The Pain & Brain Healing Center!

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Pediatric Questionnaire

Date Questionnaire Received: ____ / ____ / ____ Date of Initial Consultation: ____ / ____ /
[The above line is for office use only]

This questionnaire is to be filled out by parents seeking biomedical care for an infant, child or adolescent with complex chronic health disorders, including but not limited to: autism, Asperger's, ADHD, ADD, learning disabilities, mood and behavioral disorders, asthma, digestive disorders, and metabolic syndrome. This clinic does not provide behavioral therapy or psychological counseling; its focus is on healing your child's injured nervous system.

Dear Parent,
Real healing of your child allowing them to experience a full and vibrant life, is dependent upon revealing the actual causes of the metabolic dysfunction and pinpointing their specific nutritional needs. This is much like CSI detective work, that of gathering all the facts in their case. Once this is accomplished we can fix the problem, instead of just covering up the symptoms with drugs. To begin this journey of real healing, comprehensive information about your child's unique health profile is vital! To assist you provide **all** this information a comprehensive 26 page questionnaire follows. The **complete** filling out this form is a mandatory part of your child's care and must be received by the clinic before the first visit. You can fax the form to 763-862-7077 or mail to the clinic and was above.

Child's Name: _____
(First Last Middle Initial)

Parent(s) Name(s): _____
Address: (Street City State Zip) _____
_____

Phone: _____ Work: _____ Cell: _____
EMAIL: _____ Fax: _____
Child's Age:_____ Birth Date: ____/_____/_____ Child's Sex (Circle): Male/Female
Social Security Number (Optional): _____
Primary Care Physician: _____
City/State/Zip/Phone#_____
_____
_____
Health insurance: ID No.: _____
Referred by: _____
Siblings: _____
Name Age Sex Birth Date
_____
Name Age Sex Birth Date
_____
Name Age Sex Birth Date
_____
Name Age Sex Birth Date
Parent's occupation(s): __ _____

Diagnoses and/or explanation given to you about your child: _____
_____
_____
(Date of diagnosis: _____/_____/_____)
Other problems to be addressed:
_____
_____
_____

PERSONAL INFORMATION (Continued)

Describe your child to me, including his/her history. Please be as detailed as possible to use back of this sheet if more room is needed.

_____
_____
_____
_____
_____
_____
_____
_____

When did you first notice your child's problem?

_____
_____
_____
_____

What did you first notice?

_____
_____
_____
_____
_____

Was the onset of your child's problem sudden or gradual?

_____
_____

Was there an event or illness that you or others think brought on your child's symptoms?

_____
_____
_____
_____

Please make notation of any other event, action, etc. that you think may have some bearing/relationship to your child's condition. Again, be as detailed as possible and do not hesitate to mention anything, no matter how small or insignificant, that you believe is related to your child's problem(s):

_____
_____
_____

CHILD'S MEDICAL HISTORY

PRIMARY DOCTOR(S)

Name	Phone	City, State

THERAPIST(S)

Name	Type	Phone	City	Hrs/Wk

Specialists

Name	Type	Phone	City	

CHIROPRACTOR(S)/NATUROPATH(S)/HOMEOPATH(S)

NUTRITIONIST/HERBALISTS

OTHER

Age of Diagnosis for Autism/ADHD/Learning or Behavioral Disorder/Asthma: _____
Official Diagnosis _____
Is child classified as Mild ___ Moderate ___ Severe ___
Symptoms became apparent at what age? _____
What signs and symptoms first became noticeable that alarmed you as a parent? (Please list as many initial developmental problems as possible, i.e. poor eye contact, aggressive behavior, etc.)

_____
_____
_____
_____
_____

MOTHER'S MEDICAL HISTORY

___Low Thyroid ___ Thyroid Cancer ___ Parathyroid problems ___ Night blindness (poor night vision)
___Autoimmune Disorders (Lupus, Connective Tissue, Rheumatoid Arthritis, Autoimmune Thyroid)
___Mercury Fillings in Mouth ___ Dental work that contains Nickel
Other, please explain_____
Did Mom have any dental work done during pregnancy ___Yes ___No
Did mom have mercury fillings removed while breastfeeding child ___Yes ___No

PRENATAL HISTORY

Maternal age at delivery: _____ years
Antibiotics during pregnancy: _____
Illnesses during pregnancy: _____
_____
Medication during pregnancy: _____
Other complications during pregnancy: _____ High Blood Pressure ____ Seizures
____ Diabetes _____ Bacterial Infections ____ Viral Infections ____Other
Please explain:_____
Does Mom know her Rh status ___ (+ or -) Blood Type ___
Did Mom receive Rhogam during pregnancy ___Yes ___No
Did Mom receive any vaccinations during pregnancy ___No ___Yes, which ones
_____
Complications during labor and delivery: _____
_____
Mode of delivery: C-section/vaginal? _____
If C-section, explain why: _____
_____
If vaginal delivery, did you have forceps/vacuum? _____
Was there any concern for birth trauma _____
Medication(s) during labor and delivery? _____
_____
_____
Full term/premature? (Circle one) How many weeks? _____
Complications after delivery? _____
_____
Medications given to child during hospital stay? _____
_____
Did Mom receive any vaccinations after pregnancy while breastfeeding ___No ___Yes, which ones_____

Child's ANTIBIOTIC HISTORY

How many courses of antibiotics has your child received in lifetime (approx): ___ 0 ___ 1-5 ___5-10 ___10-15___15-20 ___20+
Main reason for antibiotic use: ___Ear Infections ___Bronchitis ___Pneumonia ___Sinus Infection ___Intestinal Infection ___Other (please explain) _____
Was your child ever treated for a yeast infection following antibiotic use _____

Child's DIGESTIVE HEALTH

Does child have periodic loose stools/diarrhea___ Yes ___ No Offensive Gas ___Yes ___No
Undigested Food in Stools ___Yes ___No Offensive Breath ___Yes ___ No
Is you child potty trained ___Yes ___No Does your child suffer with reflux/heartburn ___Yes ___No
Is your child currently taking an acid-blocking medication such as Tagamet, Pepcid, etc. ___Yes ___ No
Did occurrence of digestive problems occur following a particular vaccine ___Yes ___No ___ Unsure
Does your child produce formed stools ___Yes ___ No
Have they ever produced formed stools ___Yes ___ No
Please describe your child's stool pattern (Examples: daily, foul, large, mushy, etc.):
_____

Child's DIETARY/NUTRITIONAL HISTORY

Breast-fed? Yes/No If yes, how long? _____
Bottle-fed? Brand of formula? _____ Begun at what age? _____
For how long? _____
Solid Foods? Begun at what age? _____
First Foods?_____
_____
Whole milk? Yes/No If yes, begun at what age? _____Cow_____Goat_____Soy_____Rice_____
Known allergies to food? (Please list): _____
_____
_____
Suspected sensitivities to foods? (Please list):
_____
_____
Food cravings? (Please list): _____

Check the most appropriate description below of your child's diet:

_____ Mostly baby foods
_____ Mostly carbohydrates (bread, pasta, etc.)
_____ Mostly dairy (milk, cheese, etc.)
_____ Mostly meat
_____ Mostly vegetarian (vegetables, fruits, grains, etc.)
Other. Describe:_____
_____
Is child on a Gluten Free Diet ___Yes ___No
Is child on a Casein Free Diet ___Yes ___No
Has child benefited by being on a GF/CF diet?_____
Is child on a Specific Carbohydrate Diet? _____
Is child on a Low Oxalate Diet? _____

FOODS MY CHILD EATS

(Place **x** in appropriate column)

