Creation's Own, Corp.®
Jeff Bradstreet, MD FAAFP • Dan Rossignol, MD FAAFP

Initial Interview Form

Patient Name ____ **Date** _________________

Date of Birth ____________________ **Height** ___________________ **Weight** _______________

Appointment Date ___________________ **with** ☐ **Dr. Bradstreet** ☐ **Dr. Rossignol**

What medications (not supplements) are being taken:

Drug: Dose:

Drug: Dose:

Drug: Dose:

List any other medications

What supplements are being taken?

Supplement: Dose:

Supplement: Dose:

Supplement: Dose:

Supplement: Dose:

Supplement: Dose:

List any other nutritional supplements:

Behavior:

Sleep Patterns:

Bowel Habits:

Eye Contact:

Expressive Speech:

Fine Motor:

Gross Motor:

Stereotypias (stimming):

Play and Interaction with peers:

Melbourne:
3800 W. Eau Gallie Blvd. Suite 105
Melbourne, FL 32934
321•259•7111 • Fax: 321•259•7222

Satellite Office:
California Integrative Hyperbaric Center
16251 Laguna Canyon Rd., Ste. 175
Irvine, CA 92618

www.creationsown.com

What therapies are being used?

Diet:

Gluten & Casein Free?

Is the child eating adequate quantities and varieties of food?

What do you want to address during today's consult?

TO BE COMPLETED BY THE DOCTOR OR PHYSICIAN ASSISTANT:

Symptoms and PE: Vtial Signs: T: Ht: Wt: HC:

Sleep Patterns:

Bowel Habits:

Eye Contact:

Receptive Speech:

Expressive Speech:

Fine Motor:

Gross Motor:

Stereotypias (stimming):

Play and Interaction with peers:

Abdomen:

Skin:

ENT:

Neuro (motor tone, tics, coordination, cognition, etc):

Activity Level (Hyper, Passive etc):

IMPRESSIONS and DIAGNOSES:

ACTIONS TO BE TAKEN: