Date of Initial Consultation: _____ Who is present at initial consult: _____

[The above is for office use only]

Name of patient: _____ ____ Male ____ Female

Date of birth: _____ Age ___

Pediatrician:_____ Allergies: _____

Who has legal custody?_____

Name of mother: _____ Mother's employer: _____

Mother's home phone: _____ Work: _____ Cell: _____

Email address: _____

Address: _____

_____

Name of Father: _____ Father's employer: _____

Father's home phone: _____ Work: _____ Cell: _____

Address: _____

_____

Mother's social security #: _____Father's social security #:_____

Name of Specialists: _____ Institution: _____

List any diagnoses or explanations you have been given for your child:

_____

Which doctor/center provided the diagnosis: _____

Age at time of diagnosis: ___ How did you hear about us? _____

What are your goals with us today? _____

Is your child on any time-release, delayed-release, or extended-release medication? _____

Does your child have a medical card? ___Y ___N The Title 19 Waiver Program? ___ Y___N

Is your child in the Birth to Three Program? ___Y ___N

Please bring copies of any tests or lab work that have been done on your child.

Please attach a toddler photo and a current photo if possible. We will take photos at the initial consultation and at follow-up visits, which will be kept in your child's chart.

A. Maternal Health

1. Y__ N__ Is this your biological child?
   (*If no, please answer numbers 2-7 for the biological mother if you have the information, otherwise go on to Section B)*
2. Y__ N__ History of miscarriages. If yes, how many? _____
3. Number of silver dental fillings at time of pregnancy: _____
4. Y__ N__ Did you have any new silver fillings put in, or any old ones repaired or removed during the pregnancy?
5. Y__ N__ Did you receive any flu shots during the pregnancy? How many? _____
6. Y__ N__ Did you ever receive Rhogam shots? How many? _____
7. Mother's occupation before and during pregnancy: _____
8. During the pregnancy, did you use any: (all answers are kept confidential)
   Y__ N__ Street Drugs Which ones: _____
   Y__ N__ Alcohol How much and how often:_____
   Y__ N__ Cigarettes How many packs a day? _____
   Y__ N__ Prescription Drugs Which ones: _____
   Y__ N__ Were you on SSRI's? (for depression)

B. The Pregnancy

1. Any problems with the pregnancy? Y__ N__
   If yes, please describe:_____
2. Y__ N__ Any infections or antibiotics?
3. Y__ N__ Hospitalized during the pregnancy?
4. Y__ N__ Use of infertility drugs?
5. Y__ N__ In-vitro fertilization?

C. The Birth

1. __Vaginal __C-Section* __VBAC
2. Y__ N__ Premature? If yes, how many weeks early? _____
3. Y__ N__ Were you given ptocin?
4. APGAR Scores ___/___ Or do you remember if they were they good or poor? _____
5. Birth weight: _____
6. Adverse Events *_____
   _____
   _____
7. Y__ N__ Did the baby receive any antibiotics at the hospital?
8. Y__ N__ Did the baby receive the Hepatitis B vaccine while in the hospital?

D. Infancy/Toddler Years Birth to 2 years of age (attach 2 photos if possible)

1. Y__ N__ Breastfed? For how long? _____
2. Y__ N__ Bottle-fed?
3. Y__ N__ Difficulty latching on?
4. Y__ N__ Difficulty swallowing?
5. Y__ N__ Excessive drooling?
6. Y__ N__ Poor head control - “Floppy baby”? (Low muscle tone)
7. Y__ N__ Colic reflux?
8. Y__ N__ Would “crash” when sick→got dehydrated or even hospitalized.
9. Y__ N__ Ear Infections? How many? ___ Were antibiotics given? Y__ N__
10. Y__ N__ Tubes in ears? Date: _____
11. Y__ N__ History of thrush? (White overgrowth in mouth) How many times? ___
12. Y__ N__ History of strep? How many times? ___ Antibiotics? Y__ N__
13. Y__ N__ Sinus infections? How many times? ___ Antibiotics? Y__ N__
14. Y__ N__ Seizures?
15. Y__ N__ Any vaccine reactions? Describe: _____
16. Y__ N__ Any rashes or lumps/bumps at injection sites?
17. Y__ N__ Any asthma/allergies/sensitivities? Describe: _____
18. Y__ N__ Any body rashes? Location: _____
    How often? _____
19. Y__ N__ Anal red ring/cracking/bleeding?
20. Describe his/her sleep habits as an infant and as a toddler:
    _____
    _____

21. Texture of feces (poop): __ hard "rabbit pellets"
    __ enormous rock hard bowel movements
    __ formed, hard
    __ formed, soft (normal)
    __ "mashed potatoes"
    __ diarrhea
    __ diarrhea **and** constipation

22. How often were the bowel movements? _____
23. Y__ N__ Did you have to give laxatives?
24. Y__ N__ Were the bowel movements very foul smelling?
25. Y__ N__ Was he/she very gassy?
26. Y__ N__ Was the gas very foul-smelling?

27. Y__ N__ Caught a lot of colds as an infant?

28. List any surgeries or procedures, age 2 or younger: _____

29. CDC's Developmental Health Watch (by 12 months) **Circle all that apply.**

- Does not crawl
- Drags one side of body while crawling (for over one month)
- Cannot stand when supported
- Does not search for objects that are hidden while he or she watches
- Says no single words ("mama" or "dada")
- Does not learn to use gestures, such as waving or shaking head
- Does not point to objects or pictures
- Experiences a dramatic loss of skills he or she once had.

30. CDC's Developmental Health Watch (by 24 months) **Circle all that apply.**

- Cannot walk by 18 months
- Fails to develop a mature heel-toe walking pattern after several months of walking, or walks only on his toes
- Does not speak at least 15 words
- Does not use two-word sentences by age 2
- By 15 months, does not seem to know the function of common household objects (brush, telephone, bell, fork, spoon)
- Does not imitate actions or words by the end of this period
- Does not follow simple instructions by age 2
- Cannot push a wheeled toy by age 2
- Experiences a dramatic loss of skills he or she once had

31. Choose from the following three scenarios:
    ____ Your child hit milestones and spoke on time, then abruptly changed and was "lost".
    ____ Your child was never really right from birth, didn't hit milestones or speak on time.
    ____ Your child was developing normally, and then just hit a plateau. (no abrupt change)
    Other: _____
32. Y__ N__ If your child had speech and then lost it at some point:
    Age when speech was lost: _____
    Describe: _____
33. Please describe any illness, surgery, vaccines, antibiotics, etc. that occurred at the time of the speech loss: _____
34. If vaccine related, what happened? _____
35. Y__ N__ Was your baby ever accidently double vaccinated?
36. Y__ N__ Did you ever have to "catch up" on vaccinations?
37. Y__ N__ Good eye contact? Circle one: Excellent Good Fair Poor None

E. Older childhood (2 years of age and up)

1. Please check all that apply:
   __ Does your child speak now?
   __ Does your child understand what is being said to him?
   __ Does he/she express needs and wants?
   __ Does he use “I want” statements?
   __ Will he/she go get items that you ask for?
   __ Does he answer by repeating your question?
   __ Does he/she initiate conversations?

2. Describe his speech: (Check all that apply.)

   __ 0 words, no noises
   __ 0 words, mumbles, makes some noises
   __ 1-2 words in a row
   __ 3-4 words in a row
   __ 1 sentence at a time
   __ 2-3 sentences in a row
   __ Many sentences in a row
   __ Language is highly developed, and appropriate
   __ A "wall" of one-way conversation, always talking, doesn’t need you to answer
   __ Can sustain a back-and-forth conversation, not just reply to questions

3. How is your child doing in school? _____
4. Y__ N__ Performs work on his/her grade level?
5. Y__ N__ Is your child in an Autism or Special Education class?
6. Y__ N__ Does your child hit, kick, bite, etc. other students or teachers?
7. How is your relationship with the school? _____

Vision Therapy Screening Section:

8. Y__ N__ Good eye contact Circle one: Excellent Good Fair Poor None (1a)
9. Y__ N__ Finger stimming/flapping right in front of eyes
10. Y__ N__ Does he or she do any sideways glancing?
11. Y__ N__ Does he hold toys up very close to eyes, just above or to the side of eyes?
12. Y__ N__ Head frequently tilted to one side?
13. Y__ N__ History of Lazy Eye? Which eye? Circle: R L
14. Y__ N__ Are eyes crossed? (Strabismus)
15. Y__ N__ Large pupils
16. Y__ N__ Are gross motor skills poor? (clumsy to run, jump, catch a ball)
    Is he/she hesitant to go up and down stairs? _____
17. Y__ N__ Has had prism lenses or Vision Therapy? When? _____

Sensory:

18. Y__ N__ Any rocking, flapping, swinging, twirling?
    Describe the stimming pattern: _____
19. Y__ N__ Sensitive to noise/sounds
    Describe: _____
20. Y__ N__ Do textures of finger paints, Playdoh, etc. bother him/her?
21. Y__ N__ Does it bother him /her to have their teeth brushed?
22. Y__ N__ Sensitive to hot or cold foods
23. Y__ N__ Sensitive to textures of food
24. Y__ N__ Sensitive to smells
25. Y__ N__ Sensitive to light
26. Y__ N__ Do seams and tags on clothing bother him/her?
27. Y__ N__ Likes to be hugged or touched
28. Y__ N__ Is pressure calming? (Burrows under pillows, mattresses, blankets)
29. Y__ N__ Sensory seeker (Loves to swing, twirl, jump, textures no problem)
30. Y__ N__ Sensory avoider (avoids the playground equipment, textures are a problem)
31. Y__ N__ Does not like crowds

GI - Immune - Yeast:

32. Y__ N__ High pain tolerance
    Describe: _____
33. Y__ N__ Skin is very pale
34. Y__ N__ Dark under eye circles Circle: mild moderate very dark
35. Y__ N__ Lines that run from the inner corner of eye and cut down across the cheekbones (Malar festoons)
36. Y__ N__ Puffiness under lower lashes?
37. Y__ N__ Frequent runny nose/Seasonal allergies?
38. Y__ N__ Frequent, brief grabbing at penis or vaginal area, as if felt a sharp pain?
39. Y__ N__ Cheeks and ears sometimes flush bright red for no reason (Not when exercising or has a fever, just at odd random times)
40. Y__ N__ Cheeks have bumpy red patches.
41. Y__ N__ Are there allergies or sensitivities?
    Please list: _____
    Y__ N__ Does your child have food allergies? _____
42. Y__ N__ Your child is hardly ever sick
43. Y__ N__ Your child has asthma
    Y__ N__ Your child uses an inhaler
44. Y__ N__ Eczema, rashes, hives (Circle all that apply)
45. Y__ N__ Silly, "drunken" laughter that is inappropriate
46. Y__ N__ Red ring right around the anus
47. Y__ N__ Rectal or vaginal itching
48. Y__ N__ Cracking or peeling hands or feet
49. Y__ N__ Ridged, discolored nails or toenails
50. Y__ N__ Jock itch or athlete's foot

51. Check all that apply:
    ___ Wet hair smells funny or like a wet dog
    ___ Scalp is crusty or flaky?
    ___ Dry flaky skin around the ears, eyebrows or nose?
    ___ Persistent cradle cap
52. Y__ N__ Does he or she have geographic tongue? (map-like)
53. Y__ N__ Any toe-walking?
54. Y__ N__ Sinus infections How many? ___ Antibiotics: Y__ N__
55. Y__ N__ Ear infections over the age of 2? Y__ N__ How many? _____
56. Y__ N__ Do any smokers live in the home?
57. Y__ N__ Frequent colds, seems to catch everything
58. Y__ N__ Does your child seem less autistic when they have a fever?
59. Y__ N__ Strep infections How many? ___
60. Y__ N__ Warts. If yes, how many? _____
61. Y__ N__ Molluscum contagiosum
62. Y__ N__ Cold sores (fever blisters)
63. Y__ N__ Urinary tract or kidney infections? How many? ___
64. Y__ N__ Frequently grabs penis or vaginal area?
65. Y__ N__ Eye-poking behavior?
66. _____ How many rounds of antibiotics has your child had in their entire life?
67. Y__ N__ Spaced out, foggy, in a different world
68. Y__ N__ Cravings for desserts and sugary foods
69. Y__ N__ Depression or irritability
70. Y__ N__ Tics (involuntary movements or noises, not stimming) __Motor __ Vocal
71. Y__ N__ Repeated blinking, snorting, coughing. Circle all that apply.
72. Y__ N__ Self-biting or picking at skin

73. Y__ N__ Has rigid, inflexible routines
    Routines are functional (Useful but rigid routines) _____
    Routines are non-functional. (Strange obsessive/compulsive type) _____

74. **Mitochondrial screening section:**
    Y__ N__ Poor muscle tone
    Y__ N__ Curved back, ”C” shape when sitting
    Y__ N__ Difficulty knowing self in space
    Y__ N__ Tires easily
    Y__ N__ Eye-hand coordination is poor
    Y__ N__ Joints are hyper-flexible
    Y__ N__ Expressive and Receptive speech is poor
    Y__ N__ “Crashes” when they get sick→gets dehydrated or even hospitalized

75. Y__ N__ Opens and closes doors, or sliding doors, for long periods of time
76. Y__ N__ Plays with parts of toys, not the whole toy (spins the wheels, but doesn't play trains)
77. Y__ N__ Stares at fans
78. Y__ N__ Fine motor skills are poor (writing letters, eg.)
79. Y__ N__ Meticulously lines up or stacks toys
80. Y__ N__ Parallel play (plays near other children, not with them)
81. Y__ N__ Has imaginary play (makes up storylines, makes car noises, etc)
82. Y__ N__ Repeats stories he/she has heard on TV (scripting)
83. Y__ N__ Echoes or repeats what you say
84. Y__ N__ Repeats some words or phrases over and over all day
85. Y__ N__ Speaks in a mechanical voice
86. Y__ N__ Speaks in a singsong voice
87. Mental status, to the best of your knowledge
    - __ Normal
    - __ Above average
    - __ Mental impairment suspected
88. Y__ N__ Gets obsessed about certain topics, toys, videos,etc
89. Y__ N__ Concrete thinking (does not understand slang phrases)
90. Y__ N__ Has a sense of humor
    Y__ N__ Does not get jokes
91. Y__ N__ Aggression/Destruction. Describe: _____
92. Y__ N__ Hyperactivity
    Diagnosis of ADD or ADHD? ____
93. Y__ N__ Depression
94. Y__ N__ Anxiety
95. Y__ N__ History of being sexually, physically or verbally abused (Circle)

96. Current sleep habits: (check all that apply) Usual Bedtime: _____
    Wake-up Time: _____
    - __ Falls asleep easily
    - __ Difficulty falling asleep
    - __ Once asleep, stays asleep all night and body is peaceful and calm
    - __ Stays asleep all night but body is restless, tosses and turns (covers all torn up)
    - __ Awakens only once or so a night, every night, goes right back to sleep
    - __ Frequent night awakenings, does not go back to sleep easily
    - __ Not unusual to “be up for the day” at extremely early hour, e.g. 2 or 3 a.m.
    - __ Other, describe _____
    - __ Sleeps in own bed
    - __ Sleeps with parents
    - __ Sleeps more than normal
    - __ Sleeps less than normal

97. Y__ N__ Moans or cries in his/her sleep
98. Y__ N__ Do they sweat at night?

99. Y__ N__ Do they have funny body odors at night?

100. How many caffeinated drinks are consumed each day? _____

101. Y__ N__ Do you give any supplements or prescriptions to help him/her sleep?
Please list:_____
What happens without the medications? _____

102. Foods that your child eats:

Vegetables: _____ Dairy: _____
& Fruits _____ _____
_____ _____
_____ _____
_____ _____

Meats: _____ Snacks: _____
_____ _____
_____ _____
_____ _____
_____ _____

Breads, pastas, pizzas, etc: _____
_____
_____

103. Y__ N__ Does your child consume diet foods and drinks?

104. Y__ N__ Is your child a picky eater?

105. Which foods does he/she crave or want every day? _____

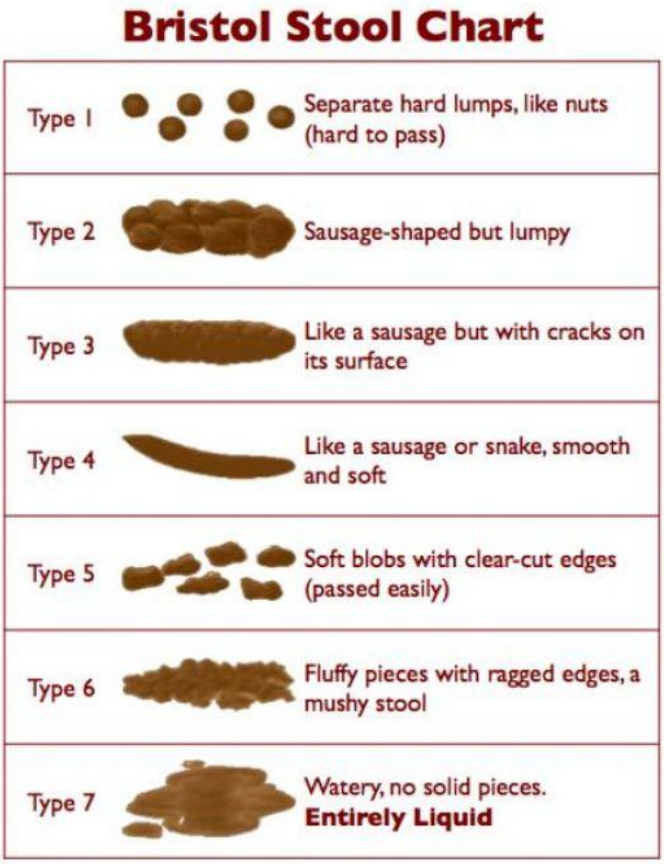
106. If your child were on a desert island, which 3 foods would he take with him?

107. Y__ N__ Drinks a lot of cow's milk. (white/chocolate/strawberry) # of glasses/day: _____
How much would he/she drink if you let him have all he wanted?_____

108. Y__ N__ Ever been on the Gluten-free/Casein-free Diet For how long?____
Was it done strictly? _____
What happened? _____

109. Y__ N__ Any other diets? (Specific Carbohydrate, Feingold Diet, Low Oxalate Diet)

110. Using the following chart, describe your child's stools: **Circle all that apply**.



Check all that apply:

__ enormous bowel movements
__ Diarrhea **and** constipation
__ Don't know, don't go in with him/her anymore
__ Undigested food present in stools
__ Mucus in the stools
__ Sandy or gritty-looking stools
__ Sticky stools, or child has trouble cleaning self after BM, uses too much paper

111. Y__ N__ Do you give any enemas, suppositories, laxatives, etc?
112. Y__ N__ Does your child have to crouch/perch on the toilet seat to have a bowel movement?
113. How often does he or she have a bowel movement? _____
114. Y__ N__ Is it very foul smelling?
115. Y__ N__ Is there lots of gassiness?
116. Y__ N__ Foul-smelling gas?
117. What does his/her breath smell like?