Food	Daily	3 – 5 times/ w week	1 – 3 times/ week	Never or almost never	Used to eat a Lot, but no Longer does
Cookies					
Candy					
Sweet foods					
Caffeine (soda, tea, etc.)					
Chocolate					
Milk: Whole					
2%					
1%					
Skim					
Cheese					
Ice Cream					
Salty Foods					
Meat					
Pasta					
Bread: White					
Wheat					
Other					

Please list the foods and beverages normally consumed by your child for three entirely different, but typical days:

DAY 1

Breakfast: _____

Morning snack(s): _____

Lunch: _____

Afternoon snack(s): _____

Dinner: _____

Other _____

DAY 2

Breakfast: _____

Morning snack(s): _____

Lunch: _____

Afternoon snack(s): _____

Dinner: _____

Other _____

DAY 3

Breakfast: _____

Morning snack(s): _____

Lunch: _____

Afternoon snack(s): _____

Dinner: _____

Other _____

DAN! OR ALTERNATIVE THERAPIES

Has child received Secretin ___Yes ___No. If yes, have they benefited_____
Is child receiving Cod Liver Oil ___Yes ___No. Any benefits?_____
Is your child receiving Bethanocol Treatment ___Yes ___No. Any benefits?_____
Has child received IVIG (Intravenous Immunoglobulins) ___Yes ___No. Any benefits?_____
Is child currently receiving IVIG therapy ___Yes ___No
Does child currently have Mercury/Amalgam/Silver Fillings? ___Yes ___No
Has child received Mercury Chelation ?
DMSA ___Yes ___No DMPS ___Yes ___No EDTA ___Yes ___No
Any benefits from chelation therapy?_____
Has child received Chelation Therapy for other Heavy Metals besides Mercury?
_____
Has your child taken antifungals in the past?
Nystatin,? ___Yes ___No Diflucan ___Yes ___No
Is child taking Transfer Factor? ___Yes ___No Colostrum? ___Yes ___No
Valtrex? ____Yes ____No Low Dose Naltrexone (LDN)? ____ Yes ____No
Actos? ____ Yes ____ No Spironolactone? ____Yes ___ No
Other Biomedical Therapies_____
Have you attended a "Defeat Autism Now!" seminar? ___Yes ____ No
Other biomedical Autism Conferences? ___Yes ___No
TACA seminars or classes? ___Yes ___No
Other biomedical autism support groups? ___Yes ___No
What autism-related books have you read? _____
_____
Internet articles or websites?_____
What biomedical therapies are you interested in? _____

FAMILY HISTORY
List any allergies, major illnesses, genetic diseases or problems for each of the following family members of your child.
Mother:
Father:
Siblings:
Paternal Grandparents:
Is there a family history of Developmental Disorders, i.e. Autism, PDD, ADHD, learning disabilities, etc? Who/What?
Is there a family history of Neurological Disorders, i.e. Multiple Sclerosis, Alzheimer's, Parkinson's disease, Who/What?
Is there a family history of Asthma/Allergies/Autoimmune Disorders/ i.e. Lupus, Rheumatoid Arthritis, etc. Who/What?
Is there a family history of Clotting or Blood Disorders, Stokes, Hemophilia, Platelet Disorders? Who/What?

Is there a family history of Psychiatric Disorders, i.e. Depression, Schizophrenia, etc.
Is there a family history of Genetic disorders?
Is there a family history of Seizures, Vaccine Reactions?

SOCIAL HISTORY
Who lives in the home with your child?
Are any children in your family adopted?
Pets in the house?
***Caregivers besides parents*:**
List the people most important in your child's life:
Recent changes, losses, births, deaths, divorce, remarriage or moves:
Recent travel:
Child's response to these changes:
Is your child involved in any sports, music or there activities? Please describe:
How does your child interact with other children?
With adults?
What makes your child happy?
What makes your child Sad?
What makes your child Angry?
What makes your child Stressed?
How do you as a parent deal with these emotions in your child?

