WHOLE PERSON HEALING

Dr. Deanine Picciano AP, LMT

Date: _____
Childs Name: _____ Birthday:_____
Parents Name:_____
Phone #:H_____ Cell: _____ W:_____
Address:_____City:_____
State:_____ Zip Code:_____
Email address:_____
Do you have a Pediatrician: yes no Name:_____
When was the last time they were seen? Approximately_____
Have they had any blood or lab work done: y/n
If yes where (please
list):_____
_____
What concerns do you want to work on? List as many as you have.

What significant illnesses are in your family?

What significant illnesses, surgeries or injuries or traumas has your child experienced?

Is your child immunized? y/n Religiously exempt?y/n Select Shots y/n
What Immunizations have they received?
Do they bruise easily? y/n Is the child anemic? y/n
Was your child born via c-section or vaginal delivery (circle one)
Were there any significant birth issues: y/n
Breast fed: y/n Bottle Fed: y/n
What is their Blood Type: O A B AB

List supplements/Herbs/medications the child currently takes:

On the back of this form-Tell me a typical daily diet of your child as well as food dislikes and preferences: