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PERSONAL INFORMATION

Date Questionaire Received____/____/____ Date of Initial Consult:____/____/____

Child's Name: First: Last: Middle Initial:

Parent(s) Name(s):

Address: Street: City:

State: Zip: Phone: ( ) -

Work Phone: ( ) - Cell: ( ) -

EMAIL: Fax: ( ) -

Child's Birthdate: Month: Day: Year: Child's Sex: Male/Female

Social Security Number (Optional): - -

Primary Care Physician: Name: City:

State: Zip:

Health Insurance: ID No:

Referred by:

Siblings: Name: Sex: Birth Date:

Male/Female Month: Day: Year:

Male/Female Month: Day: Year:

Male/Female Month: Day: Year:

Parent's Occupation (s):

Diagnosis or explanation given to you about your child: Date of Diagnosis: _____/_____/_____

Other problems to be addressed:

Please list known allergies to the following:

Medications:

Environmental:

Food, dairy, peanuts:

Suspected sensitivities to:

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PERSONAL INFORMATION (Continued)

Describe your child to me, including his/her history. Please be as detailed as possible:

- 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 any 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 anything, no matter how small or insignificant, that you believe is related to your child's problem(s):

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PATIENT'S BIRTH HISTORY

Place of Birth: City & State:

Length of Stay: day(s)

Birthdate: Date admitted:

Gestation: _____ weeks Labor Lengh: _____ hours

Complications during labor and delivery: _____

Method of Delivery: C-Section/vaginal?

If C-Section, explain why:

Birth weight: Birth Height:

Head circum: Chest circum:

Blood type:

Fetal Distress:

If fetal distress, please explain:

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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 Areas/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 (pillows, upholstry, 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 where appropriate and list specific products if possible:

____ Perfumes/Cosmetics?	____Mold
____ Cleaning Products?	____Pollens/Grasses?
____ Soaps?	____Animals (dander)?
____ Detergents?	____Gasoline
____ Dust?	____Paint?
____ Other?	

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FAMILY HISTORY
List any allergies, major illnesses, genetic diseases or problems for eachof the following family members of your child:
Mother:
Father:
Siblings:
Maternal Grandmother: Maternal Grandfather:
Paternal Grandmother: Paternal Grandfather:
Others:

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CHILD'S MEDICAL HISTORY

PRIMARY DOCTOR(S)

Name	Phone Numbers	City

THERAPIST(S)

Speech – Occupational – Physical - Other

Name	Type of Therapist	Phone	City	City	Hours/Wk

Other Care-Givers

Specialist(s)

Name	Phone	City	Date of Evaluation

Naturopath(s)/Homeopath(s)

Nutritionist

Other

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MEDICAL HISTORY - Scan		
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	DATE(S)	RESULTS
Ear Infections		
Sinus Infections		
Bronchitis		
Pneumonia		
Thrush		
Chicken Pox		
Seizures		
Mono		

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MEDICAL HISTORY (continued) - Scan		
Please mark which tests have been done and provide date and results		
Evaluation/Test	Date	Results (normal, abnormal or unsure)
24 Hour Amino Acids		
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		
Fragile X Chromosome Study		
Hair Elements		
Hearing Test		
Immune Profile		
Intestinal Permeability		
Liver Detox Profile		
MRI (specify area)		
Organic Acids – fungal/bacteria		
Organic Acids – metabolism		
PET Scan		

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MEDICAL HISTORY (continued) - Scan		
Please mark which tests have been done and provide date and results		
Evaluation/Test	Date	Results (normal, abnormal or unsure)
Pinworm Prep		
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:		

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PREGNANCY HISTORY
Maternal age at delivery:_____years
Illnesses during pregnancy:
Medication during pregnancy:
Other complications during pregnancy:
Complications during labor and delivery:
Method of Delivery: C-Section/vaginal?
If C-Section, explain why:
Medication(s) during labor and delivery:
Full term/premature? (Circle one) How many weeks? _____weeks
Complications after delivery:
Medications given to child during hospital stay?

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SOCIAL HISTORY
Are any children in your family adopted?
Caregivers besides parents?
Child's response to change:
How do you as a parent deal with these emotions in your child?
How does your child interact with other adults? · With other children?
Who lives in the home with your child? Do you have pets? If so, please list what:
Is your child involved in any sports, music or other activities? Please describe:
List the people most inportant in your child's life:
How make your child happy?
• Sad?
• Angry?
• Stressed?
Please describe any relaxation/stress management techniques used:
Recent changes, losses, births, deaths, divorce, remarriage or moves?
Recent travel?

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SIGNS AND SYMPTOMS						
Please check 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, biting 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 withbuttons, 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					

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SIGNS AND SYMPTOMS						
Please check any signs/symptoms your child may demonstrate and note duration and details if appropriate.						
No.	Description	Mild	Moderate	Severe	Duration	Unique Details
30	Reccurent/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	Ear aches					
49	Ringing in ears					
50	Sensitive to sound/noise					
51	Bad breath					
52	Nose bleeds					
53	Acute sense of smell					
54	Sore throat					
55	Hoarseness					
56	Cough					
57	Wheezing					
58	Geographic tongue					
59	Swollen gums					

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SIGNS AND SYMPTOMS						
Please check any signs/symptoms your child may demonstrate and note duration and details if appropriate.						
No.	Description	Mild	Moderate	Severe	Duration	Unique Details
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					
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					

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MEDICATIONS OR SUPPLEMENTS - Scan