__ not bad
__ like freshly baked bread
__ stinky, bad
__ just like poop

118. Y__ N__ Abdominal bloating?
119. Y__ N__ Does he/she drape their tummy or lean over tables, chairs, or arms of couches?
120. Y__ N__ Presses tummy up against the edges of tables or stands?
121. Y__ N__ Self-injuring behavior ___Only when angry ___ Random, no reason
Y__ N__ Eye poking behavior? (Needs calcium)
122. Y__ N__ Random sadness or crying, or unexplained tantrums
123. Y__ N__ Head-banging ___Only when angry ___ Random, no reason
124. Y__ N__ Has inflammation of the esophagus, stomach or intestinal tract
How was this confirmed? _____

Reflux screening section:

125. Y__ N__ Has known reflux
Y__ N__ Swallows or clears throat frequently
Y__ N__ Facial grimacing
Y__ N__ Gritting teeth
Y__ N__ Wincing
Y__ N__ Sighing, groaning
Y__ N__ Burping
Y__ N__ Pacing around the house, hyperactive, jumping up and down
Y__ N__ Puts off going to sleep
Y__ N__ Frequent waking at night
Y__ N__ Falls asleep propped up in bed, propped up on couch, or bent over a pillow

126. Y__ N__ Staring spells

127. Y__ N__ Seizures
Type of seizures: _____
Frequency of seizures: _____
Date of last seizure: _____
Do you carry the Diastat suppository? ___Y ___N

128. Signs of zinc deficiency:
Y__ N__ Has white dots or lines on fingernails
Y__ N__ Acne/sparse hair/psoriasis
Y__ N__ Canker sores
Y__ N__ Chews on toys, objects, clothing

129. Signs of an essential fatty acid deficiency:
Y__ N__ Keratosis pilaris
Y__ N__ Dry, coarse hair

130. Signs of a magnesium deficiency:
Y__ N__ Muscle twitches/tingling
Y__ N__ Sighing
Y__ N__ Salt craving
Y__ N__ Chews on toys, objects, clothing

131. Y__ N__ Eats inedible things (pica)
132. Y__ N__ Does he/she grind her teeth at night?
133. Y__ N__ Are there pets in the home now? Describe: _____
Are they indoor or outdoor pets?: _____
Were there pets around when your child was a baby? _____
134. Y__ N__ Spotting of feces in underwear
135. Y__ N__ Potty-trained At what age?_____
136. Y__ N__ Stays dry at night
137. Y__ N__ Seems to urinate excessively

138. List any therapies your child has now or in the past:

___ Speech
___ Physical Therapy
___ Occupational
___ ABA
___ Counseling
___ Anger Management
___Floor Time
___Other

___Son Rise
___Vision Therapy
___ Social Skills
___Sensory Integration
___Light Therapy
___Music Therapy
___Listening therapy
___Relationship Development Intervention

Which therapies help the most? _____

139. How many homes does the child live in, or divide his/her time between? ____

If more than one home, will both homes be cooperative with treatment plans? ____

140. Who lives in the home?

__ Mother
__ Father
__ Stepmother
__ Stepfather
__ Girlfriend
__ Boyfriend
__ Brothers Ages: _____
__ Sisters Ages: _____

__ Grandmother
__ Grandfather
__ Others List: _____
_____
_____
_____

141. Y__ N__ Please list any surgeries from the age of 2 and older:

_____

_____

142. Family history (Please check all that apply)

__ Allergies
__ Alzheimer's
__ Asthma
__ Autism
__ Celiac disease
__ Chronic Fatigue syndrome
__ Crohn's disease
__ Eczema Yeast problems
__ Fibromyalgia
__ Genetic disorders
__ Irritable Bowel Syndrome
__ Lupus
__ Multiple Sclerosis
__ Obsessive Compulsive disorder
__ Parkinson's
__ Seizures
__ Tic disorders
__ Thyroid disorders
__ Tourette disorder
__ Ulcerative colitis
__ Wheat (gluten) sensitivity

143. Y__ N__ Ever had full psychological testing and evaluation?
Please include a copy of the report.

144. Y__ N__ Does he/she ever run away?
How often? _____

145. Y__ N__ Ever been in a residential treatment center?
Name of facility _____
Reason: _____

146. Y__ N__ Ever been arrested?
How many times? _____
Reason: _____

147. Full name, address and phone number of Preschool/School:

_____

_____

_____

_____

148. What county is the school in? _____

Medication Log

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10._____