**Dr. Vyacheslav Alec Pekler NMD**

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**www.DrHakunaMatata.com**

Thank you for your interest in becoming a patient with Dr. Alec Pekler . All new patients must complete the following forms and questionnaires. Dr.Pekler will review all of this information *before* meeting with you for the first time. Copies of your medical records, including lab work and diagnostic testing are required **before scheduling an appointment** (a review of past medical records is included in the fees for your initial consultation). Prior to your initial appointment, Dr. Pekler will review all your intake forms and medical records that you have provided. **The initial consultation lasts 1.5 - 2 hours and include the following:**

* Reviewing of past medical history
* Reviewing of the labwork and diagnosis
* Thorough Physical Exam
* 45 - 60 min of Craniosacral Therapy session
* Design of a comprehensive treatment plan

The goal of the visit is to gather necessary details about you and your medical condition so proper testing can be ordered to determine root causes of symptoms and necessary recommendations for care.

* **The cost for the services are listed on the website www.DrHakunaMatata.com**

Dr. Pekler will then review the test results from the lab tests he ordered along with your intake forms

and the information gathered from your initial consultation. You will then be scheduled for a follow up consultation. At this appointment Dr. Pekler will present his *specific* recommendations pertaining to your health. **Expect the report of findings to last about 45-60 minutes or longer, depending on the complication of your case**.

* + **Supplements: Supplements are sold through an online vendor. If patient wishes to use his or her own source, it is their right to do so**

It is important to understand that successful management of any complicated case requires proper testing,

diagnosis, financial commitments and realistic patient expectations.

* **The single most important criteria for effective case management is a comprehensive and detailed health history**.

Please answer the following questions with **as much detail as possible**, because it is vital to know everything about you and your case. Please schedule enough time (about 3-6 hours) to be thorough in completing the questions and intake forms; the more details you provide, the better Dr. Pekler can assess your health. In some cases it may be easier to take the forms in small bites, just answering a few questions each day. Don't be overwhelmed by the forms. Keep in mind these detailed forms are for your benefit, so Dr. Pekler can help you to his fullest.

* **Please fill these forms electronically and submit through the electronic health record portal by uploading them into the system.**

Thank you in advance for your time and effort in completing these forms. The information derived from these forms will provide Dr. Pekler invaluable data allowing for the appropriate course of care.

Questionnaire for Children with Autism & Related Developmental and/or Attention Problems (rtf)

**Note:** In this questionnaire “you” is used as if the child were answering questions, avoiding repetition of him/her**.**

|  |  |
| --- | --- |
| **Example: Please follow the example below to a T. I will use it to past into your child’s record.** | |
| **Patient Name:**  **Address:**  **-**  **-**  **-**  **Phone: Home,,,,Work....Cell**  **Birth Date:**  **Email.**  **Referred by:**  **Pharmacy Name Phone: & doctors’fax** | **Parent Name:**  **Address:**  **Home phone:**  **Work:**  **Birth Date:**  **Email.**    **Referred by:**  **Pharmacy Phone: FAX** |

|  |  |  |  |
| --- | --- | --- | --- |
| Male  Female | Eye Color: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Hair Color: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Birth Order. |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Blood Type: | | | Allergy to medication:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Hair Texture: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (lbs) | | | (optional)  SS#: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_ | |
| Mother's Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Father's Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Occupation:\_\_\_\_\_\_\_\_\_\_ | |
| Person(s) filling out this questionnaire:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |

**Insurance Information:**

|  |  |  |
| --- | --- | --- |
| **Insured’s Name** (last, first, middle initial) | **Insured’s Policy/Group Number:** | **Insured’s DOB** (mm/dd/yy)**:** |
|  |  | **Sex:** Male o Female |
| **In Insured’s Address:** | **City, State, Zip Code:** | **Phone Number:** |
|  |  |  |
| **Employer’s Name:** | **Insurance Plan Name:** | **Out of Pocket Maximum Deductible:** |
|  |  |  |
| **Total Annual Deductible:** | **Out of Pocket Maximum:** | **Current Funds Paid:** |
|  |  |  |

**Important**:

1. Before doing anything with this questionnaire please go to Autism360.org and record as many profile items as you feel accurately capture your individuality. The degree of detail that your record in the non-required fields is up to you! Then record all past and present treatments and rate their effects and, again, the detail as to dosage and timing is up to you..
2. After you have done that use this questionnaire to record other information that was not captured in Autism360 as well as you’d like.
3. Then you may wish to return to Autism360 for a few added details that were brought to mind by the questionnaire.   
   Please keep in mind that Autism360 is neither a questionnaire nor a survey on purpose! It is intended to be a means for you to record what you feel is important and not to be a vehicle for me to tell you what I want to know. There will be plenty of time for that, if needed, down the road.

**Symptom score sheet for monitoring progress: Record the main problems in the Symptom column. I will paste these symptoms and a distillation of the x’d in the questionnaire below in to the record we will use to track progress. Put a “P” in the first column for problems that were present only in the past. Put a “L” in the first column to mark lab tests of importance. Put a score in the third (date) column for each symptom.**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **# =rank, P= past, L= lab,** | | **(symptom scores go in the columns below dates)** | | | | | | | | |
| **⇓** | **Symptom** (0= Absent, 3= mild, 6= Moderate, 9=severe, 12= incapacitating.) | Date |  |  |  |  |  |  |  |  |
| 0 | Example: Poor expressive language | 9 |  |  |  |  |  |  |  |  |
| 1 |  |  |  |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |  |  |  |
| 8 |  |  |  |  |  |  |  |  |  |  |
| 9 |  |  |  |  |  |  |  |  |  |  |
| 10 |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| P |  |  |  |  |  |  |  |  |  |  |
| P |  |  |  |  |  |  |  |  |  |  |
| P |  |  |  |  |  |  |  |  |  |  |
| L |  |  |  |  |  |  |  |  |  |  |
| L |  |  |  |  |  |  |  |  |  |  |
| L |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |

Laboratory data:

| Evaluation/Test | Date | Done? | Abnormal? | Not sure? |
| --- | --- | --- | --- | --- |
| 24 hour urine amino acids |  |  |  |  |
| Amino acid screen |  |  |  |  |
| Blood chemistry screen |  |  |  |  |
| Blood count |  |  |  |  |
| Blood test for fatty acids |  |  |  |  |
| Blood test for food allergies |  |  |  |  |
| CAT scan |  |  |  |  |
| Colonoscopy |  |  |  |  |
| DMSA loading study |  |  |  |  |
| EEG |  |  |  |  |
| Folic acid |  |  |  |  |
| Fragile X chromosome study |  |  |  |  |
| Hair elements |  |  |  |  |
| Immune profile |  |  |  |  |
| Intestinal permeability |  |  |  |  |
| Liver Detoxification profile |  |  |  |  |
| MRI |  |  |  |  |
| Organic acids quantitative – fungal/bacterial metabolites |  |  |  |  |
| Organic acids quantitative – metabolism |  |  |  |  |
| Organic acids screen |  |  |  |  |
| PET scan |  |  |  |  |
| 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 test (blood or urine) |  |  |  |  |
| Urinary Peptides |  |  |  |  |
| Urine elements |  |  |  |  |
| Urine Kryptopyrrole |  |  |  |  |

**Personal Descriptive Information**

|  |
| --- |
| With whom do you live? And what do they do? (Include children, parents, relatives, friends...please include ages ) {Example: Wendy, age 7, sister, George, Dad, age 40, Lawyer] |
| Who are the main people who care for you? |
| Please describe your strengths and/or unusual skills: |
| What pets live with you - indoor or outdoors only? |
| When and where have you lived or traveled outside of the United States? |
| Major life changes recent or soon for you or your family? |
| Have you experienced any major losses in life? |
| What is your religion and how important is religion/spirituality in you and your family’s life? |
| Do you have a favorite toy or object?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Is there something else about you that I should know? |

**Past and present professionals:**

|  |  |  |
| --- | --- | --- |
| **Primary Care:** |  |  |
| **Primary Care** |  |  |
| **Specialist:** |  |  |
| **Specialist:** |  |  |
| **Therapist:** |  |  |
| **Other** |  |  |
| **Homeopathic:** |  |  |
| **Chiropractor:** |  |  |
| **Who made the initial diagnosis of autism/other disorder? When?** |  |  |

**Past Evaluations**

Please indicate if you have had any of the following evaluations, treatments, or consultations by placing a **check mark** in the appropriate columns. **Please attach any copies of reports or provide the addresses where the evaluations took place**. Add comments (to back or attach sheet if needed).

|  |  |  |  |
| --- | --- | --- | --- |
| X if Yes | X Abnormal | Date | Evaluation/Test |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Psychological Evaluations |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Wechsler Preschool & Primary Scale of Intelligence |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Speech and Language Evaluations |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Genetic Evaluation |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Neurological Evaluations |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Gastroenterology Evaluations |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Celiac/Gluten testing |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Allergy Evaluation |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Nutritional Evaluation |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Auditory Evaluation |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Vision Evaluation |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Osteopathic |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Acupuncture |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Physical Therapy |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Occupational Therapy |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Sensory Integration Therapy |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Language Classes |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Sign Language |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Homeopathic |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Naturopathic |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Craniosacral |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Chiropractic |

**Hospitalizations**

|  |  |  |
| --- | --- | --- |
| **Age** | **Reason for hospitalization** | **Discharge summary attached?** |
|  |  |  |
|  |  |  |

**Operations Injuries**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Please indicate approximate age when you had an operation for: | AGE |  | Please describe any injuries | AGE |
| Appendix |  |  | Head injury |  |
| Circumcision |  |  | Broken bone |  |
| Hernia |  |  | Broken bone |  |
| Tonsils |  |  | Eye injury |  |
| Adenoids |  |  | Neck injury |  |
| P.E. Tubes in Ears |  |  | Abdominal injury |  |
| Other surgery |  |  | Other injury |  |

Please use this space for comments or narrative.

You may wish to highlight those consultations, tests or treatments you found most, or least, helpful.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_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|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Immunization | | Please give approximate date if you don’t have a specific one. | | Did you have any of the following reactions:  “Bowel” means any bowl symptom such as diarrhea, “Swelling” means swelling at the site of the injection. | | | | | | | |
| **Diphtheria-Pertussis-Tetanus** | | Date | | Bowel | Swelling | Crying | Seizure | Irritable | Fever | Other | |
| DPT 1 | |  | |  |  |  |  |  |  |  | |
| DPT 2 | |  | |  |  |  |  |  |  |  | |
| DPT 3 | |  | |  |  |  |  |  |  |  | |
| DPT 4 | |  | |  |  |  |  |  |  |  | |
| DPT 5 | |  | |  |  |  |  |  |  |  | |
| Adult Diphtheria-Tetanus | |  | |  |  |  |  |  |  |  | |
| Pediatric Diphtheria- Tetanus | |  | |  |  |  |  |  |  |  | |
| **H Influenza type B** | | Date | | Bowel | Swelling | Crying | Seizure | Irritable | Fever | Other | |
| Hib 1 | |  | |  |  |  |  |  |  |  | |
| Hib 2 | |  | |  |  |  |  |  |  |  | |
| Hib 3 | |  | |  |  |  |  |  |  |  | |
| Hib 4 | |  | |  |  |  |  |  |  |  | |
| **Oral Polio Vaccine** | | Date | | Bowel | Swelling | Crying | Seizure | Irritable | Fever | Other | |
| OPV 1 | |  | |  |  |  |  |  |  |  | |
| OPV 2 | |  | |  |  |  |  |  |  |  | |
| OPV 3 | |  | |  |  |  |  |  |  |  | |
| OPV 4 | |  | |  |  |  |  |  |  |  | |
| OPV 5 | |  | |  |  |  |  |  |  |  | |
| **Polio Vaccine Injection** | | Date | | Bowel | Swelling | Crying | Seizure | Irritable | Fever | Other | |
| Polio Vaccine Injection 1 | |  | |  |  |  |  |  |  |  | |
| Polio Vaccine Injection 2 | |  | |  |  |  |  |  |  |  | |
| Polio Vaccine Injection 3 | |  | |  |  |  |  |  |  |  | |
| Polio Vaccine Injection 4 | |  | |  |  |  |  |  |  |  | |
| Polio Vaccine Injection 5 | |  | |  |  |  |  |  |  |  | |
| **Measles-Mumps-Rubella** | | Date | | Bowel | Swelling | Crying | Seizure | Irritable | Fever | Other | |
| MMR 1 xxx | |  | |  |  |  |  |  |  |  | |
| MMR 2 | |  | |  |  |  |  |  |  |  | |
| **Hepatitis-b Vaccine** | | Date | | Bowel | Swelling | Crying | Seizure | Irritable | Fever | Other | |
| HBV 1 | |  | |  |  |  |  |  |  |  | |
| HBV 2 | |  | |  |  |  |  |  |  |  | |
| HBV 3 | |  | |  |  |  |  |  |  |  | |
| HBV 4 | |  | |  |  |  |  |  |  |  | |
| **Miscellaneous** | | Date | | Bowel | Swelling | Crying | Seizure | Irritable | Fever | Other | |
| Varivax (Chicken Pox) | |  | |  |  |  |  |  |  |  | |
| Tine Test | |  | |  |  |  |  |  |  |  | |
| Other: | |  | |  |  |  |  |  |  |  | |
|  | |  | |  |  |  |  |  |  |  | |

**Mother’s Past Pregnancies: number of:**

|  |  |  |
| --- | --- | --- |
| Pregnancies\_\_\_\_\_ | Live births\_\_\_\_\_ | Miscarriages\_\_\_\_\_ |

**Mother’s Pregnancy:** Place a **check mark** if any of the following occurred during your mother's pregnancy:

**Did your mother: (Please describe if applicable)**

|  |  |  |
| --- | --- | --- |
| Difficulty getting pregnant (more than 6 months) |  |  |
| Infertility drugs used |  | Specify: |
| In vitro fertilization |  |  |
| Drink alcohol |  |  |
| Drink coffee |  |  |
| Smoke tobacco |  |  |
| Take Progesterone |  |  |
| Take prenatal vitamins |  |  |
| Take antibiotics |  | During Labor? [ ] |
| Take other drugs |  | Specify: |
| Excessive vomiting, nausea (more than 3 weeks) |  |  |
| Have a viral infection |  |  |
| Have a yeast infection |  |  |
| Have amalgam fillings put in teeth |  |  |
| Have amalgam fillings removed from teeth |  |  |
| Have how many fillings in her teeth during? |  | Number of fillings in your mom’s teeth when pregnant?\_\_\_\_\_\_\_\_\_ |
| Have bleeding (which months?) |  |  |
| Have birth problems |  |  |
| Group B strep infection |  |  |
| Have c-section because of |  |  |
| Use induction for labor (such as Pitocin) |  |  |
| Have anesthesia -what was used? |  |  |
| Use oxygen during labor |  |  |
| Have an x-ray |  |  |
| Have Rhogam, if so how many shots |  | How many when pregnant?\_\_\_\_\_ |
| Gestational Diabetes |  |  |
| High blood pressure (pre-eclampsia) |  |  |
| High blood pressure/toxemia |  |  |
| Have chemical exposure |  |  |
| Father have chemical exposure |  |  |
| Move to a newly built house |  |  |
| House painted indoors |  |  |
| House painted outdoors |  |  |
| House exterminated for insects |  |  |

**Pregnancy:**

|  |  |
| --- | --- |
| Total weight gain during pregnancy\_\_\_\_\_\_\_\_\_lb | Dotal weight loss during pregnancy\_\_\_\_\_\_\_\_\_lb |
| Please describe diet during pregnancy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Please describe labor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Perinatal**

:

|  |  |  |
| --- | --- | --- |
| Pregnancy duration: X following the week of gestation.  24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40 (full term), 41, 42, 43, 44 Weeks | | |
|  | YES | NO |
| Very active before birth |  |  |
| Hospital/Birthing Center |  |  |
| Needed Newborn Special Care |  |  |
| Appeared healthy |  |  |
| Easily consoled during first month? |  |  |
| Antibiotics first month |  |  |
| Experienced no complications first month of life |  |  |

**Birth Weight and Apgar**

|  |  |  |
| --- | --- | --- |
| Weight at birth: \_\_\_\_\_\_\_\_ lbs | Apgar score at one minute\_\_\_\_\_ | Apgar score at 5 mins \_\_\_\_\_\_\_ |

**Early Childhood Illnesses**

|  |
| --- |
| Number of earaches in the first two years: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Number of other infections in the first two years: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Number of times you had antibiotics in the first two years of life: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Number of courses of prophylactic antibiotics in first 2 years of life: \_\_\_\_\_\_\_\_\_ |
| First antibiotic at \_\_\_\_ months. |
| First illness at \_\_\_\_ months. |

**Description of Developmental Problems**

|  |
| --- |
| At what age did developmental problems appear to begin? 0-1months  [ ] 2-6 months [ ] 6-15 months [ ] 16-24 months [ ] After 24 months |
| Is this impression shared among parents and others caring for the child?:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| …Or does this impression as to the timing of onset differ among parents and others caring for the child?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Is the impression as to the timing of onset weak?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| … or is the impression strong:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Developmental History**

Please indicate the approximate age in months for the following milestones: (example: walking 14 months):

|  |  |  |
| --- | --- | --- |
|  |  | Never |
| Sitting up | \_\_\_ months | [ ] |
| Crawl | \_\_\_ months | [ ] |
| Pulled to stand | \_\_\_ months | [ ] |
| Potty trained | \_\_\_ months | [ ] |
| Walked alone | \_\_\_ months | [ ] |
| Dry at night | \_\_\_ months | [ ] |
| First words ("mama, dada" etc.) | \_\_\_ months | [ ] |
| Spoke clearly | \_\_\_ months | [ ] |
| Lost language | \_\_\_,months | [ ] |
| Lost eye contact | \_\_\_ months | [ ] |

**Medications and Supplements Past and Present:**

|  | **Medication or Supplement**  *(please mark the response with lower case x’s* | **Taking now?** | VERY GOOD GOOD | GOOD | NO RESPONSE | BAD | VERY BAD | DON’T KNOW | NEGATIVE, THEN GOOD | **Comments.** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| aast | **SUBSTANCES AFFECTING:** |  |  |  |  |  |  |  |  |  |
| CN | CENTRAL NERVOUS SYSTEM |  |  |  |  |  |  |  |  |  |
| cnap | Clozaril (clozapine) |  |  |  |  |  |  |  |  |  |
| CNAP | Haldol |  |  |  |  |  |  |  |  |  |
| CNAP | Prolixin |  |  |  |  |  |  |  |  |  |
| CNAP | Risperdal |  |  |  |  |  |  |  |  |  |
| CNAP | Seroquel |  |  |  |  |  |  |  |  |  |
| CNAP | Stelazine |  |  |  |  |  |  |  |  |  |
| CNAP | Thorazine |  |  |  |  |  |  |  |  |  |
| cnap | Zyprexa |  |  |  |  |  |  |  |  |  |
| CNO | Antihistamine |  |  |  |  |  |  |  |  |  |
| CNO | Clonidine |  |  |  |  |  |  |  |  |  |
| CNO | Cogentin |  |  |  |  |  |  |  |  |  |
| CNO | Deanol (deaner, DMAE) |  |  |  |  |  |  |  |  |  |
| CNO | Dextromethorphan |  |  |  |  |  |  |  |  |  |
| CNO | Lithium |  |  |  |  |  |  |  |  |  |
| CNO | Naltrexone |  |  |  |  |  |  |  |  |  |
| CNO | St John’s wort |  |  |  |  |  |  |  |  |  |
| CNs | Anafranil |  |  |  |  |  |  |  |  |  |
| CNs | Depakene for behavior |  |  |  |  |  |  |  |  |  |
| CNs | Depakene for seizures |  |  |  |  |  |  |  |  |  |
| CNs | Depakote for behavior |  |  |  |  |  |  |  |  |  |
| CNs | Depakote for seizures |  |  |  |  |  |  |  |  |  |
| CNs | Dilantin |  |  |  |  |  |  |  |  |  |
| CNs | Felbatol |  |  |  |  |  |  |  |  |  |
| CNs | Gabitril |  |  |  |  |  |  |  |  |  |
| CNs | Keppra |  |  |  |  |  |  |  |  |  |
| CNs | Klonopin |  |  |  |  |  |  |  |  |  |
| CNs | Lamictal |  |  |  |  |  |  |  |  |  |
| CNs | Luvox |  |  |  |  |  |  |  |  |  |
| CNs | Mysoline |  |  |  |  |  |  |  |  |  |
| CNs | Neurontin |  |  |  |  |  |  |  |  |  |
| CNs | Paxil |  |  |  |  |  |  |  |  |  |
| CNs | Phenobarbital |  |  |  |  |  |  |  |  |  |
| CNs | Tegretol |  |  |  |  |  |  |  |  |  |
| CNs | Topamax |  |  |  |  |  |  |  |  |  |
| CNs | Trileptal |  |  |  |  |  |  |  |  |  |
| CNs | Valium |  |  |  |  |  |  |  |  |  |
| CNs | Zarontin |  |  |  |  |  |  |  |  |  |
| CNs | Zonegran |  |  |  |  |  |  |  |  |  |
| CNss | Adderall |  |  |  |  |  |  |  |  |  |
| CNss | Prozac |  |  |  |  |  |  |  |  |  |
| CNss | Zoloft |  |  |  |  |  |  |  |  |  |
| CNst | Amphetamine |  |  |  |  |  |  |  |  |  |
| CNst | Cylert |  |  |  |  |  |  |  |  |  |
| CNst | Dexedrine, Dextroamphetamine |  |  |  |  |  |  |  |  |  |
| CNst | Fenfluramine |  |  |  |  |  |  |  |  |  |
| CNst | Focalin |  |  |  |  |  |  |  |  |  |
| CNst | Ritalin |  |  |  |  |  |  |  |  |  |
| CNtr | Buspar |  |  |  |  |  |  |  |  |  |
| CNtr | Chloral hydrate |  |  |  |  |  |  |  |  |  |
| CNtr | Valium |  |  |  |  |  |  |  |  |  |
| CNtri | Desipramine |  |  |  |  |  |  |  |  |  |
| CNtri | Mellaril |  |  |  |  |  |  |  |  |  |
| CNtri | Tofranil |  |  |  |  |  |  |  |  |  |
| CNtrt | Klonapin |  |  |  |  |  |  |  |  |  |
| df | Antibiotics |  |  |  |  |  |  |  |  |  |
| df | Bactrim (Septra) |  |  |  |  |  |  |  |  |  |
| Df | Biochoice |  |  |  |  |  |  |  |  |  |
| df | Bismuth |  |  |  |  |  |  |  |  |  |
| df | Colostrum |  |  |  |  |  |  |  |  |  |
| df | Diflucan |  |  |  |  |  |  |  |  |  |
| df | DIGESTIVE FLORA |  |  |  |  |  |  |  |  |  |
| df | Humatin |  |  |  |  |  |  |  |  |  |
| df | Lamisil |  |  |  |  |  |  |  |  | [ ] Had die off? |
| df | Nizoral |  |  |  |  |  |  |  |  | [ ] Had die off? |
| df | Nystatin |  |  |  |  |  |  |  |  | [ ] Had die off? |
| df | Probiotics (acidphilus, etc) |  |  |  |  |  |  |  |  | [ ] Had die off? |
| df | Saccharomyces boulardii |  |  |  |  |  |  |  |  | [ ] Had die off? |
| df | Sporonax |  |  |  |  |  |  |  |  | [ ] Had die off? |
| df | Transfer factor (oral) |  |  |  |  |  |  |  |  | [ ] Had die off? |
| df | Yodoxin |  |  |  |  |  |  |  |  |  |
| Dg | Bethanecol |  |  |  |  |  |  |  |  |  |
| Dg | DIGESTION |  |  |  |  |  |  |  |  |  |
| Dg | Digestive enzymes |  |  |  |  |  |  |  |  |  |
| Dg | Pepsid |  |  |  |  |  |  |  |  |  |
| Dg | Peptidase Enzymes |  |  |  |  |  |  |  |  |  |
| Dg | Probiotics |  |  |  |  |  |  |  |  |  |
| Dtx | DETOXIFICATION |  |  |  |  |  |  |  |  |  |
| Dtx | DMPS |  |  |  |  |  |  |  |  |  |
| Dtx | DMSA (succimer, Chemet) |  |  |  |  |  |  |  |  |  |
| Dtx | Reduced glutathione (transderm) |  |  |  |  |  |  |  |  |  |
| Dtx | Reduced glutathione IV |  |  |  |  |  |  |  |  |  |
| Dtx | Reduced glutathione oral |  |  |  |  |  |  |  |  |  |
| M | B6 & Magnesium |  |  |  |  |  |  |  |  |  |
| M | Brain child supplements |  |  |  |  |  |  |  |  |  |
| M | Folic Acid |  |  |  |  |  |  |  |  |  |
| M | Melatonin |  |  |  |  |  |  |  |  |  |
| M | Multivitamin high potency |  |  |  |  |  |  |  |  |  |
| M | Multivitamin regular potency |  |  |  |  |  |  |  |  |  |
| m | **Nutrition and Metabolism** |  |  |  |  |  |  |  |  |  |
| M | Super Nu Thera |  |  |  |  |  |  |  |  |  |
| M | Ultra Clear Sustain |  |  |  |  |  |  |  |  |  |
| M | Vitamin B3 (Niacin) |  |  |  |  |  |  |  |  |  |
| M | Vitamin B6 |  |  |  |  |  |  |  |  |  |
| Maa | 5 HPT |  |  |  |  |  |  |  |  |  |
| Maa | Alpha Keto Glutarate |  |  |  |  |  |  |  |  |  |
| Maa | Amino Acid Mix |  |  |  |  |  |  |  |  |  |
| Maa | Deanol |  |  |  |  |  |  |  |  |  |
| Maa | Dimethylglycine (DMG) |  |  |  |  |  |  |  |  |  |
| Maa | DMG |  |  |  |  |  |  |  |  |  |
| Maa | Glutamine |  |  |  |  |  |  |  |  |  |
| Maa | SAMe (SAM, Samyr) |  |  |  |  |  |  |  |  |  |
| Maa | TMG |  |  |  |  |  |  |  |  |  |
| Maa | Tryptophan |  |  |  |  |  |  |  |  |  |
| Maa | Tyrosine |  |  |  |  |  |  |  |  |  |
| Min | Calcium |  |  |  |  |  |  |  |  |  |
| Min | Magnesium |  |  |  |  |  |  |  |  |  |
| Min | Manganese |  |  |  |  |  |  |  |  |  |
| Min | Selenium |  |  |  |  |  |  |  |  |  |
| Min | Zinc |  |  |  |  |  |  |  |  |  |
| Misc | Human Growth Factor |  |  |  |  |  |  |  |  |  |
| Misc | IV Immune Globulin |  |  |  |  |  |  |  |  |  |
| Misc | Kutapressin |  |  |  |  |  |  |  |  |  |
| Misc | Oral Immune globulin |  |  |  |  |  |  |  |  |  |
| Misc | Secretin IV |  |  |  |  |  |  |  |  |  |
| Misc | Secretin transdermal |  |  |  |  |  |  |  |  |  |
| Misc | Steroids |  |  |  |  |  |  |  |  |  |
| Mv | TTFD |  |  |  |  |  |  |  |  |  |
| Oil | DHA rich oils |  |  |  |  |  |  |  |  |  |
| Oil | EPA rich oils |  |  |  |  |  |  |  |  |  |
| Oil | Omega 6 rich oils |  |  |  |  |  |  |  |  |  |
| Oil | Omega brite |  |  |  |  |  |  |  |  |  |
| Oils | Cod liver oil |  |  |  |  |  |  |  |  |  |
| Oils | Flax Oil |  |  |  |  |  |  |  |  |  |
| Other | Alka Gold |  |  |  |  |  |  |  |  |  |
| SEIZ | Carbatrol |  |  |  |  |  |  |  |  |  |
| TrA | Tranxene |  |  |  |  |  |  |  |  |  |
| Vir | Famvir |  |  |  |  |  |  |  |  |  |
| Vir | Valtrex |  |  |  |  |  |  |  |  |  |
| Vir | Zovirax |  |  |  |  |  |  |  |  |  |
| Z | Actos |  |  |  |  |  |  |  |  |  |
| Z |  |  |  |  |  |  |  |  |  |  |
| Z |  |  |  |  |  |  |  |  |  |  |
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| Z |  |  |  |  |  |  |  |  |  |  |
| Z |  |  |  |  |  |  |  |  |  |  |