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

Now	Past	Medication and Supplement	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments
		Central Nervous System							
		Clozaril (clozapine)							
		Haldol							
		Prolixin							
		Risperdal							
		Seroquel							
		Stelazine							
		Thorazine							
		Zyprexa							
		Clonidine							
		Cogentin							
		Deanol (deaner, DMAE)							
		Dextromethorphan							
		Lithium							
		Naltrexone							
		St. John's Wort							
		Anafrarul							
		Depakene for behavior							
		Depaken for seizures							
		Depakote for behavior							
		Depakote for seizures							
		Dilantin							
		Felbatol							
		Gabritril							
		Keppra							
		Klonopin							
		Lamictal							
		Luvox							
		Mysoline							

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MEDICATIONS OR SUPPLEMENTS (continued)

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

Now	Past	Medication and Supplement	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments
		Central Nervous System							
		Neutrontin							
		Paxil							
		Phenobarbital							
		Straterra							
		Tegretol							
		Tegretol							
		Topamax							
		Trileptal							
		Valium							
		Zarotin							
		Zonegran							
		Adderall							
		Prozac							
		Zoloft							
		Amphetamine							
		Cylert							
		Dexedrine, dextroamphetamine							
		Fenfluramine							
		Focalin							
		Ritalin							
		Buspar							
		Chloral hydrate							
		Despipramine							
		Mallaril							
		Tofranil							
		Klonapin							
		Antihistamines							

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MEDICATIONS OR SUPPLEMENTS (continued)									
Please check substances taken now or in the past and mark the appropriate reaction									
Now	Past	Medication and Supplement	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments
		Claritin							
		Singulair							
		Zyrtec							
		Digestive Flora							
		Antibiotics (specify type and number of times)							
		Bactrim (septra)							
		Diflucan							
		Humatin							
		Lamisil							
		Nizoral							
		Nystatio							
		Saccharomyces boulardii							
		Sporonax							
		Transfer Factor (oral) Colostrum							
		Yodoxin							
		Digestion							
		Bethenccol							
		Digestive enzymes							
		Pepsid							
		Peptidase enzymes							
		Probiotics							
		Detoxification							
		DMPS							
		DMSA (succimer, chemel)							
		Reduced glutathione (TTFD)							
		Reduced glutathione (IV)							
		Reduced glutathione (Oral)							
		Folic Acid							
		Melatonin							

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MEDICATIONS OR SUPPLEMENTS (continued)									
Please check substances taken now or in the past and mark the appropriate reaction									
Now	Past	Medication and Supplement	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments
		Nutrition & Metabolism							
		Multivitamin – (Specify)							
		Vitamin A							
		Vitamin C							
		Vitamin B3 (Niacin)							
		Vitamin B6							
		5 HTP							
		Alpha Keto Glutarale (AKG)							
		Amino Acid Mix							
		Deanol							
		Dimethylglyeine (DMG)							
		GABA							
		Glutamine							
		SAMe (SAM, Samyr)							
		TMG							
		Taurine							
		Tryptophan							
		Tyrosine							
		Calcium							
		Magnesium							
		Manganese							
		Selenium							
		Zinc							
		Human Growth Factor							
		IV Immune Globulin							
		Kutapressin							

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MEDICATIONS OR SUPPLEMENTS (continued)									
Please check substances taken now or in the past and mark the appropriate reaction									
Now	Past	Medication and Supplement	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments
		Nutrition/Metabolism (cont.)							
		Oral, Immune globulin							
		Secretin (IV)							
		Secretin (transdermal/sublingual)							
		Steroids (oral)							
		Steroids (topical)							
		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:							

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DEVELOPMENTAL HISTORY(EMR Medical Info)
Please list age when following skills were mastered and any problems associated with these skills
First words: (_____)
Phrases or sentences: (Age:_____)
Walking: (Age:_____)
Sitting up: (Age:_____)
Crawling: (Age:_____)
Running: (Age:_____)
Walking up/down steps without help: (Age:_____)
Jumping: (Age:_____)
Learned to pedal: (Age:_____)
Rode 2-wheel bicycle: (Age:_____)
Put on clothing: (Age:_____)

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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
		Acupuncture							
		Auditory Training							
		Craniosacral							
		Energy Therapy (Specify)							
		Homeopathy							
		Lovaas (ABA)							
		Natruopathy							
		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
		Gluten Free							
		Casein Free							
		Yeast Free							
		High Protein/Low Carb							
		Salicyclate Free							
		Low Pheonolics							
		lgG reactive food avoidances							
		Specific Carbohydrate Diet							
		Other:							

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DIETARY/NUTRITIONAL HISTORY - Scan

Breast-fed? Yes/No (Circle One): If yes, how long? _____

Bottle fed? Yes/No (Circle One): Brand of Formula?_____ Begun at what age?_____

For how long?_____

Foods? Begun at what age? _____ First foods?_____

_____

Whole milk? Yes/No (Circle One) If yes, begun at what age? _____

Known allergies to food? (Please list): _____

Suspected sensitivities to foods? (Please list): _____

_____

Food cravings? (Please list):_____

Foods my child eats: (Place check in appropriate column)

Food	Daily	3-5 times/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					

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DIETARY/NUTRITIONAL HISTORY (Continued) - Scan
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:
Please describe your child's stool pattern (Examples: daily, foul, large, mushy, etc):
Please list the foods and beverages normally consumed by your child for three 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:

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IMMUNIZATIONS -Scan								
Please indicate date and any reactions for those immunizations that your child has received. If exact date isn't known, please approximate. "Bowel" refers to any symptoms 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 inj.)	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 (pnemococcal)								
Miscellaneous	Date	Bowel	Swelling	Crying	Seizure	Irritable	Fever	Other
Varivax (Chicken Pox)								
Tine Test								
Flu Vaccine								
Other								