? ❒Yes ❒No Age started ________ If yes how many cigarettes per day do you smoke?___________

SEXUALITY
Are you currently in an intimate relationship? ❒Yes ❒No For how long?____
Are or have you ever been sexually active? ❒Yes ❒No If yes, at what age did you become active ___________________
What form of birth control are you using? ____
What is your sexual orientation? (e.g. Hetero/Homosexual)____
Have you ever been sexually abused? ❒Yes ❒No Explain ____

Name: ____ **Adolescent Developmental History page 2**

Girls Only
Typical length of menses (days) _______ **Typical length of cycle** from 1st day to 1st day of menses __________
Bleeding □Regular □Irregular □In-between Spotting. **#Tampons/ Pads** per day _____ Per night _____
□Heavy Flow □ Scanty Flow **Painful Periods** □ Before □ Middle □ End □ After □Want pressure □No pressure **Menses Color:** □Pale □Bright □Dark □Purple □Red □Brown **@:** Start ________Middle _______ End _________ □ **Clots** □Hot Flashes □ #Miscarriages ________ □ # Abortions ________
Emotion Around Period □ Normal □ Abnormal □ Crying □ Depressed □ Irritability □ Anger □ Sadness
□Other ____
Describe any symptoms that you experience before/during and/or after your period □ breast tenderness □ cramps □ bloating □ Nausea/Vomiting □ fatigue □ food cravings etc ____
Other ____
Vaginal Discharge □ Normal □ Abnormal Color ___________ Consistency _____________ Smell ______________
□ Fibroids □ Cysts □ Other
Breast □ Lumps □ Tenderness □ Heaviness □ Comes and goes with cycle □ Fibroids □ Cysts
Nipple □ Discharge color __________ □ Deviation Other ____________________________________
□ Cancer ______________ □ **Hormone Use** Type ___________________________________How Long ____________
Anything else?
____
____
____
____
____
____
____
____

Boys Only

Desire for sex □ Aversion □ Low □Excessive **Masturbation** □Excessive explain ___________________________
Pain □ Yes □ No where and describe: ____
□Want pressure □No pressure □Swelling or Lumps (where) ____________________________________
□**Itchin**g where and describe: ____
Penis □Blood □Mucous □Discharge (color) ____________ □Abnormal Erections □ Seminal discharge color __________
□Warts □Rashes □Spots □Nocturnal Emissions □ STD □Complaint or problem with intercourse?
____
Anything else?
____
____
____
____
____
____
____

Diet Diary

Breakfast							
Lunch							
Dinner							
Snacks							
Notes							