| **Therapies** | **Taking now?** | VERY GOOD GOOD | GOOD | NO RESPONSE | BAD | VERY BAD | DON’T KNOW | NEGATIVE, THEN GOOD | **Comments.** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Acupuncture |  |  |  |  |  |  |  |  |  |
| Auditory training |  |  |  |  |  |  |  |  |  |
| Craniosacral |  |  |  |  |  |  |  |  |  |
| EPD |  |  |  |  |  |  |  |  |  |
| Homeopathy |  |  |  |  |  |  |  |  |  |
| Inst. For Human Potential |  |  |  |  |  |  |  |  |  |
| Lovaas |  |  |  |  |  |  |  |  |  |
| Neural therapy |  |  |  |  |  |  |  |  |  |
| Occupational therapy |  |  |  |  |  |  |  |  |  |
| Osteopathy |  |  |  |  |  |  |  |  |  |
| Speech therapy |  |  |  |  |  |  |  |  |  |
| Vision therapy |  |  |  |  |  |  |  |  |  |
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| **Diets** | **Doing now?** | VERY GOOD GOOD | GOOD | NO RESPONSE | BAD | VERY BAD | DON’T KNOW | NEGATIVE, THEN GOOD | **Comments.** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Gluten free |  |  |  |  |  |  |  |  |  |
| Casein free |  |  |  |  |  |  |  |  |  |
| Yeast free |  |  |  |  |  |  |  |  |  |
| High protein / Low carbohydrate |  |  |  |  |  |  |  |  |  |
| Feingold |  |  |  |  |  |  |  |  |  |
| Salicylate free diet |  |  |  |  |  |  |  |  |  |
| Low phenolics diet |  |  |  |  |  |  |  |  |  |
| IgG reactive food avoidance diet |  |  |  |  |  |  |  |  |  |
| Low oxalate diet |  |  |  |  |  |  |  |  |  |
| Specific Carbohydrate Diet |  |  |  |  |  |  |  |  |  |
| Other diet: |  |  |  |  |  |  |  |  |  |
| Other diet: |  |  |  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |  |  |  |

Food

|  |  |  |
| --- | --- | --- |
| **In the past:** | Yes | No |
| Were you breast fed |  |  |
| Problem “latching on” |  |  |
| Vigorous sucker |  |  |
| Good sucker |  |  |
| Poor sucker |  |  |
| Choke or gag on milk |  |  |
| Were you bottle fed |  |  |
| Did you refuse to chew solids |  |  |
| Exclusively breast-fed until | \_\_\_\_\_ | months |
| Exclusively formula fed until | \_\_\_\_\_ | months |
| Exclusively soy formula fed until | \_\_\_\_\_ | months |
| Exclusively milk based\* formula until | \_\_\_\_\_ | months |
| Introduction of cow's milk at | \_\_\_\_\_ | months |
| Introduction of rice cereal | \_\_\_\_\_ | months |
| Introduction of wheat and other grains | \_\_\_\_\_ | months |

\*Enfamil, Similac, SMA, etc.

|  |  |  |
| --- | --- | --- |
| **In the present do you eat:** | Yes | No |
| A lot of ice cream |  |  |
| A lot of sweet food |  |  |
| A lot of sugar/candy |  |  |
| Large amounts of food |  |  |
| Only cold food |  |  |
| Only 3-5 foods daily |  |  |
| A lot of cookies |  |  |
| A lot of white bread |  |  |
| A lot of soda/diet soda |  |  |
| Only one or two foods daily |  |  |
| Only hot food |  |  |
| Milk at least once a day |  |  |
| Salty foods |  |  |
| Sensory issues with food |  |  |
|  |  |  |

**Past and Present Symptoms**

Please use a lower case x to indicate the best description of your symptoms. Indicate frequency and severity unless (mild, moderate or severe)and (occasional, frequent or always) do not apply. If the problem was present in the past, please check the “PAST ONLY” column. Many of the descriptions are similar – use the ones that best fit your impressions. . (please make any text comments outside this table or on a printed copy – I will be moving the table to Excel to distill it for the record and it is best for me to just have to deal with x’s. Thanks.)

|  |  | MILD | MOD | SEVERE | OCCAS | FREQ | ALWAYS | PAST ONLY |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | **STRENGTHS** |  |  |  |  |  |  |  |
| 2 | **Especially attractive** |  |  |  |  |  |  |  |
| 3 | **Accepts new clothes** |  |  |  |  |  |  |  |
| 4 | **Cuddly** |  |  |  |  |  |  |  |
| 5 | **Physically coordinated** |  |  |  |  |  |  |  |
| 6 | **Happy** |  |  |  |  |  |  |  |
| 7 | **Pleasant/easy to care for** |  |  |  |  |  |  |  |
| 8 | **Sensitive/affectionate** |  |  |  |  |  |  |  |
| 9 | **Wants to be liked** |  |  |  |  |  |  |  |
| 10 | **Responsible** |  |  |  |  |  |  |  |
| 11 | **Draws accurate pictures** |  |  |  |  |  |  |  |
| 12 | **Sensitive to peoples feelings** |  |  |  |  |  |  |  |
| 13 | **OK if parents leave** |  |  |  |  |  |  |  |
| 14 | **Answers parent** |  |  |  |  |  |  |  |
| 15 | **Follows instructions** |  |  |  |  |  |  |  |
| 16 | **Pronounces words well** |  |  |  |  |  |  |  |
| 17 | **Unusual memory** |  |  |  |  |  |  |  |
| 18 | **Perfect musical pitch** |  |  |  |  |  |  |  |
| 19 | **Good with math** |  |  |  |  |  |  |  |
| 20 | **Good with computer** |  |  |  |  |  |  |  |
| 21 | **Good with fine work** |  |  |  |  |  |  |  |
| 22 | **Good throwing and catching** |  |  |  |  |  |  |  |
| 23 | **Good climbing** |  |  |  |  |  |  |  |
| 24 | **Strong desire to do things** |  |  |  |  |  |  |  |
| 25 | **Swimming** |  |  |  |  |  |  |  |
| 26 | **Bold, free of fear** |  |  |  |  |  |  |  |
| 27 | **Likes to be held** |  |  |  |  |  |  |  |
| 28 | **Likes to be swaddled** |  |  |  |  |  |  |  |
| 29 | **SLEEP** |  |  |  |  |  |  |  |
| 30 | **Sleeps in own bed** |  |  |  |  |  |  |  |
| 31 | **Sleeps with parent(s)** |  |  |  |  |  |  |  |
| 32 | **Awakens screaming/crying** |  |  |  |  |  |  |  |
| 33 | **Awakes at night** |  |  |  |  |  |  |  |
| 34 | **Difficulty falling asleep** |  |  |  |  |  |  |  |
| 35 | **Early waking** |  |  |  |  |  |  |  |
| 36 | **Insomnia** |  |  |  |  |  |  |  |
| 37 | **Sleeps less than normal** |  |  |  |  |  |  |  |
| 38 | **Daytime sleepiness** |  |  |  |  |  |  |  |
| 39 | **Jerks during sleep** |  |  |  |  |  |  |  |
| 40 | **Nightmares** |  |  |  |  |  |  |  |
| 41 | **Sleeps more than normal** |  |  |  |  |  |  |  |
| 42 | **PHYSICAL** |  |  |  |  |  |  |  |
| 43 | **Looks sick** |  |  |  |  |  |  |  |
| 44 | **Glazed look** |  |  |  |  |  |  |  |
| 45 | **Overweight** |  |  |  |  |  |  |  |
| 46 | **Underweight** |  |  |  |  |  |  |  |
| 47 | **Pupils unusually large** |  |  |  |  |  |  |  |
| 48 | **Unusual long eye lashes** |  |  |  |  |  |  |  |
| 49 | **Pupils unusually small** |  |  |  |  |  |  |  |
| 50 | **Dark circles under eyes** |  |  |  |  |  |  |  |
| 51 | **Red lips** |  |  |  |  |  |  |  |
| 52 | **Red fingers** |  |  |  |  |  |  |  |
| 53 | **Red toes** |  |  |  |  |  |  |  |
| 54 | **Webbed toes** |  |  |  |  |  |  |  |
| 55 | **Red ears** |  |  |  |  |  |  |  |
| 56 | **Double jointed** |  |  |  |  |  |  |  |
| 57 | **High arched palate** |  |  |  |  |  |  |  |
| 58 | **Lymph nodes enlarged neck** |  |  |  |  |  |  |  |
| 59 | **Head warm** |  |  |  |  |  |  |  |
| 60 | **Head sweats** |  |  |  |  |  |  |  |
| 61 | **Night sweats** |  |  |  |  |  |  |  |
| 62 | **Abnormal fatigue** |  |  |  |  |  |  |  |
| 63 | **Failure to thrive** |  |  |  |  |  |  |  |
| 64 | **Cold all over** |  |  |  |  |  |  |  |
| 65 | **Cold hands and feet** |  |  |  |  |  |  |  |
| 66 | **Cold intolerance** |  |  |  |  |  |  |  |
| 67 | **Hands/feet - very sweaty** |  |  |  |  |  |  |  |
| 68 | **Head very hot/sweaty** |  |  |  |  |  |  |  |
| 69 | **Night sweats** |  |  |  |  |  |  |  |
| 70 | **Perspiration - odd odor** |  |  |  |  |  |  |  |
| 71 | **SKIN** |  |  |  |  |  |  |  |
| 72 | **Paleness, severe** |  |  |  |  |  |  |  |
| 73 | **Fungus / fingernails** |  |  |  |  |  |  |  |
| 74 | **Fungus / toenails** |  |  |  |  |  |  |  |
| 75 | **Dandruff** |  |  |  |  |  |  |  |
| 76 | **Chicken skin** |  |  |  |  |  |  |  |
| 77 | **Oily skin** |  |  |  |  |  |  |  |
| 78 | **Patchy dullness** |  |  |  |  |  |  |  |
| 79 | **Seborrhea on face** |  |  |  |  |  |  |  |
| 80 | **Thick calluses** |  |  |  |  |  |  |  |
| 81 | **Athletes foot** |  |  |  |  |  |  |  |
| 82 | **Feet - stinky** |  |  |  |  |  |  |  |
| 83 | **Diaper rash** |  |  |  |  |  |  |  |
| 84 | **Odd body odor** |  |  |  |  |  |  |  |
| 85 | **Strong body odor** |  |  |  |  |  |  |  |
| 86 | **Acne** |  |  |  |  |  |  |  |
| 87 | **Dark circle under eyes** |  |  |  |  |  |  |  |
| 88 | **Ears get red** |  |  |  |  |  |  |  |
| 89 | **Eczema** |  |  |  |  |  |  |  |
| 90 | **Flushing** |  |  |  |  |  |  |  |
| 91 | **Red face** |  |  |  |  |  |  |  |
| 92 | **Sensitive to insect bites** |  |  |  |  |  |  |  |
| 93 | **Stretch marks** |  |  |  |  |  |  |  |
| 94 | **Blotchy skin** |  |  |  |  |  |  |  |
| 95 | **Bugs love to bite you** |  |  |  |  |  |  |  |
| 96 | **Cradle cap** |  |  |  |  |  |  |  |
| 97 | **Dry Hair** |  |  |  |  |  |  |  |
| 98 | **Dry Scalp** |  |  |  |  |  |  |  |
| 99 | **Hair Unmanageable** |  |  |  |  |  |  |  |
| 100 | **Bites nails** |  |  |  |  |  |  |  |
| 101 | **Nails brittle** |  |  |  |  |  |  |  |
| 102 | **Nails frayed** |  |  |  |  |  |  |  |
| 103 | **Nails pitted** |  |  |  |  |  |  |  |
| 104 | **Nails soft** |  |  |  |  |  |  |  |
| 105 | **Skin pale** |  |  |  |  |  |  |  |
| 106 | **Dark birth mark(s)** |  |  |  |  |  |  |  |
| 107 | **Easy bruising** |  |  |  |  |  |  |  |
| 108 | **Inability to tan** |  |  |  |  |  |  |  |
| 109 | **Light birth mark(s)** |  |  |  |  |  |  |  |
| 110 | **Ragged cuticles** |  |  |  |  |  |  |  |
| 111 | **Thickening finger nails** |  |  |  |  |  |  |  |
| 112 | **Thickening toenails** |  |  |  |  |  |  |  |
| 113 | **Vitiligo** |  |  |  |  |  |  |  |
| 114 | **White spots or lines in nails** |  |  |  |  |  |  |  |
| 115 | **Dry skin in general** |  |  |  |  |  |  |  |
| 116 | **Feet cracking** |  |  |  |  |  |  |  |
| 117 | **Feet peeling** |  |  |  |  |  |  |  |
| 118 | **Hands cracking** |  |  |  |  |  |  |  |
| 119 | **Hands peeling** |  |  |  |  |  |  |  |
| 120 | **Lower legs dry** |  |  |  |  |  |  |  |
| 121 | **Skin lackluster** |  |  |  |  |  |  |  |
| 122 | **Itchy skin in general** |  |  |  |  |  |  |  |
| 123 | **Itchy scalp** |  |  |  |  |  |  |  |
| 124 | **Itchy ear canals** |  |  |  |  |  |  |  |
| 125 | **Itchy eyes** |  |  |  |  |  |  |  |
| 126 | **Itchy nose** |  |  |  |  |  |  |  |
| 127 | **Itchy room of mouth** |  |  |  |  |  |  |  |
| 128 | **Itchy arms** |  |  |  |  |  |  |  |
| 129 | **Itchy hands** |  |  |  |  |  |  |  |
| 130 | **Itchy legs** |  |  |  |  |  |  |  |
| 131 | **Itchy feet** |  |  |  |  |  |  |  |
| 132 | **Itchy Anus** |  |  |  |  |  |  |  |
| 133 | **Itchy penis** |  |  |  |  |  |  |  |
| 134 | **Itchy vagina** |  |  |  |  |  |  |  |
| 135 | **DIGESTIVE** |  |  |  |  |  |  |  |
| 136 | **Breath bad** |  |  |  |  |  |  |  |
| 137 | **Increased salivation** |  |  |  |  |  |  |  |
| 138 | **Drooling** |  |  |  |  |  |  |  |
| 139 | **Cracking lip corners** |  |  |  |  |  |  |  |
| 140 | **Cold sores on lips, face** |  |  |  |  |  |  |  |
| 141 | **Geographic tongue (map-like)** |  |  |  |  |  |  |  |
| 142 | **Sore tongue** |  |  |  |  |  |  |  |
| 143 | **Tongue coated** |  |  |  |  |  |  |  |
| 144 | **Canker sores in mouth** |  |  |  |  |  |  |  |
| 145 | **Gums bleed** |  |  |  |  |  |  |  |
| 146 | **Teeth grinding** |  |  |  |  |  |  |  |
| 147 | **Tooth cavities** |  |  |  |  |  |  |  |
| 148 | **Tooth with amalgam fillings** |  |  |  |  |  |  |  |
| 149 | **Mouth thrush (yeast infection)** |  |  |  |  |  |  |  |
| 150 | **Sore throat** |  |  |  |  |  |  |  |
| 151 | **Fecal belching** |  |  |  |  |  |  |  |
| 152 | **Burping** |  |  |  |  |  |  |  |
| 153 | **Nausea** |  |  |  |  |  |  |  |
| 154 | **Reflux** |  |  |  |  |  |  |  |
| 155 | **Spitting up** |  |  |  |  |  |  |  |
| 156 | **Vomiting** |  |  |  |  |  |  |  |
| 157 | **Abdominal bloating** |  |  |  |  |  |  |  |
| 158 | **Lower abdominal bloating** |  |  |  |  |  |  |  |
| 159 | **Colic** |  |  |  |  |  |  |  |
| 160 | **Abdomen distended** |  |  |  |  |  |  |  |
| 161 | **Abdominal pain** |  |  |  |  |  |  |  |
| 162 | **Colic** |  |  |  |  |  |  |  |
| 163 | **Intestinal parasites** |  |  |  |  |  |  |  |
| 164 | **Pinworms** |  |  |  |  |  |  |  |
| 165 | **Crampy pain with pooping** |  |  |  |  |  |  |  |
| 166 | **Constipation** |  |  |  |  |  |  |  |
| 167 | **Diarrhea** |  |  |  |  |  |  |  |
| 168 | **Farting - regular** |  |  |  |  |  |  |  |
| 169 | **Farting - stinky** |  |  |  |  |  |  |  |
| 170 | **Anal fissures** |  |  |  |  |  |  |  |
| 171 | **Red ring around anus** |  |  |  |  |  |  |  |
| 172 | **Stools bulky** |  |  |  |  |  |  |  |
| 173 | **Stools light color** |  |  |  |  |  |  |  |
| 174 | **Stools very stinky** |  |  |  |  |  |  |  |
| 175 | **Stools with blood** |  |  |  |  |  |  |  |
| 176 | **Stools with mucous** |  |  |  |  |  |  |  |
| 177 | **Stools with undigested food** |  |  |  |  |  |  |  |
| 178 | **Flatulence** |  |  |  |  |  |  |  |
| 179 | **Stool odor foul** |  |  |  |  |  |  |  |
| 180 | **Stool odor yeasty** |  |  |  |  |  |  |  |
| 181 | **Stools pale** |  |  |  |  |  |  |  |
| 182 | **Stools slimy** |  |  |  |  |  |  |  |
| 183 | **Stools watery** |  |  |  |  |  |  |  |
| 184 | **EATING** |  |  |  |  |  |  |  |
| 185 | **Poor appetite** |  |  |  |  |  |  |  |
| 186 | **Thirst** |  |  |  |  |  |  |  |
| 187 | **Extreme water drinking** |  |  |  |  |  |  |  |
| 188 | **Bingeing** |  |  |  |  |  |  |  |
| 189 | **Bread craving** |  |  |  |  |  |  |  |
| 190 | **Craving for carbohydrates** |  |  |  |  |  |  |  |
| 191 | **Craving for juice** |  |  |  |  |  |  |  |
| 192 | **Craving for salt** |  |  |  |  |  |  |  |
| 193 | **Diet soda craving** |  |  |  |  |  |  |  |
| 194 | **Pica (eating non-edibles)** |  |  |  |  |  |  |  |
| 195 | **Abnormal food cravings** |  |  |  |  |  |  |  |
| 196 | **Carbohydrate intolerance** |  |  |  |  |  |  |  |
| 197 | **Starch/disaccharide intol.** |  |  |  |  |  |  |  |
| 198 | **Sugar intolerance** |  |  |  |  |  |  |  |
| 199 | **Salicylate intolerance** |  |  |  |  |  |  |  |
| 200 | **Oxalate intolerance** |  |  |  |  |  |  |  |
| 201 | **Phenolics intolerance** |  |  |  |  |  |  |  |
| 202 | **MSG intolerance** |  |  |  |  |  |  |  |
| 203 | **Food coloring intolerance** |  |  |  |  |  |  |  |
| 204 | **Gluten Intolerance** |  |  |  |  |  |  |  |
| 205 | **Casein intolerance** |  |  |  |  |  |  |  |
| 206 | **Specific food(s) intolerance** |  |  |  |  |  |  |  |
| 207 | **Lactose intolerance** |  |  |  |  |  |  |  |
| 208 | **Behavior worse with food** |  |  |  |  |  |  |  |
| 209 | **Behavior better when fasting** |  |  |  |  |  |  |  |
| 210 | **BEHAVIOR** |  |  |  |  |  |  |  |
| 211 | **Behavior purposeless** |  |  |  |  |  |  |  |
| 212 | **Unusual play** |  |  |  |  |  |  |  |
| 213 | **Uses adults hand for activity** |  |  |  |  |  |  |  |
| 214 | **Aloof, indifferent, remote** |  |  |  |  |  |  |  |
| 215 | **Doesn't do for self** |  |  |  |  |  |  |  |
| 216 | **Extremely cautious** |  |  |  |  |  |  |  |
| 217 | **Hides skill/knowledge** |  |  |  |  |  |  |  |
| 218 | **Lacks initiative** |  |  |  |  |  |  |  |
| 219 | **Lost in thought, unreachable** |  |  |  |  |  |  |  |
| 220 | **No purpose to play** |  |  |  |  |  |  |  |
| 221 | **Poor focus, attention** |  |  |  |  |  |  |  |
| 222 | **Sits long time staring** |  |  |  |  |  |  |  |
| 223 | **Uninterested in live pet** |  |  |  |  |  |  |  |
| 224 | **Watches television long time** |  |  |  |  |  |  |  |
| 225 | **Won't attempt/can't do** |  |  |  |  |  |  |  |
| 226 | **Poor sharing** |  |  |  |  |  |  |  |
| 227 | **Rejects help** |  |  |  |  |  |  |  |
| 228 | **Curious/gets into things** |  |  |  |  |  |  |  |
| 229 | **Erratic** |  |  |  |  |  |  |  |
| 230 | **Unable to predict actions** |  |  |  |  |  |  |  |
| 231 | **Destructive** |  |  |  |  |  |  |  |
| 232 | **Hyperactive** |  |  |  |  |  |  |  |
| 233 | **Constant movement** |  |  |  |  |  |  |  |
| 234 | **Melt downs** |  |  |  |  |  |  |  |
| 235 | **Tantrums** |  |  |  |  |  |  |  |
| 236 | **Self mutilation** |  |  |  |  |  |  |  |
| 237 | **Runs away** |  |  |  |  |  |  |  |
| 238 | **Jumps when pleased** |  |  |  |  |  |  |  |
| 239 | **Whirls self like a top** |  |  |  |  |  |  |  |
| 240 | **Climbs to high places** |  |  |  |  |  |  |  |
| 241 | **Insists on what wanted** |  |  |  |  |  |  |  |
| 242 | **Tries to control others** |  |  |  |  |  |  |  |
| 243 | **Head banging** |  |  |  |  |  |  |  |
| 244 | **Falls gets hurt running climbing** |  |  |  |  |  |  |  |
| 245 | **Does opposite/asked** |  |  |  |  |  |  |  |
| 246 | **Teases others** |  |  |  |  |  |  |  |
| 247 | **Silly** |  |  |  |  |  |  |  |
| 248 | **Shrieks** |  |  |  |  |  |  |  |
| 249 | **Holds hands in strange pose** |  |  |  |  |  |  |  |
| 250 | **Spends time w/ pointless task** |  |  |  |  |  |  |  |
| 251 | **Stares at own hands** |  |  |  |  |  |  |  |
| 252 | **Toe walking** |  |  |  |  |  |  |  |
| 253 | **Arched back with bright lights** |  |  |  |  |  |  |  |
| 254 | **Imitates others** |  |  |  |  |  |  |  |
| 255 | **Finger flicking** |  |  |  |  |  |  |  |
| 256 | **Flaps hands** |  |  |  |  |  |  |  |
| 257 | **Licking** |  |  |  |  |  |  |  |
| 258 | **Likes spinning objects** |  |  |  |  |  |  |  |
| 259 | **Likes to flick finger in eye** |  |  |  |  |  |  |  |
| 260 | **Likes to spin things** |  |  |  |  |  |  |  |
| 261 | **Rhythmic rocking** |  |  |  |  |  |  |  |
| 262 | **Slapping books** |  |  |  |  |  |  |  |
| 263 | **Tooth taping** |  |  |  |  |  |  |  |
| 264 | **Visual stims** |  |  |  |  |  |  |  |
| 265 | **Wiggle finger front of face** |  |  |  |  |  |  |  |
| 266 | **Wiggle finger side of face** |  |  |  |  |  |  |  |
| 267 | **Bites or chews fingers** |  |  |  |  |  |  |  |
| 268 | **Bites wrist or back of hands** |  |  |  |  |  |  |  |
| 269 | **Chews on things** |  |  |  |  |  |  |  |
| 270 | **MOOD** |  |  |  |  |  |  |  |
| 271 | **Apathy** |  |  |  |  |  |  |  |
| 272 | **Blank look** |  |  |  |  |  |  |  |
| 273 | **Depression** |  |  |  |  |  |  |  |
| 274 | **Detached** |  |  |  |  |  |  |  |
| 275 | **Disinterested** |  |  |  |  |  |  |  |
| 276 | **Eye contact poor** |  |  |  |  |  |  |  |
| 277 | **Isolates** |  |  |  |  |  |  |  |
| 278 | **Negative** |  |  |  |  |  |  |  |
| 279 | **Fright without cause** |  |  |  |  |  |  |  |
| 280 | **Always frightened** |  |  |  |  |  |  |  |
| 281 | **Anguish** |  |  |  |  |  |  |  |
| 282 | **Discontented** |  |  |  |  |  |  |  |
| 283 | **Does not want to be touched** |  |  |  |  |  |  |  |
| 284 | **Inconsolable crying** |  |  |  |  |  |  |  |
| 285 | **Irritable** |  |  |  |  |  |  |  |
| 286 | **Looks like in pain** |  |  |  |  |  |  |  |
| 287 | **Moaning** |  |  |  |  |  |  |  |
| 288 | **Moaning, groaning** |  |  |  |  |  |  |  |
| 289 | **Phobias** |  |  |  |  |  |  |  |
| 290 | **Restless** |  |  |  |  |  |  |  |
| 291 | **Severe mood swings** |  |  |  |  |  |  |  |
| 292 | **Unhappy** |  |  |  |  |  |  |  |
| 293 | **Agitated** |  |  |  |  |  |  |  |
| 294 | **Anxious** |  |  |  |  |  |  |  |
| 295 | **SENSORY** |  |  |  |  |  |  |  |
| 296 | **Bothered by certain sounds** |  |  |  |  |  |  |  |
| 297 | **Covers ears with sounds** |  |  |  |  |  |  |  |
| 298 | **Ear pain** |  |  |  |  |  |  |  |
| 299 | **Ear ringing** |  |  |  |  |  |  |  |
| 300 | **Hearing acute** |  |  |  |  |  |  |  |
| 301 | **Hearing loss** |  |  |  |  |  |  |  |
| 302 | **Likes certain sounds** |  |  |  |  |  |  |  |
| 303 | **Sensitive to loud noise** |  |  |  |  |  |  |  |
| 304 | **Sounds seem painful** |  |  |  |  |  |  |  |
| 305 | **Tinnitus** |  |  |  |  |  |  |  |
| 306 | **Acute sense of smell** |  |  |  |  |  |  |  |
| 307 | **Examines by smell** |  |  |  |  |  |  |  |
| 308 | **Intensely aware of odors** |  |  |  |  |  |  |  |
| 309 | **Blinking** |  |  |  |  |  |  |  |
| 310 | **Bothered by bright lights** |  |  |  |  |  |  |  |
| 311 | **Distorted vision** |  |  |  |  |  |  |  |
| 312 | **Conjunctivitis** |  |  |  |  |  |  |  |
| 313 | **Eye crusting** |  |  |  |  |  |  |  |
| 314 | **Eye problem** |  |  |  |  |  |  |  |
| 315 | **Lid margin redness** |  |  |  |  |  |  |  |
| 316 | **Examines by sight** |  |  |  |  |  |  |  |
| 317 | **Fails to blink at bright light** |  |  |  |  |  |  |  |
| 318 | **Likes fans** |  |  |  |  |  |  |  |
| 319 | **Likes flickering lights** |  |  |  |  |  |  |  |
| 320 | **Looks out of corner of eye** |  |  |  |  |  |  |  |
| 321 | **Poor vision** |  |  |  |  |  |  |  |
| 322 | **Puts eye to bright light or sun** |  |  |  |  |  |  |  |
| 323 | **Strabismus (crossed eye)** |  |  |  |  |  |  |  |
| 324 | **Fearful of harmless object** |  |  |  |  |  |  |  |
| 325 | **Fearful of unusual events** |  |  |  |  |  |  |  |
| 326 | **Unaware of danger** |  |  |  |  |  |  |  |
| 327 | **Unaware of peoples feelings** |  |  |  |  |  |  |  |
| 328 | **Unaware of self as person** |  |  |  |  |  |  |  |
| 329 | **Upset if things change** |  |  |  |  |  |  |  |
| 330 | **Upset of things aren't right** |  |  |  |  |  |  |  |
| 331 | **Adopts complicated rituals** |  |  |  |  |  |  |  |
| 332 | **Car, truck, train obsession** |  |  |  |  |  |  |  |
| 333 | **Collects particular things** |  |  |  |  |  |  |  |
| 334 | **Draws only certain things** |  |  |  |  |  |  |  |
| 335 | **Fixated on one topic** |  |  |  |  |  |  |  |
| 336 | **Lines objects precisely** |  |  |  |  |  |  |  |
| 337 | **Repeats old phrases** |  |  |  |  |  |  |  |
| 338 | **Repetitive play/objects** |  |  |  |  |  |  |  |
| 339 | **Finger tip squeezing** |  |  |  |  |  |  |  |
| 340 | **Hates wearing shoes** |  |  |  |  |  |  |  |
| 341 | **Insensitive to pain** |  |  |  |  |  |  |  |
| 342 | **Likes head burrowed** |  |  |  |  |  |  |  |
| 343 | **Likes head pressed hard** |  |  |  |  |  |  |  |
| 344 | **Likes head rubbed** |  |  |  |  |  |  |  |
| 345 | **Likes head under blanket** |  |  |  |  |  |  |  |
| 346 | **Likes to be held upside down** |  |  |  |  |  |  |  |
| 347 | **Likes to be swung in the air** |  |  |  |  |  |  |  |
| 348 | **Very insensitive to pain** |  |  |  |  |  |  |  |
| 349 | **Very sensitive to pain** |  |  |  |  |  |  |  |
| 350 | **NEUROMUSCULAR** |  |  |  |  |  |  |  |
| 351 | **Clumsiness** |  |  |  |  |  |  |  |
| 352 | **Coordination** |  |  |  |  |  |  |  |
| 353 | **Fine motor poor** |  |  |  |  |  |  |  |
| 354 | **Gross motor poor** |  |  |  |  |  |  |  |
| 355 | **Holds bizarre posture** |  |  |  |  |  |  |  |
| 356 | **Hyperactivity** |  |  |  |  |  |  |  |
| 357 | **Physically awkward** |  |  |  |  |  |  |  |
| 358 | **Rocking** |  |  |  |  |  |  |  |
| 359 | **Stiffens body when held** |  |  |  |  |  |  |  |
| 360 | **Calf cramps** |  |  |  |  |  |  |  |
| 361 | **Foot cramps** |  |  |  |  |  |  |  |
| 362 | **Muscle pain** |  |  |  |  |  |  |  |
| 363 | **Muscle tone tense** |  |  |  |  |  |  |  |
| 364 | **Muscle twitches** |  |  |  |  |  |  |  |
| 365 | **Fist clenching** |  |  |  |  |  |  |  |
| 366 | **Jaw clenching** |  |  |  |  |  |  |  |
| 367 | **Poor muscle tone/limp** |  |  |  |  |  |  |  |
| 368 | **Tics** |  |  |  |  |  |  |  |
| 369 | **Muscle tone low trunk** |  |  |  |  |  |  |  |
| 370 | **Muscle weakness, atrophy** |  |  |  |  |  |  |  |
| 371 | **Muscle tone low all over** |  |  |  |  |  |  |  |
| 372 | **Tremors** |  |  |  |  |  |  |  |
| 373 | **Cognitive delays** |  |  |  |  |  |  |  |
| 374 | **Memory poor** |  |  |  |  |  |  |  |
| 375 | **Poor attention, focus** |  |  |  |  |  |  |  |
| 376 | **Slow and sluggish** |  |  |  |  |  |  |  |
| 377 | **Expressive language delay** |  |  |  |  |  |  |  |
| 378 | **SPEECH** |  |  |  |  |  |  |  |
| 379 | **Never spoke** |  |  |  |  |  |  |  |
| 380 | **Occas. words when excited** |  |  |  |  |  |  |  |
| 381 | **Expressive language poor** |  |  |  |  |  |  |  |
| 382 | **No answers simple questions** |  |  |  |  |  |  |  |
| 383 | **Points to objects/can't name** |  |  |  |  |  |  |  |
| 384 | **Speech apraxia** |  |  |  |  |  |  |  |
| 385 | **Does not asks questions** |  |  |  |  |  |  |  |
| 386 | **Babbling** |  |  |  |  |  |  |  |
| 387 | **Asks using "you" not "I"** |  |  |  |  |  |  |  |
| 388 | **Answers by repeating question** |  |  |  |  |  |  |  |
| 389 | **Receptive language poor** |  |  |  |  |  |  |  |
| 390 | **Says "I"** |  |  |  |  |  |  |  |
| 391 | **Says "no"** |  |  |  |  |  |  |  |
| 392 | **Says "yes"** |  |  |  |  |  |  |  |
| 393 | **Lost language @ 12-24 months** |  |  |  |  |  |  |  |
| 394 | **Lost language after 24 months** |  |  |  |  |  |  |  |
| 395 | **Scripting** |  |  |  |  |  |  |  |
| 396 | **Stuttering** |  |  |  |  |  |  |  |
| 397 | **Talks to self** |  |  |  |  |  |  |  |
| 398 | **Poor auditory processing** |  |  |  |  |  |  |  |
| 399 | **Unusual sound of cry** |  |  |  |  |  |  |  |
| 400 | **Uses one word for another** |  |  |  |  |  |  |  |
| 401 | **Rigid behaviors** |  |  |  |  |  |  |  |
| 402 | **Poor confidence** |  |  |  |  |  |  |  |
| 403 | **Timid** |  |  |  |  |  |  |  |
| 404 | **Corrects imperfections** |  |  |  |  |  |  |  |
| 405 | **Tidy** |  |  |  |  |  |  |  |
| 406 | **RESPIRATORY** |  |  |  |  |  |  |  |
| 407 | **Pneumonia** |  |  |  |  |  |  |  |
| 408 | **Bad odor in nose** |  |  |  |  |  |  |  |
| 409 | **Breath holding** |  |  |  |  |  |  |  |
| 410 | **Bronchitis** |  |  |  |  |  |  |  |
| 411 | **Congestion chg. season** |  |  |  |  |  |  |  |
| 412 | **Congestion in the fall** |  |  |  |  |  |  |  |
| 413 | **Congestion in the spring** |  |  |  |  |  |  |  |
| 414 | **Congestion in the summer** |  |  |  |  |  |  |  |
| 415 | **Congestion in the winter** |  |  |  |  |  |  |  |
| 416 | **Cough** |  |  |  |  |  |  |  |
| 417 | **Post nasal drip** |  |  |  |  |  |  |  |
| 418 | **Runny nose** |  |  |  |  |  |  |  |
| 419 | **Sighing** |  |  |  |  |  |  |  |
| 420 | **Sinus fullness** |  |  |  |  |  |  |  |
| 421 | **Wheezing** |  |  |  |  |  |  |  |
| 422 | **Yawning** |  |  |  |  |  |  |  |
| 423 | **REPRODUCTIVE:** |  |  |  |  |  |  |  |
| 424 | **Girls: Early first period** |  |  |  |  |  |  |  |
| 425 | **Boys: Large testicles** |  |  |  |  |  |  |  |
| 426 | **Early breast development** |  |  |  |  |  |  |  |
| 427 | **Early pubic hair** |  |  |  |  |  |  |  |
| 428 | **Girls: vaginal odor** |  |  |  |  |  |  |  |
| 429 | **Girls: vaginal odor** |  |  |  |  |  |  |  |
| 430 | **Girls: vaginal odor** |  |  |  |  |  |  |  |
| 431 | **URINARY:** |  |  |  |  |  |  |  |
| 432 | **Frequent urination** |  |  |  |  |  |  |  |
| 433 | **Bed wetting after age 4** |  |  |  |  |  |  |  |
| 434 | **Odd urinary odor** |  |  |  |  |  |  |  |
| 435 | **Urinary hesitancy** |  |  |  |  |  |  |  |
| 436 | **Urinary tract infections** |  |  |  |  |  |  |  |
| 437 | **Urinary urgency** |  |  |  |  |  |  |  |
| 438 | **Dry at night** |  |  |  |  |  |  |  |
| 439 | **Seizures - focal** |  |  |  |  |  |  |  |
| 440 | **Seizures - generalized** |  |  |  |  |  |  |  |
| 441 | **Seizures - petit mal** |  |  |  |  |  |  |  |
| 442 | **Seizures - petit mal** |  |  |  |  |  |  |  |
| 443 | **Unusual fast heart beat** |  |  |  |  |  |  |  |
| 444 | **Heart murmur** |  |  |  |  |  |  |  |
| 445 | **Headaches** |  |  |  |  |  |  |  |
| 446 | **Joint pains** |  |  |  |  |  |  |  |
| 447 | **Leg pains** |  |  |  |  |  |  |  |
| 448 | **Muscle pains** |  |  |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Environmental History (please indicate past and present exposures)** | | |  | **Some things about your parents:** |  |
| **Exposure:** | **Past** | **Present** |  | When were your parents married: |  |
| Mold in bathroom |  |  |  | If separated, when: |  |
| Damp cellar |  |  |  | If divorced, when |  |
| Pest extermination - Inside |  |  |  | If remarried, when |  |
| Pest extermination - Outside |  |  |  | Custody arrangements |  |
| Forced hot air heat |  |  |  | **Mother - Personal** |  |
| Had water in basement |  |  |  | Age at your birth |  |
| Mold visible on exterior of house |  |  |  | Education |  |
| Heavily wooded or damp surroundings |  |  |  | Ethnicity |  |
| Mold in cellar, crawl space, or basement |  |  |  | Blood type |  |
| Moldy, musty school/daycare |  |  |  | **Father - Personal** |  |
| Tobacco smoke |  |  |  | Age at your birth |  |
| Well water |  |  |  | Education |  |
| Carpet in bedroom |  |  |  | Ethnicity |  |
| Carpet in most parts of house |  |  |  | Blood type |  |
| Feather or down bedding |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | **Mother’s Side** | | **Father’s Side** | |  |  |
| Family Medical History | **Father** | **Mother** | **Sibling(s)** | **Grand-mother** | **Grand-father** | **Grand-mother** | **Grand-father** | **First Cousin** | **Other** |
| Alcoholism |  |  |  |  |  |  |  |  |  |
| Allergies |  |  |  |  |  |  |  |  |  |
| Anorexia |  |  |  |  |  |  |  |  |  |
| Anxiety |  |  |  |  |  |  |  |  |  |
| Arthritis |  |  |  |  |  |  |  |  |  |
| Asthma |  |  |  |  |  |  |  |  |  |
| Autism |  |  |  |  |  |  |  |  |  |
| Autoimmune problems |  |  |  |  |  |  |  |  |  |
| Bulimia |  |  |  |  |  |  |  |  |  |
| Celiac disease |  |  |  |  |  |  |  |  |  |
| Colitis |  |  |  |  |  |  |  |  |  |
| Crohn’s disease |  |  |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |  |  |  |
| Eczema |  |  |  |  |  |  |  |  |  |
| Endometriosis |  |  |  |  |  |  |  |  |  |
| Food allergies |  |  |  |  |  |  |  |  |  |
| Gout/high uric acid level |  |  |  |  |  |  |  |  |  |
| Hay Fever |  |  |  |  |  |  |  |  |  |
| Heart disease |  |  |  |  |  |  |  |  |  |
| High blood pressure |  |  |  |  |  |  |  |  |  |
| Hives |  |  |  |  |  |  |  |  |  |
| Hypoglycemia |  |  |  |  |  |  |  |  |  |
| Identical twins |  |  |  |  |  |  |  |  |  |
| Irritable |  |  |  |  |  |  |  |  |  |
| Left handedness |  |  |  |  |  |  |  |  |  |
| Malabsorption |  |  |  |  |  |  |  |  |  |
| Mental Illness |  |  |  |  |  |  |  |  |  |
| Mild respiratory allergy |  |  |  |  |  |  |  |  |  |
| Milk (casein) sensitivity |  |  |  |  |  |  |  |  |  |
| Mitral valve prolapse |  |  |  |  |  |  |  |  |  |
| Obesity |  |  |  |  |  |  |  |  |  |
| Retardation |  |  |  |  |  |  |  |  |  |
| Schizophrenia Psychosis |  |  |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |  |  |
| Strong moodiness |  |  |  |  |  |  |  |  |  |
| Tendency to be" loner" |  |  |  |  |  |  |  |  |  |
| Thyroid problem |  |  |  |  |  |  |  |  |  |
| Wheat (gluten) sensitivity |  |  |  |  |  |  |  |  |  |
| Yeast problems |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |

Thank you for taking the time and effort to complete this questionnaire. I suggest you make copies it for your records.