Center for Holistic Medicine
Pediatric Intake Form

GENERAL INFORMATION

Name: _____
First *Middle* *Last*

Preferred Name: _____

Date of Birth: _____

Age: _____

Gender ○ Male ○ Female

Ethnic Background: ☐ African ☐ European ☐ Native American ☐ Mediterranean
☐ Asian ☐ Ashkenazi ☐ Middle Eastern ☐ _____

Mother's Name: _____Occupation:_____

Father's Name: _____Occupation: _____

Primary Address (person completing this questionnaire)

_____
Number, Street *Apt. No.*

_____
City *State* *Zip*

_____

Alternate Address:

_____
Number, Street *Apt. No.*

_____
City *State* *Zip*

_____

Home Phone 1: _____ Home Phone 2: _____

Parent's Work Phone: _____ Parent's Cell Phone:_____

Fax: _____ Email:_____

Emergency Contact:
Name *Phone Number*

_____ _____
Address *Apt. No.*

_____
City *State* *Zip*

_____

Referred by: ○ Website ○ Media ○ Friend or Family Member ○ Other

_____

PHARMACY INFORMATION

Primary Pharmacy: _____ *Phone Number*_____

Address _____

*City*_____*State*_____*Zip*_____

*Email*_____*Fax**_____

*It is extremely important that you list the pharmacy's fax number

PHARMACY INFORMATION

Compounding/Supplement Pharmacy: _____ *Phone Number*_____

Address _____

*City*_____*State*_____*Zip*_____

*Email*_____*Fax**_____

*It is extremely important that you list the pharmacy's fax number

CREDIT CARD INFORMATION

Preferred Method of Payment *(please circle one)*: Cash / Check / Credit Card

Credit Card Type *(please circle one*): VISA MASTERCARD DISCOVER

**Note: If Discover is your primary card, please provide another card (i.e., MC or Visa) for transactions (i.e., supplement orders, etc.) that we may need to process. Some pharmacies do not accept Discover*

PRIMARY CARD

Name on Card_____

Card Type ○ Visa ○ MasterCard ○ Discover

Account Number_____

Expiration Date (mm/yy) _____

CVV#_____

SECONDARY CARD

Name on Card_____

Card Type ○ Visa ○ MasterCard ○ Discover

Account Number_____

Expiration Date (mm/yy) _____

CVV#_____

Pediatric Medical Questionnaire

What diagnoses has your child been given and at what age?

_____

_____

_____

Who gave you that diagnosis?_____

Describe your child to me and tell his or her story being as detailed as possible:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Allergies

Medication/Supplement/Food/environment	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Complaints/Concerns

What do you hope to achieve in your visit with us? _____

_____

If you had a magic wand and could help your child in three ways, what would they be?

1._____

2._____

3._____

When was the last time you felt your child was well? _____

_____

Did something trigger your child's change in health? _____

_____

Is there anything that makes your child feel worse? _____
_____

Is there anything that makes your child feel better? _____
Please list current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe	Prior Treatment/Approach	Success: Excellent	Good	Fair
Example: Difficulty Maintaining Attention		X		Elimination Diet	X		

Diseases/Diagnosis/Conditions (*Check appropriate box and provide date of onset)*

GASTROINTESTINAL

Past	Current	
☐	☐	Irritable Bowel Syndrome_____
☐	☐	Inflammatory Bowel Disease _____
☐	☐	Crohn's _____
☐	☐	Ulcerative Colitis _____
☐	☐	Gastritis or Peptic Ulcer Disease _____
☐	☐	GERD (reflux) _____
☐	☐	Celiac Disease _____
☐	☐	Other _____

CARDIOVASCULAR

Past	Current	
☐	☐	Heart Disease_____
☐	☐	Elevated Cholesterol_____
☐	☐	Hypertension (high blood pressure) _____
☐	☐	Rheumatic Fever_____
☐	☐	Mitral Valve Prolapse_____
☐	☐	Other_____

METABOLIC/ENDOCRINE

Past	Current	
☐	☐	Type 1 Diabetes_____
☐	☐	Type 2 Diabetes_____
☐	☐	Hypoglycemia_____
☐	☐	Metabolic Syndrome (Insulin Resistance or Pre-Diabetes) _____
☐	☐	Hypothyroidism (low thyroid)_____
☐	☐	Hyperthyroidism (overactive thyroid) _____
☐	☐	Endocrine Problems_____
☐	☐	Polycystic Ovarian Syndrome (PCOS) _____
☐	☐	Weight Gain_____
☐	☐	Weight Loss_____
☐	☐	Frequent Weight Fluctuations_____
☐	☐	Bulimia_____
☐	☐	Anorexia_____
☐	☐	Binge Eating Disorder_____
☐	☐	Night Eating Syndrome_____
☐	☐	Other_____