Please indicate to the best of your ability the age in months your child developed the following to indicate level of development
FD = Fully Developed (indicate age) or BD = Beginning to Develop (indicate age) or NPN = Not Present Now

DEVELOPMENTAL HISTORY

Gross Motor Development	**Normal Range**	**Age – FD/BD or NPN (See above code)**	**After Treatment**
Face Down – Lifts Head Off Floor	1 to 4 months		
Rolling front to back	3 to 6 months		
Rolling back to front	4 to 7 months		
Sitting independently	5 to 9 months		
Crawling hands and knees (Variations _____)	6 to 11 months		
Pulls self to a stand	6 to 12 months		
Walking (Clumsiness? _____)	9 to 17 months		
Running (Clumsiness?_____)	13 to 20 months		
Jumps on two feet	17 to 34 months		
Kicks Ball	18 to 30 months		
Climbs stairs with alternating feet	28 to 36 months		
Pedals tricycle	30 to 48 months		
Fine Motor/Adaptive	**Normal Range**	**Age – FD/BD or NPN (See above code)**	**After Treatment**
Bats at objects	2 to 5 months		
Bring toys or objects to midline of body	3 to 6 months		
Transfers objects	4 to 7 months		
Full Fingers Raking grasp	5 to 10 months		
Finger feeds	5 to 10 months		
Neat pincer grasp – Thumb & 1st Finger	7 to 10 months		
Helps with dressing self	10 to 16 months		
Spoon feeds	12 to 18 months		
Uses cup open/sippy	10 to 18 months		
Imitates housework/parent activities	14 to 24 months		
Developed Dominant Rt. / Lt. Handedness	18 to 30 months		
Helps with undressing	22 to 30 months		

Undresses self	30 to 40 months		
Toilet trained	24 to 36 months		
Social/Emotional Development	**Normal Range**	**Age – FD/BD or NPN (See above code)**	**After Treatment**
Smile Response to Parents Face	1 to 3 months		
Object permanence – know objects exists even when hidden	6 to 12 months		
Stranger anxiety or distress	6 to 12 months		
Affective sharing=broad smiles, vocalization, pointing out objects to others	9 to 18 months		
Uses mother as secure base=separation distress	9 to 18 months		
Independence / Exploration	12 to 36 months		
Parallel play=plays beside but not with others	12 to 30 months		
Cooperative play=plays and interacts with others	24 to 48 months		
Language Development	**Normal Range**	**Age – FD/BD or NPN (See above code)**	**After Treatment**
Cooing	1 to 4 months		
Laughs	3 to 6 months		
Turns to voice	3 to 6 months		
Babbling	5 to 9 months		
Dada/mama non-specifically	6 to 10 months		
Gesture games (peek-a-boo)	7 to 12 months		
Understands No!	9 to 18 months		
Mama/dada specifically	9 to 14 month		
Understands one step command with a gesture	10 to 16 months		
Understands one step command w/out gesturing	12 to 20 months		
Points to body parts when asked	12 to 24 months		
Puts two words together	20 to 30 months		
Uses pronouns inappropriately	22 to 30 months		
Two step command understood	22 to 30 months		
States first name to others	30 to 40 months		
Pronouns used appropriately	30 to 42 months		

ENVIRONMENTAL HISTORY

Do you, your child, or any family members practice any relaxation/stress management techniques? Please describe:

CIRCLE THE APPROPRIATE ANSWERS TO THE FOLLOWING QUESTIONS:
Location of home: City/Suburban/Wooded/Farm Other (describe):

Water: City/well Purification system: Yes / No If yes, please describe:

Type of heat: Electric / gas / oil / other If other, please describe:

Do you live near: Power lines / woods / industrial area / water?

If you live near water, list type: Swamp / river / ocean / other If other, please describe:

Does your home have a lot of: Dust / mold / down or feather items (pillow, upholstery, stuffed animals)?
If so, please give details:

Describe your child's bedroom (Circle appropriate response)

Bedding: Synthetic/down/feather Mattress cover: Yes / No Crib / Junior Bed / Adult Bed

Flooring: Carpet / Wall-to-wall or area rug / Wood / Glued down / Synthetic pad

Window Treatment: Shades / Blinds / Thin Curtain / Heavy Curtain / Valance / Other
If other, describe:

Other items in room including furniture, toys, stuffed animals:

Flooring in other rooms

Child's bathroom:

Living room:

Family room/play room:

Is your child sensitive to or bothered by any of the following? Please check list below and mark as YES/NO/MAYBE
List specific products if possible under other:

_____ Perfumes/Cosmetics	**_____ Mold**
_____ Cleaning products	**_____ Pollens/Grasses**
_____ Soaps	**_____ Animals (dander)**
_____ Detergents	**_____ Gasoline**
_____ Dust	**_____ Paint**

_____ Other

Please list known allergies:

MEDICAL HISTORY		
Please mark which tests have been done and provide date and results		
Evaluation/Test-Mark YES/NO/ Unsure **If Yes Name Doctor Who Ordered Tests**	**Date Ordered** **Where Tests Performed**	**Results** **(normal, abnormal or unsure)**
Amino Acid Screen-		
Blood Chemistry Screen-		
Blood Count (CBC)-		
Blood Test—Fatty Acid-		
Blood Test—Food Allergies-		
CT Scan (specify area)-		
Colonoscopy-		
DMSA Loading Study-		
EEG-		
Folic Acid/Homocysteine-		
Fragile X Chromosome Study-		
Hair Elements- Toxic Metals and/or Nutritive		
Hearing Test-		
Immune Profile-		
Intestinal Permeability		
Liver Detox Profile		
MRI (specify area)		
Urinary Organic Acids—fungal/bacteria		
Urinary Organic Acids—Metabolism-		
PET Scan of the Brain-		
Pinworm Prep-		

MEDICAL HISTORY		
Please mark which tests have been done and provide date and results		
Evaluation/Test-Mark YES/NO/ Unsure **If Yes Name Doctor Who Ordered Tests**	**Date Ordered** **Where Tests Performed**	**Results** **(normal, abnormal or unsure)**
Plasma Amino Acids		
Plasma or Serum Zinc		
RBC Elements		
Serum Ferritin (Iron stores)		
Serum Methylmalonic Acid		
Serum Vitamin A		
Small Bowel Biopsy		
Stool Culture		
Stool Parasites		
Thyroid Profile		
Uric Acid (blood or urine)		
Urinary Peptides		
Urine Elements		
Urine Kryptopyrrole		
X-Rays (specify)		
Other:		

MEDICAL HISTORY(Continued)

Major surgeries - Please describe and give dates:

SURGERY	DATE(S)	RESULTS

Major injuries - Please describe and give dates:

INJURY	DATE(S)	RESULTS

Illnesses - Please list appropriate dates and any complications:

ILLNESS: Mark YES/NO DATE(S)	Mild/Moderate/Severe/Chronic	COMPLICATIONS and CHRONICITY
Ear infections-		
Sinus infections-		
Bronchitis-		
Pneumonia-		
Thrush-		
Chicken Pox-		
Seizures-		
Mono-		
Other:		
Other:		

Immunizations

Please indicate date and any reactions for those immunizations that your child has received. If exact date isn't known, please approximate. Mark symptom boxes: YES/NO/Maybe "Bowel" refers to any bowel symptom such as diarrhea. "Swelling" refers to the site of the injection.								
Diptheria/Pertussis/ Tetanus	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**Other**
DPT 1								
DPT 2								
DPT 3								
DPT 4								
DPT 5								
Adult								
Diptheris/Tetanus								
Pediatric Diptheris/ Tetanus								
H Influenza Type B	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**Other**
Hib 1								
Hib 2								
Hib 3								
Hib 4								
Polio (circle Oral or Injection)	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**Other**
OPV 1 / Injection 1								
OPV 2/ Injection 2								
OPV 3/ Injection 3								
OPV 4/ Injection 4								
OPV 5/ Injection 5								
Measles/Mumps/Rubella	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**Other**
MMR 1								
MMR 2								
Hepatitis B Vaccine	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**Other**
HBV 1								
HBV 2								
HBV 3								
Prevnar (pneumococcal)								
Miscellaneous	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**Other**
Varivax (chicken Pox)								
Tine Test								
Flu Vaccine								
Other								

Parents' Last Name	
Child's First Name	

Medication or Supplements

Please check (X) substances taken now or in the past and mark the appropriate reaction

Now	Past	Medication or Supplement	Good	Okay	None	Bad	Very Bad	Bad then Good	Please State Diagnosis or Reason Taking the Drug or Add Any Comments on Use
		Central Nervous System Drugs							
		Clozaril (clozapine)							
		Haldol							
		Prolixin							
		Risperdal							
		Seroquel							
		Stelazine							
		Thorazine							
		Zyprexa							
		Clonidine							
		Cogentin							
		Deanol (deaner, DMAE)							
		Dextromethorphan							
		Lithium							
		Naltrexone							
		St. John's Wort							
		Anafranil							
		Depakene for behavio							
		Depakene for seizures							
		Depakote for behavior							
		Depakote for seizures							
		Dilantin							
		Felbatol							
		Gabitril							
		Keppra							
		Klonopin							
		Lamictal							
		Luvox							
		Mysoline							

Medication or Supplements

Please check (X) substances taken now or in the past and mark the appropriate reaction

Now	Past	Medication or Supplement	Good	Okay	None	Bad	Very Bad	Bad then Good	Please State Diagnosis or Reason Taking the Drug or Add Any Comments on Use
		Central Nervous System							
		Neurontin							
		Paxil							
		Tegretol							
		Straterra							
		Topamax							
		Trileptal							
		Valium							
		Zarotin							
		Zonegran							
		Adderall							
		Prozac							
		Zoloft							
		Amphetamine							
		Cylert							
		Dexedrine, dextroamphetamine							
		Fenfluramine							
		Focalin							
		Ritalin							
		Buspar							
		Chloral hydrate							
		Desipramine							
		Mallaril							
		Tofranil							
		Klonapin							
		Antihistamines							
		Benadryl							
		Phenobarvial							
		Claritin							
		Singular							
		Zyrtec							

Medication or Supplements

Please check (X) substances taken now or in the past and mark the appropriate reaction

Now	Past	Medication or Supplement	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments: It's vital to know the I.U., milligram or gram dose per each supplement!
		Digestive Flora							
		Antibiotics-specify type & number of times							
		Bactrim (septra)							
		Diflucan							
		Humatin							
		Lamisil							
		Nizoral							
		Nystatin							
		Saccharomyces boulardii							
		Sporonax							
		Transfer Factor (oral)/Colostrum							
		Yodoxin							
		Digestion							
		Bethenecol							
		Digestive enzymes							
		Pepsid							
		Peptidase enzymes							
		Probiotics							
		Detoxification							
		DMPS							
		DMSA (succimer, chemet)							
		Reduced glutathione(TTFD)							
		Reduced glutathione (IV)							
		Reduced glutathione (oral)							
		Folic Acid							
		Melatonin							

Medication or Supplements

Please check (X) substances taken now or in the past and mark the appropriate reaction

Now	Past	Medication or Supplement	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments: It's vital to know the daily I.U., milligram or gram dose per day of each supplement!
		Nutrition and Metabolism-							
		Multivitamin (Specify)							
		Vitamin A							
		Vitamin C							
		Vitamin B3 (Niacin)							
		Vitamin B6							
		5 HTP							
		Alpha Keto Glutarate (AKG)							
		Amino Acid Mix							
		Deanol							
		Dimethylglycine (DMG)							
		GABA							
		Glutamine							
		SAMe							
		TMG							
		Tryptophan							
		Tyrosine							
		Calcium							
		Magnesium							
		Selenium							
		Zinc							
		Human Growth Factor							
		IV Immune globulin							
		Kutapressin							
		Taurine							
		Oral Immune globulin							
		Secretin (IV)							

Medication or Supplements

Please check (X) substances taken now or in the past and mark the appropriate reaction

Now	Past	Medication or Supplement	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments: It's vital to know the daily I.U., milligram or gram dose per day of each supplement!
		Secretin(transderm /sublingual)							
		Steroids (oral)							
		Steroids (topical)							
		Omega 3 fatty acids							
		DHA rich oils							
		EPA rich oils							
		Omega 6 rich oils							
		Cod liver oil							
		Flax oil							
		Other							
		Activated Charcoal							
		Alka Gold							
		Carbatrol							
		Tranxene							
		Famvir Valtrex							
		Zovirax							
		OTHER:							

Parents' Last Name	
Child's First Name	

Therapies and Diets

Please indicate therapies and diets you have used and/or are using.

Now	Past	**Therapies**	Very Good	Good	None	Bad	Very Bad	Bad then Good	**Comments: It's vital to know how often and how long these therapies were used**
		Acupuncture							
		Chiropractic							
		Craniosacral							
		Energy Therapy (Specify)							
		Homeopathy							
		Lovaas (ABA)							
		Naturopathy							
		Neural Therapy							
		Occupational Therapy							
		Osteopathy							
		Physical Therapy							
		Sensory Diet							
		Speech Therapy							
		Other:							
Now	**Past**	**Diets**	**Very Good**	**Good**	**None**	**Bad**	**Very Bad**	**Bad then Good**	**Comments: It's vital to know for how long diet tried or if utilized now**
		Gluten Free							
		Casein Free							
		Yeast Free							
		High Protein/ Low Carb							
		Salicylate Free							
		Low Phenolics							
		IgG reactive food Avoidance							
		Specific Carbohydrate Diet							
		Other:							

Please circle the symptom and put a 1, 2 or 3 underneath for level of frequency or severity – 3 is the highest

Inattention and distraction
Short attention span Trouble listening Very active Easily distracted

Impulsiveness
Acts before thinking Disorganized Poor planning Frequently interrupts

Activity
Restless Fidgety Talks excessively Difficulty staying seated Touches everything

Easily excited Lethargic/fatigued

Non-compliance
Frequently disobeys Argumentative Needs special seating in class

Attention-getting Behavior
Engages in negative behavior Needs to be center of attention Interrupts

Class clown

Immaturity
Behavior resembles that of younger child Prefers younger relationships

Achievement, Visual/Motor Skills
Learning Difficulties Poor memory for directions and instructions Sloppy writing

Vision or motor impairment

Emotional Difficulties
Frequent mood swings Irritable Frustrated easily Temper Self-control difficulties

Often anxious Outbursts Depressed or unhappy

Behavioral Difficulties
Blames others Often bored Not satisfied Attitude changes after meals

Unpredictable repetitive behaviors

Peer Relationships
Possible a loner Trouble with group activities Difficulty following rules

Bullies or bosses Rejected or avoided Teases excessively

School Difficulties
Teacher or faculty concerns Held back a grade Tutoring needed Special classes

Family Interaction Problems
Please describe and rate intensity

_____

_____

_____

SIGNS AND SYMPTOMS						
Please check (X) any signs/symptoms your child may demonstrate and note duration and details if appropriate:						
No.	**Description**	**Mild**	**Moderate**	**Severe**	**Duration**	**Unique details**
1	**Stimming (repetitive actions or movements)**					
2	**Rocking**					
3	**Head banging**					
4	**Self-mutilation**					
5	**Nail biting**					
6	**Hand/arm biting**					
7	**Nail/skin picking**					
8	**Aggressiveness (hitting, kicking, b others)**					
9	**Mood swings**					
10	**Irritability/tantrums**					
11	**Fears/anxieties**					
12	**Hyperactivity**					
13	**Inability to concentrate /focus**					
14	**Always fidgety in his/her seat**					
15	**Impulsive**					
16	**Breath holding**					
17	**Dizziness**					
18	**Seizures**					
19	**Poor coordination**					
20	**Problems with buttons, ties, snaps or zippers**					
21	**Processing problems -visual, motor, language, etc**					
22	**Problems with social interactions**					
23	**Sensitive to crowds**					
24	**Trouble remembering**					
25	**Low self-esteem**					
26	**Fatigue**					
27	**Cold hands/feet**					
28	**Cold intolerance**					
29	**Heat intolerance**					

SIGNS AND SYMPTOMS

Please check (X) any signs/symptoms your child may demonstrate and note duration and details if appropriate:

No.	Description	Mild	Moderate	Severe	Duration	Unique details
30	Recurrent/chronic fever					
31	Flushing					
32	Difficulty falling to sleep					
33	Night waking					
34	Nightmares					
35	Difficulty waking					
36	Bed wetting/soiling					
37	Day time wetting/soiling					
38	Numbness/tingling in hands/feet					
39	Headache					
40	Blinking					
41	Tics					
42	Eye discharge					
43	Dark circles/puffiness under eyes					
44	Night-blindness in child/family					
45	Congestion					
46	Dripping nose					
47	Sensitivity to bright lights					
48	Earaches					
49	Ringing in ears					
50	Sensitive to sounds/noise					
51	Bad breath					
52	Nose bleeds					
53	Acute sense of smell					
54	Sore throats					
55	Hoarseness					
56	Cough					
57	Wheezing					
58	Geographic tongue					
59	Swollen gums					
60	Canker sores					
61	Dry lips/mouth					
62	Diarrhea					
63	Constipation					
64	Bloating					
65	Passing gas					
66	Belching					
67	Stomach ache					
68	Refusal to eat					
69	Sensitive to texture of food					
70	Difficulty swallowing					

SIGNS AND SYMPTOMS

Please check (X) any signs/symptoms your child may demonstrate and note duration and details if appropriate:						
No.	**Description**	**Mild**	**Moderate**	**Severe**	**Duration**	**Unique details**
71	**Food Craving**					
72	**Grinding teeth**					
73	**Mucous/blood in Stools**					
74	**Anal itching**					
75	**Calf cramps**					
76	**Other muscle cramps/spasms**					
77	**Tremors**					
78	**Weakness**					
79	**Stiffness**					
80	**Eczema**					
81	**Psoriasis**					
82	**Hives**					
83	**Acne**					
84	**Seborrhea (cradle cap)**					
85	**Other rashes**					
86	**Easy bruising**					
87	**Itchy scalp**					
88	**Dry skin**					
89	**Oily skin**					
90	**Pale skin**					
91	**Sensitivity to insect bites**					
92	**Sensitive to texture of clothes**					
93	**Cracking/peeling hands**					
94	**Cracking/peeling feet**					
95	**Strong body odor**					
96	**Strong urine odor**					
97	**Strong stool odor**					
98	**Soft nails**					
99	**Thickening of nails**					
100	**Ridges/pitting of nails**					
101	**White spots/lines on nails**					
102	**Brittle nails**					
103	**Any OCD (obsessive compulsive)behaviors**					
104	**Strategies to put pressure on abdomen**					
105	**Gastric or Acid Reflux**					
106	**Persistent colic**					
107	**Toe walking**					
108	**Other Major Symptoms:**					

SIGNS AND SYMPTOMS (Continued)

Describe any other symptoms you would like me to know about your child:
List any other history, pertinent thoughts or questions that you want to address:

Note: Please bring a fairly recent picture of your child that we may keep plus a baby picture that we may look at and return.

The above information is true and accurate to the best of my knowledge.

_____ _____

Signature **Date**

□ Understand what the initial consultation includes
□ Want to be evaluated by Dr. Greg Fors and become a part of the practice

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____