CANCER

Past	Current

☐	☐	_____

GENITAL AND URINARY SYSTEMS

Past	Current	
☐	☐	Kidney Stones_____
☐	☐	Urinary Tract Infections_____
☐	☐	Yeast Infections_____
☐	☐	Other_____

MUSCULOSKELETAL/PAIN

Past	Current	
☐	☐	Arthritis_____
☐	☐	Fibromyalgia_____
☐	☐	Chronic Pain_____
☐	☐	Other_____

INFLAMMATORY/AUTOIMMUNE

Past	Current	
☐	☐	Chronic Fatigue Syndrome_____
☐	☐	Autoimmune Disease_____
☐	☐	Rheumatoid Arthritis_____
☐	☐	Lupus SLE_____
☐	☐	Immune Deficiency Disease_____
☐	☐	Severe Infectious Disease_____
☐	☐	Poor Immune Function (frequent infections) _____
☐	☐	Food Allergies_____
☐	☐	Environmental Allergies_____
☐	☐	Multiple Chemical Sensitivities___
☐	☐	Latex Allergy_____
☐	☐	Other_____

RESPIRATORY DISEASES

Past	Current	
☐	☐	Frequent Ear Infections_____
☐	☐	Frequent Upper Respiratory Infections _____
☐	☐	Asthma_____
☐	☐	Chronic Sinusitis_____
☐	☐	Bronchitis_____
☐	☐	Sleep Apnea_____
☐	☐	Other_____

SKIN DISEASES

Past	Current	
☐	☐	Eczema_____
☐	☐	Psoriasis_____
☐	☐	Acne_____
☐	☐	Other_____

NEUROLOGIC/MOOD

Past	Current	
☐	☐	Depression_____
☐	☐	Anxiety_____
☐	☐	Bipolar Disorder_____
☐	☐	Schizophrenia_____
☐	☐	Headaches_____
☐	☐	Migraines_____
☐	☐	ADD/ADHD_____
☐	☐	Sensory Integrative Disorder _____
☐	☐	Autism_____
☐	☐	Mild Cognitive Impairment_____
☐	☐	Multiple Sclerosis_____
☐	☐	Seizures_____
☐	☐	Other Neurological Problems_____

☐	☐	Chiropractic _____
☐	☐	MRI _____
☐	☐	CT Scan _____
☐	☐	Upper Endoscopy _____
☐	☐	Upper GI Series _____
☐	☐	Ultrasound_____
☐	☐	_____

INJURIES

Check box if yes and provide date

Past	Current	
☐	☐	Back injury _____
☐	☐	Neck Injury _____
☐	☐	Head Injury _____
☐	☐	Broken Bones_____
☐	☐	Other _____

PREVIOUS EVALUATIONS

*Check box if yes and provide **date***

Past	Current	
☐	☐	Full Physical Exam_____
☐	☐	Psychological Evaluations _____
☐	☐	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 _____
☐	☐	Speech Classes _____
☐	☐	Sign Language _____
☐	☐	Homeopathic _____
☐	☐	Naturopathic_____
☐	☐	Craniosacral _____

SURGERIES

Check box if yes and provide date

Past	Current	
☐	☐	Appendectomy _____
☐	☐	Circumcision _____
☐	☐	Hernia _____
☐	☐	Tonsils/Adenoids _____
☐	☐	Dental Surgery_____
☐	☐	Tubes in Ears_____
☐	☐	Other _____

BLOOD TYPE: ○A ○B ○AB ○0
○Rh+ ○unknown

Please attach a copy of all Lab testing that have been performed.

HOSPITALIZATIONS ☐ None

Date	Reason

PSYCHOSOCIAL

Has your child experienced any major life changes that may have impacted his/her health? ○Yes ○No

Have your child ever experienced any major losses? _____

STRESS/COPING

Have you ever sought counseling for your child? ○Yes ○No

Is your child or family currently in therapy? ○Yes ○No Describe: _____

Does your child have a favorite toy or object? ○Yes ○No_____

Check all that apply: ☐Yoga ☐Meditation ☐Imagery ☐Breathing ☐Tai Chi ☐Prayer ☐Other: _____

Has your child ever been abused, a victim of a crime, or experienced a significant trauma? ○Yes ○No

SLEEP/REST

Average number of hours your child sleeps per night: ○>12 ○10-12 ○8-10 ○< 8

Does your child have trouble falling asleep or wakes up frequently?_____

Does your child feel rested upon awakening? ○Yes ○No

Does your child snore? ○Yes ○No

ROLES/RELATIONSHIPS

List Family Members:

Family Member and Relationship	Age	Gender

Who are the main people who care for your child? _____

_____

Resources for emotional support:

Check all that apply: ☐Spouse ☐Family ☐Friends ☐Religious/Spiritual ☐Pets ☐Other: _____

GYNECOLOGIC HISTORY *(FOR WOMEN ONLY)*

Menstrual History

Age at first period: _____ Menses Frequency:_____ Length:_____
Pain: ○Yes ○No Clotting: ○Yes ○No
Has your period ever skipped? _____ For how long? _____
Last Menstrual Period: _____
Use of hormonal contraception such as: ☐Birth Control Pills ☐Patch ☐Nuva Ring How long?_____

GI HISTORY

Has your child traveled to foreign countries? ○Yes ○No Where? _____
Wilderness Camping? ○Yes ○No Where? _____
Ever had severe: ○Gastroenteritis ○Diarrhea

DENTAL HISTORY

☐Silver Mercury Fillings How many? _____
☐Gold Fillings ☐Root Canals ☐Implants ☐Tooth Pain ☐Bleeding Gums
☐Gingivitis ☐Problems with Chewing
Do you floss regularly? ○Yes ○No

PATIENT BIRTH HISTORY

Mother's Past Pregnancies
Number of: Pregnancies: _____ Live births: _____ Miscarriages: _____

Mother's Pregnancy *Check box if yes and provide description 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 _____
☐ Number of fillings in 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 Total 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

Very active before birth? ○Yes ○No

Hospital/Birthing Center? ○Yes ○No

Needed Newborn Special Care? ○Yes ○No

Appeared healthy? ○Yes ○No

Easily consoled during first month? ○Yes ○No

Antibiotics first month? ○Yes ○No

Experienced no complications first month of life? ○Yes ○No

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

If your child has developmental problems, at what age did they occur?

○0-1 months ○2-6 months ○6-15 months ○16-24 months ○After 24 months

Is this impression shared among parents and others caring for the child? ○Yes ○No

Does this impression, as to the timing of onset, differ among parents and others caring for the child? ○Yes ○No

Is the impression, as to the timing of onset, weak? ○Yes ○No
Or is the impression strong? ○Yes ○No

DEVELOPMENTAL HISTORY

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

Sitting up _____ months ○Never
Crawl _____ months ○Never
Pulled to stand _____months ○Never
Potty trained _____ months ○Never
Walked alone _____ months ○Never

Dry at night _____ months ○Never

First words (mama, dada) ____months ○Never
Spoke clearly _____ months ○Never
Lost language _____ months ○Never
Lost eye contact _____months ○Never

MEDICATIONS

Current Medications

Medication	Dose	Frequency	Start Date (month/year)	Reason for Use

Previous Medications: *Last 10 years*

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

Nutritional Supplements (Vitamins/Minerals/Herbs/Homeopathy)

Supplication and Brand	Dose	Frequency	Start Date (month/year)	Reason for Use

Have your medications or supplements ever caused you unusual side effects or problems? ○Yes ○No
Describe: _____

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, Motrin, Aspirin etc.)? ○Yes ○No

Have you had prolonged or regular use of Tylenol? ○Yes ○No

Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.)
○Yes ○No

Frequent antibiotics > 3 times/year ○Yes ○No

Long term antibiotics ○Yes ○No

Use of steroids (prednisone, nasal allergy inhalers) in the past ○Yes ○No

Use of oral contraceptives ○Yes ○No

Other medications/supplements or side effects/ comments or other information you would like to discuss:

_____

_____

FAMILY HISTORY

Check family members that apply

	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandfathe	Paternal Grandmoth	Aunts	Uncles	Other
Age (if still alive)										
Age at death (if deceased)										
Cancers										
Colon Cancer										
Breast or Ovarian Cancer										
Obesity										
Diabetes										
Stroke										
Inflammatory Arthritis (rheumatoid, Psoriatic, Ankylosing Sondylitis)										
Inflammatory Bowel Disease										
Multiple Sclerosis										
Auto Immune Disease (such as Lupus)										
Irritable Bowel Syndrome										
Celiac Disease (Wheat Sensitivity)										
Asthma										
Eczema / Psoriasis										
Food Allergies, Sensitivities or Intolerances										
Environmental Sensitivities										
Dementia										
Parkinson’s										
ALS or other Motor Neuron Diseases										
Genetic Disorders										
Substance Abuse (such as alcoholism)										
Psychiatric Disorders										
Depression										

Schizophrenia										
ADHD										
Autism										
Bipolar Disease										

Immunizations:

Please list child's reaction to immunization (Change in stools, crying, seizures, irritability, fever, rash, poor sleep etc.)

Age	Vaccinations given	Response or observation
0-2 months	_____	_____
2-4 months	_____	_____
4-6 months	_____	_____
6-9 months	_____	_____
9-12 months	_____	_____
12-15 months	_____	_____
15-18 months	_____	_____
18-24 months	_____	_____
Other	_____	_____

Do you have any other questions or concerns regarding immunizations?

_____
_____
_____
_____

_____

_____

_____

NUTRITIONAL HISTORY

Has your child ever had a nutrition consultation? ○ Yes ○ No

Have you made any changes in your child's diet because of health problems? ○ Yes ○ No
Describe_____

Does your child follow a special diet or nutritional program? ○ Yes ○ No
Check all that apply:

☐ Yeast Free ☐ Feingold ☐ Weight Management ☐ Diabetic ☐ Dairy Free ☐ Wheat Free
☐ Ketogenic

☐ Specific Carbohydrate ☐ Gluten Free/Casein Free ☐ Gluten Restricted ☐ Vegetarian ☐ Vegan
☐ Low Oxalate

☐ Food Allergy (*Ex. Peanuts, Eggs, etc.*): _____

Height (feet/inches) _____ Current Weight _____

Height/Weight Fluctuations ○Yes ○No

Does your child avoid any particular foods? ○Yes ○No If yes, types and reason: _____

_____

If your child could eat only a few foods daily, what would they be?_____

_____

Who does the shopping in your household?_____

Who does the cooking in your household? _____

How many meals does your child eat out per week? ○0-1 ○1-3 ○3-5 ○>5 meals per week

Check all the factors that apply to your current lifestyle and eating habits:

☐ Fast eater
☐ Erratic eating pattern
☐ Eat too much
☐ Dislike healthy food
☐ Time constraints
☐ Eat more than 50% meals away from home
☐ Poor snack choices
☐ Sensory issues with food
☐ Picky eater
☐ Limited variety of foods <5/day
☐ Prefers cold food
☐ Prefers hot food
☐ Every meal is a struggle
☐ Most family meals together
☐ Use food as a bribe or reward
☐ Erratic mealtimes
☐ Most meals eaten at the table
☐ High juice intake
☐ Low fruit/vegetable intake
☐ High sugar/sweet intake
☐ Drinks soda or diet soda
☐ Cow's Milk 1 2 3+/ day
☐ Caffeine intake
☐ TV or videos with meals
☐ Challenges with food served outside the home (Ex. childcare, friend's home)

BREASTFED HISTORY

Breastfed? ○Yes ○No How long? _____ Problems latching on? ○Yes ○No

Sucking quality? ○Very Good ○Good ○Poor Exclusively breastfed for _____ months

BOTTLEFED HISTORY

Bottle fed? ○Yes ○No Type of formula: ○Soy ○Cow's Milk ○Low Allergy

Introduction of cow's milk at _____ months. Introduction of solid foods at _____ months.

First foods introduced at _____ months. Introduction of wheat or other grain at _____ months.

Choke/Gas/Vomit on milk? ○Yes ○No Refused to chew solids? ○Yes ○No

List mother's known food allergies or sensitivities:_____

Please describe any other eating concerns that you have regarding your child:_____

_____

ACTIVITY

List type and amount of activity daily(school, therapies, play etc.):

Type	**Amount Daily**

How much time does your child spend watching tv? _____

How much time does your child spend on the computer or playing video games? _____

ENVIRONMENTAL HISTORY

Please check appropriate box

EXPOSURES

Past	**Current**	
☐	☐	Mold in bathroom
☐	☐	Damp cellar
☐	☐	Pest extermination - Inside
☐	☐	Pest extermination - Outside
☐	☐	Forced hot air heat
☐	☐	Had water in basement
☐	☐	Mold visible on exterior of house
☐	☐	Heavily wooded or damp surroundings
☐	☐	Mold in cellar, crawl space, or basement
☐	☐	Moldy, musty school/daycare
☐	☐	Tobacco smoke
☐	☐	Well water

Bedding: Synthetic, down, feather, cotton, organic
Mattress cover: ○Yes ○No
Type: Crib, Junior bed, Adult bed

Flooring(circle): Carpet wall to wall, Area rug, Wood, Glued down, Synthetic padding, carpet throughout house.

_____

Window treatment: Shades, Blinds, Thin Curatin, Heavy curtain, Valence, Other.

Other items in room: Describe furniture, toys, stuffed animals, etc_____
_____

Is your child sensitive to any of the following?

Perfumes/Cosmetics_____ Mold _____
Cleaning products_____ Pollens/grasses_____
Soaps_____ Animals_____
Gasoline_____ Paint _____
Detergents_____ Dust _____
Other_____

SOME THINGS ABOUT YOUR PARENTS

When were your parents married: _____ If separated, when: _____
If divorced, when: _____ If remarried, when: _____
Custody arrangements: _____

MOTHER – PERSONAL

Age at your birth _____
Education_____
Ethnicity _____
Blood type _____

FATHER - PERSONAL

Age at your birth _____
Education _____
Ethnicity _____
Blood type _____

SYMPTOM REVIEW

Please check all current symptoms occurring or present in the past 6 months.

STRENGTHS

☐ Accepts new clothes
☐ Cuddly
☐ Physically coordinated
☐ Happy
☐ Pleasant/easy to care for
☐ Sensitive/affectionate
☐ Wants to be liked
☐ Responsible
☐ Draws accurate pictures
☐ Sensitive to peoples' feelings
☐ OK if parents leave
☐ Answers parent
☐ Follows instructions
☐ Pronounces words well
☐ Unusual memory
☐ Perfect musical pitch
☐ Good with math
☐ Good with computer
☐ Good with fine work
☐ Good throwing and catching
☐ Good climbing
☐ Strong desire to do things
☐ Swimming
☐ Bold, free of fear
☐ Likes to be held
☐ _____

SLEEP

☐ Sleeps in own bed
☐ Sleeps with parent(s)
☐ Awakens screaming/crying
☐ Awakes at night
☐ Difficulty falling asleep
☐ Early waking
☐ Insomnia
☐ Sleeps less than normal
☐ Daytime sleepiness
☐ Jerks during sleep
☐ Nightmares
☐ Sleeps more than normal

PHYSICAL

☐ Looks sick
☐ Glazed look
☐ Overweight
☐ Underweight
☐ Pupils unusually large
☐ Pupils unusually small
☐ Dark circles under eyes
☐ Red lips
☐ Red fingers
☐ Red toes
☐ Webbed toes
☐ Red ears
☐ Double jointed
☐ High arched palate
☐ Lymph nodes enlarged neck
☐ Head warm
☐ Head sweats
☐ Night sweats
☐ Abnormal fatigue
☐ Failure to thrive
☐ Cold all over
☐ Cold hands and feet
☐ Cold intolerance
☐ Hands/feet - very sweaty

- ☐ Head very hot/sweaty
- ☐ Night sweats
- ☐ Perspiration - odd odor

SKIN

- ☐ Paleness, severe
- ☐ Fungus / nail beds
- ☐ Dandruff
- ☐ Chicken skin
- ☐ Oily skin
- ☐ Patchy dullness
- ☐ Seborrhea on face
- ☐ Thick calluses
- ☐ Athletes foot
- ☐ Feet - stinky
- ☐ Diaper rash
- ☐ Odd body odor
- ☐ Acne
- ☐ Dark circle under eyes
- ☐ Ears get red
- ☐ Eczema
- ☐ Flushing
- ☐ Red face
- ☐ Sensitive to insect bites
- ☐ Stretch marks
- ☐ Blotchy skin
- ☐ Cradle cap
- ☐ Dry Hair
- ☐ Dry Scalp
- ☐ Hair Unmanageable
- ☐ Bites nails
- ☐ Nails brittle
- ☐ Nails frayed
- ☐ Nails pitted
- ☐ Nails soft
- ☐ Skin pale
- ☐ Dark birth mark(s)
- ☐ Easy bruising
- ☐ Inability to tan
- ☐ Light birth mark(s)
- ☐ Ragged cuticles
- ☐ Thickening finger nails
- ☐ Thickening toenails
- ☐ Vitiligo
- ☐ White spots or lines in nails
- ☐ Dry skin in general
- ☐ Feet/hands peeling
- ☐ Lower legs dry
- ☐ Itchy skin in general
- ☐ Itchy scalp
- ☐ Itchy ear canals
- ☐ Itchy eyes
- ☐ Itchy nose
- ☐ Itchy arms
- ☐ Itchy hands
- ☐ Itchy legs
- ☐ Itchy feet
- ☐ Itchy anus
- ☐ Itchy penis
- ☐ Itchy vagina

DIGESTIVE

- ☐ Breath bad
- ☐ Increased salivation
- ☐ Drooling
- ☐ Cracking lip corners
- ☐ Cold sores on lips, face
- ☐ Geographic tongue (map-like)
- ☐ Sore tongue
- ☐ Tongue coated
- ☐ Canker sores in mouth
- ☐ Gums bleed
- ☐ Teeth grinding
- ☐ Tooth cavities
- ☐ Tooth with amalgam fillings
- ☐ Mouth thrush (yeast infection)
- ☐ Sore throat
- ☐ Fecal belching
- ☐ Burping
- ☐ Nausea
- ☐ Reflux
- ☐ Spitting up
- ☐ Vomiting
- ☐ Abdominal bloating
- ☐ Colic
- ☐ Abdomen distended
- ☐ Abdominal pain
- ☐ Intestinal parasites
- ☐ Pinworms
- ☐ Crampy pain with pooping
- ☐ Constipation
- ☐ Diarrhea
- ☐ Farting - stinky
- ☐ Anal fissures
- ☐ Red ring around anus
- ☐ Stools bulky
- ☐ Stools light color
- ☐ Stools very stinky
- ☐ Stools with blood
- ☐ Stools with mucous
- ☐ Stools with undigested food
- ☐ Stool odor foul
- ☐ Stool odor yeasty
- ☐ Stools pale
- ☐ Stools watery

EATING

- ☐ Poor appetite
- ☐ Thirst
- ☐ Extreme water drinking
- ☐ Bingeing
- ☐ Bread craving
- ☐ Craving for carbohydrates
- ☐ Craving for juice
- ☐ Craving for salt
- ☐ Diet soda craving
- ☐ Pica (eating non-edibles)
- ☐ Abnormal food cravings
- ☐ Carbohydrate intolerance
- ☐ Starch/disaccharide intol.
- ☐ Sugar intolerance
- ☐ Salicylate intolerance
- ☐ Oxalate intolerance
- ☐ Phenolics intolerance
- ☐ MSG intolerance
- ☐ Food coloring intolerance
- ☐ Gluten Intolerance
- ☐ Casein intolerance
- ☐ Specific food(s) intolerance
- ☐ Lactose intolerance
- ☐ Behavior worse with food
- ☐ Behavior better when fasting

BEHAVIOR

- ☐ Behavior purposeless
- ☐ Unusual play
- ☐ Uses adults hand for activity
- ☐ Aloof, indifferent, remote
- ☐ Extremely cautious
- ☐ Hides skill/knowledge
- ☐ Lacks initiative
- ☐ Lost in thought, unreachable
- ☐ No purpose to play
- ☐ Poor focus, attention
- ☐ Sits long time staring
- ☐ Uninterested in live pet
- ☐ Watches television long time
- ☐ Won't attempt/can't do
- ☐ Poor sharing
- ☐ Rejects help
- ☐ Curious/gets into things
- ☐ Erratic
- ☐ Unable to predict actions
- ☐ Destructive
- ☐ Hyperactive
- ☐ Constant movement
- ☐ Melt downs
- ☐ Tantrums
- ☐ Self mutilation
- ☐ Runs away
- ☐ Jumps when pleased
- ☐ Whirls self like a top
- ☐ Climbs to high places
- ☐ Insists on what wanted
- ☐ Tries to control others
- ☐ Head banging

- ☐ Falls, gets hurt running climbing
- ☐ Does opposite/asked
- ☐ Teases others
- ☐ Silly/ inappropriate laughter
- ☐ Shrieks
- ☐ Holds hands in strange pose
- ☐ Spends time w/ pointless task
- ☐ Stares at own hands
- ☐ Toe walking
- ☐ Arched back with bright lights
- ☐ Imitates others
- ☐ Finger flicking
- ☐ Flaps hands
- ☐ Licking
- ☐ Likes spinning objects
- ☐ Likes to flick finger in eye
- ☐ Likes to spin things
- ☐ Rhythmic rocking
- ☐ Slapping books
- ☐ Tooth tapping
- ☐ Visual stims
- ☐ Wiggle finger front of face
- ☐ Wiggle finger side of face
- ☐ Bites or chews fingers
- ☐ Bites wrist or back of hands
- ☐ Chews on things

MOOD

- ☐ Apathy
- ☐ Blank look
- ☐ Depression
- ☐ Detached
- ☐ Disinterested
- ☐ Eye contact poor
- ☐ Isolates
- ☐ Negative
- ☐ Fright without cause
- ☐ Always frightened
- ☐ Discontented
- ☐ Does not want to be touched
- ☐ Inconsolable crying
- ☐ Irritable
- ☐ Looks like in pain
- ☐ Moaning, groaning
- ☐ Phobias
- ☐ Restless
- ☐ Severe mood swings
- ☐ Unhappy
- ☐ Agitated
- ☐ Anxious

SENSORY

- ☐ Bothered by certain sounds
- ☐ Covers ears with sounds
- ☐ Ear pain
- ☐ Ear ringing
- ☐ Hearing acute
- ☐ Hearing loss
- ☐ Likes certain sounds
- ☐ Sensitive to loud noise
- ☐ Sounds seem painful
- ☐ Tinnitus
- ☐ Acute sense of smell
- ☐ Intensely aware of odors
- ☐ Blinking
- ☐ Bothered by bright lights
- ☐ Conjunctivitis
- ☐ Eye crusting
- ☐ Eye problem
- ☐ Lid margin redness
- ☐ Examines by sight
- ☐ Fails to blink at bright light
- ☐ Likes fans
- ☐ Likes flickering lights
- ☐ Looks out of corner of eye
- ☐ Poor vision
- ☐ Puts eye to bright light or sun
- ☐ Strabismus (crossed eye)
- ☐ Fearful of harmless object
- ☐ Fearful of unusual events
- ☐ Unaware of danger
- ☐ Unaware of peoples' feelings
- ☐ Upset if things change
- ☐ Adopts complicated rituals
- ☐ Car, truck, train obsession
- ☐ Collects particular things
- ☐ Draws only certain things
- ☐ Fixated on one topic
- ☐ Lines objects precisely
- ☐ Repeats old phrases
- ☐ Repetitive play/objects
- ☐ Finger tip squeezing
- ☐ Hates wearing shoes
- ☐ Insensitive to pain
- ☐ Likes head burrowed
- ☐ Likes head pressed hard
- ☐ Likes head rubbed
- ☐ Likes head under blanket
- ☐ Likes to be held upside down
- ☐ Likes to be swung in the air
- ☐ Very insensitive to pain
- ☐ Very sensitive to pain

NEUROMUSCULAR

- ☐ Clumsiness
- ☐ Coordination
- ☐ Fine motor poor
- ☐ Gross motor poor
- ☐ Hyperactivity
- ☐ Physically awkward
- ☐ Rocking
- ☐ Stiffens body when held
- ☐ Calf cramps
- ☐ Foot cramps
- ☐ Muscle pain
- ☐ Muscle tone tense
- ☐ Muscle twitches
- ☐ Jaw clenching
- ☐ Poor muscle tone/limp
- ☐ Tics
- ☐ Muscle tone low trunk
- ☐ Muscle weakness, atrophy
- ☐ Muscle tone low all over
- ☐ Tremors
- ☐ Cognitive delays
- ☐ Memory poor
- ☐ Poor attention, focus
- ☐ Slow and sluggish
- ☐ Expressive language delay

SPEECH

- ☐ Never spoke
- ☐ Occas. words when excited
- ☐ Expressive language poor
- ☐ No answers simple questions
- ☐ Points to objects/can't name
- ☐ Speech apraxia
- ☐ Does not ask questions
- ☐ Babbling
- ☐ Asks using "you" not "I"
- ☐ Answers by repeating question
- ☐ Receptive language poor
- ☐ Says "I"
- ☐ Says "no"
- ☐ Says "yes"
- ☐ Lost language @ 12-24 months
- ☐ Lost language after 24 months
- ☐ Scripting
- ☐ Stuttering
- ☐ Talks to self
- ☐ Poor auditory processing
- ☐ Unusual sound of cry
- ☐ Uses one word for another
- ☐ Rigid behaviors
- ☐ Poor confidence
- ☐ Timid
- ☐ Corrects imperfections
- ☐ Tidy

RESPIRATORY

- ☐ Pneumonia
- ☐ Bad odor in nose
- ☐ Breath holding
- ☐ Bronchitis
- ☐ Congestion chg. season
- ☐ Congestion in the fall

☐ Congestion in the spring
☐ Congestion in the summer
☐ Congestion in the winter
☐ Cough
☐ Post nasal drip
☐ Runny nose
☐ Sighing
☐ Wheezing
☐ Yawning

REPRODUCTIVE
☐ Girls: Early first period
☐ Boys: Large testicles
☐ Early breast development
☐ Early pubic hair
☐ Girls: vaginal odor

URINARY
☐ Frequent urination
☐ Bed wetting after age 4
☐ Odd urinary odor
☐ Urinary hesitancy
☐ Urinary tract infections
☐ Urinary urgency
☐ Dry at night
☐ Seizures - focal
☐ Seizures - generalized
☐ Seizures - petit mal
☐ Unusual fast heart beat
☐ Heart murmur
☐ Headaches
☐ Joint pains
☐ Muscle pains

READINESS ASSESSMENT

Rate on a scale of: 5 (very willing) to 1 (not willing).

In order to improve your child's health, how willing is the patient in:

Significantly modifying diet - ○5 ○4 ○3 ○2 ○1

Taking several nutritional supplements each day - ○5 ○4 ○3 ○2 ○1

Keeping a record of everything eaten each day - ○5 ○4 ○3 ○2 ○1

Modifying lifestyle (e.g., work demands, sleep habits) - ○5 ○4 ○3 ○2 ○1

Practicing a relaxation technique - ○5 ○4 ○3 ○2 ○1

Engaging in regular exercise - ○5 ○4 ○3 ○2 ○1

Have periodic lab tests to assess progress - ○5 ○4 ○3 ○2 ○1

Comments_____

_____

_____

Rate on a scale of: 5 (very confident) to 1 (not confident at all)

How confident are you of your ability to organize and follow through on the above health related activities? - ○5 ○4 ○3 ○2 ○1

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities**?** _____

_____

_____

Rate on a scale of: 5 (very supportive) to 1 (very unsupportive)

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? - ○5 ○4 ○3 ○2 ○1

Comments_____

_____

_____

Rate on a scale of: 5 (very frequent contact) to 1 (very infrequent contact)

How much on-going support and contact (e.g., telephone consults, e-mail correspondence) from our professional staff would be helpful to you as you implement your child's health program? –

○5 ○4 ○3 ○2 ○1

Comments_____

_____

_____

3-DAY DIET DAIRY INSTRUCTIONS

It is important to keep an accurate record of your child's usual food and beverage intake as a part of the treatment plan. Please complete this Diet Diary for 3 consecutive days including one weekend day.

- Do not change your child's eating behavior at this time, as the purpose of this food record is to analyze present eating habits.
- Record information as soon as possible after the food has been consumed.
- Describe the food or beverage as accurately as possible e.g., milk - what kind? (whole, 2%, nonfat); toast - (whole wheat, white, buttered); chicken - (fried, baked, breaded), coffee – (decaffeinated with sugar and ½ & ½).
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, 1/2 cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
- Record all beverages, including water, coffee, tea, sports drinks, sodas/diet sodas, etc.
- Include any additional comments about your child's eating habits on this form (ex. craving sweet, skipped meal and why, when the meal was at a restaurant, etc).
- Please note all bowel movements and their consistency (regular, loose, firm, etc.)

DIET DIARY

Name _____ Date _____

DAY 1

TIME	FOOD/BEV/AMOUNT	COMMENTS

Bowel Movements (#, form, color)_____

Stress/Mood/Emotions _____

Other Comments_____

Other _____

DAY 2

TIME	FOOD/BEV/AMOUNT	COMMENTS

Bowel Movements (#, form, color)_____

Stress/Mood/Emotions _____

Other Comments_____

Other _____

DAY 3

TIME	FOOD/BEV/AMOUNT	COMMENTS

Bowel Movements (#, form, color)_____

Stress/Mood/Emotions _____

Other Comments_____

MSQ – MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

NAME: _____ DATE: _____

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps track your child's progress over time. Rate each of the following symptoms based upon your child's health profile for the past 30 days. If you are taking after the first time, record your child's symptoms for the last 48 hours ONLY.

POINTSCALE
0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

DIGESTIVE TRACT
___ Nausea or vomiting
___ Diarrhea
___ Constipation
___ Bloated feeling
___ Belching, or passing gas
___ Heartburn
___ Intestinal/Stomach pain

Total _____

EARS
___ Itchy ears Total
___ Earaches, ear infections
___ Drainage from ear
___ Ringing in ears, hearing loss

Total _____

EMOTIONS
___ Mood swings
___ Anxiety, fear or Nervousness
___ Anger, irritability, or aggressiveness
___ Depression

Total _____

ENERGY/ACTIVITY
___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity
___ Restlessness

Total _____

EYES
___ Watery or itchy eyes
___ Swollen, reddened or sticky eyelids
___ Bags or dark circles under eyes
___ Blurred or tunnel vision (does not include near-or far-sightedness)

Total _____

HEAD
___ Headaches
___ Faintness
___ Dizziness
___ Insomnia

Total _____

HEART
___ Irregular or skipped heartbeat
___ Rapid or pounding heartbeat
___ Chest pain

Total _____

JOINTS/MUSCLES
___ Pain or aches in joints
___ Arthritis
___ Stiffness or limitation of movement
___ Pain or aches in muscles
___ Feeling of weakness or tiredness

Total _____

LUNGS
___ Chest congestion
___ Asthma, bronchitis
___ Shortness of breath
___ Difficult breathing

Total _____

MIND
___ Poor memory
___ Confusion, poor comprehension
___ Poor concentration

___ Poor physical coordination
___ Difficulty in making decisions
___ Stuttering or stammering
___ Slurred speech
___ Learning disabilities

Total _____

MOUTH/THROAT
___ Chronic coughing
___ Gagging, frequent need to clear throat
___ Sore throat, hoarseness, loss of voice
___ Swollen/discolored tongue, gum, lips
___ Canker sores

Total _____

NOSE
___ Stuffy nose
___ Sinus problems
___ Hay fever
___ Sneezing attacks
___ Excessive mucus formation

Total _____

SKIN
___ Acne
___ Hives, rashes, or dry skin
___ Hair loss
___ Flushing or hot flushes
___ Excessive sweating

Total _____

WEIGHT
___ Binge eating/drinking
___ Craving certain foods
___ Excessive weight
___ Compulsive eating
___ Water retention
___ Underweight

Total _____

OTHER
___ Frequent illness
___ Frequent or urgent urination
___ Genital itch or discharge

Total _____

GRAND TOTAL_____

Key to Questionnaire: Add individual scores and total each group. Add each group scores and give a grand total. Optimal is less than 10 • Mild Toxicity: 10-50 • Moderate Toxicity: 50-100 • Severe Toxicity: over 100

Health Care Provider Team

Primary Doctor:
Name:_____
Phone:_____Email:_____
Address:_____

DAN physician:
Name:_____
Phone:_____Email:_____
Address:_____

Therapist(s):
Name:_____
Phone:_____Email:_____
Address:_____
Duration:_____Hours/wk:_____Helpfulness:_____
Type: Speech, Occupational, Physical, Social, Behavioral, Other_____

Therapist(s):
Name:_____
Phone:_____Email:_____
Address:_____
Duration:_____Hours/wk:_____Helpfulness:_____
Type: Speech, Occupational, Physical, Social, Behavioral, Other_____

Specialists:
Name:_____
Phone:_____Email:_____
Address:_____
Date of Evaluation:_____

Naturopath/Homeopath:
Name:_____
Phone:_____Email:_____
Address:_____
Date of evaluation:_____

Nutritionist:
Name:_____
Phone:_____Email:_____
Address:_____
Date of evaluation:_____

Other:
Name:_____
Phone:_____Email:_____
Address:_____
Date of evaluation:_____