Natural Care MD
Caring for your health naturally!

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Patient Name: _____ (Male/Female) Date of birth: _____Age ___
Allergies: _____
Name of Specialist(s): _____
List any diagnoses or explanations you have been given for your child:
_____
Who provided the diagnosis? _____
Age at time of diagnosis: _____
Do the biological siblings have any diagnoses? _____
What are your top 3 goals with us today? _____

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

A. Maternal Health (Biological Mother)

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 (amalgams) 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__ Use of any hormonal therapy before the pregnancy?
6. Y__ N__ Did you receive any vaccinations during the pregnancy?
7. Y__ N__ Did you receive any flu shots during the pregnancy? How many?
8. _____ Mother's Rh status, if known (+ or -)
9. Y__ N__ Did you ever receive Rhogam shots? How many? _____
10. Y__ N__ Mother's thyroid status: (Circle) Normal Hyperthyroid Hypothyroid (Low)
11. Y__ N__ Diabetic
12. Mother's occupation before and during pregnancy: _____
13. During the pregnancy, did you use any: (All answers are kept strictly confidential?)
    Y__ N__ Street Drugs Please list:
    Y__ N__ Alcohol
    Y__ N__ Cigarettes. How many packs a day? _____
    Y__ N__ Prescription Drugs. Which ones: _____
    Y__ N__ Were you on SSRI's? (For depression or anxiety)

B. The Pregnancy

1. Any problems with the pregnancy? Y__ N__
   If yes, please describe: _____
2. Y__ N__ Bacterial Infections
3. Y__ N__ Antibiotics
4. Y__ N__ Hospitalized during the pregnancy?
5. Y__ N__ Use of fertility drugs
6. Y__ N__ In-vitro fertilization

C. The Birth

1. __Vaginal
   __C-Section Reason:_____
   __VBAC (Vaginal Birth after C-Section)
2. Y__ N__ Was labor induced?
3. Y__ N__ Medications used during labor: _____
4. Y__ N__ Medications used during delivery: _____
5. Y__ N__ Full term
6. Y__ N__ Premature If yes, how many weeks early? _____
7. ___/___ APGAR Scores (Or do you remember if they were they good or poor? _____)
8. Birth weight: _____
9. Complications:_____
   _____
   _____
10. Y__ N__ Was there any concern for birth trauma?
11. Medications given to baby at the hospital: _____
    _____
12. Y__ N__ Did the baby receive any antibiotics at the hospital?
13. 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. _____ at what age were foods introduced?
6. Y__ N__ Excessive drooling?
7. Y__ N__ Poor head control - “Floppy baby”? (Low muscle tone)
8. Y__ N__ Colic or reflux
9. Y__ N__ Would “crash” when sick. Got dehydrated or even hospitalized.
10. Y__ N__ History of thrush? (White overgrowth in mouth) How many times?___
11. Y__ N__ History of strep? How many times?
12. Y__ N__ Sinus infections? How many times?
13. Y__ N__ Seizures? ___
14. Y__ N__ Antibiotics__ Y__ N__ Vaccine reactions. Describe:
15. Y__ N__ Asthma_____
16. Y__ N__ Known allergies List: _____
17. Y__ N__ Prone to diaper rash

18. Y__ N__ Prone to body rashes Location: _____
19. Y__ N__ Red ring around the anus/cracking/bleeding
20. Describe sleep habits as an infant and as a toddler:

    _____

    _____
21. Texture of bowel movements: (Age 2 years and younger)
    __ 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 as an infant? _____
23. Y__ N__ Had to use laxatives or stool softeners
24. Y__ N__ Hospitalized for constipation at age 2 years or younger
25. Y__ N__ Bowel movements were very foul smelling
26. Y__ N__ Excessively gassy
27. Y__ N__ Gas was very foul-smelling
28. Y__ N__ Caught a lot of colds as an infant
29. List any surgeries or procedures, age 2 or younger: _____ _____
30. 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.

31. CDC’s Developmental Health Watch (by 24 months) **Circle all that apply.**
    - Did not walk by 18 months
    - Failed to develop a mature heel-toe walking pattern after several months of walking, or walked only on the toes
    - Did not speak at least 15 words
    - Did not use two-word sentences by age 2
    - By 15 months, did not seem to know the function of common household objects (brush, telephone, bell, fork, spoon)
    - Did not imitate actions or words by the end of this period
    - Did not follow simple instructions by age 2
    - Could not push a wheeled toy by age 2
    - Experienced a dramatic loss of skills he or she once had

32. 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: _____
33. Y__ N__ If your child had speech and then lost it at some point

Age when speech was lost: _____
Describe: _____
_____

34. Please describe any illness, surgery, vaccines, antibiotics, etc. that occurred at the time of the speech loss: _____
_____

35. If vaccine related, what happened? _____
_____

36. Y__ N__ Was your baby ever accidently double vaccinated?
37. Y__ N__ Did you ever have to “catch up” on vaccinations?
38. Y__ N__ Good eye contact? Circle one: Excellent Good Fair Poor None
39. Y__ N__ Known genetic disorders
40. Y__ N__ Known metabolic disorders

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

1. What is your child’s primary form of communication? (Example: speaking, pointing, PECS, etc.)
_____

2. 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?

3. Describe his speech: (Check all that apply.)
__ 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

4. Y__ N__ Repeats stories he/she has heard on TV (scripting)
5. Y__ N__ Echoes or repeats what you say
6. Y__ N__ Repeats some words or phrases over and over all day
7. Y__ N__ Speaks in a mechanical voice
8. Y__ N__ Speaks in a singsong voice
9. Y__ N__ Concrete thinking (does not understand slang phrases, takes words literally)
10. Y__ N__ Has a sense of humor and easily understands jokes
11. Y__ N__ Has a sense of humor, but does not get jokes most of the time

Learning:

1. How is your child doing in school? _____
2. Y__ N__ Has learning difficulties
3. Y__ N__ Fine motor skills are poor (difficulty writing letters, e.g.)
4. Y__ N__ Performs work on his/her grade level?
5. Y__ N__ Has been held back a grade before
6. Y__ N__ Is currently being homeschooled
7. Y__ N__ Has been homeschooled in the past
8. Y__ N__ Is your child in an Autism or Special Education class?
9. Y__ N__ Does your child hit, kick, bite, etc. other students or teachers?
10. How is your relationship with the school? _____

Sensory:

1. Y__ N__ Any rocking, hand flapping, swinging, twirling?
2. Y__ N__ Sensitive to noise/sounds
   Describe: _____
3. Y__ N__ Does not like the texture of finger paints, odor of Playdoh, etc.
4. Y__ N__ Sensitive to textures of food
5. Y__ N__ Sensitive to hot or cold foods
6. Y__ N__ Does not like to have teeth brushed
7. Y__ N__ Sensitive to smells
8. Y__ N__ Sensitive to light
9. Y__ N__ Bothered by seams and tags on clothing
10. Y__ N__ Likes to be hugged or touched
11. Y__ N__ Pressure is calming
12. Y__ N__ Sensory seeker (Loves to swing, twirl, jump, textures no problem)
13. Y__ N__ Sensory avoider (avoids the playground equipment, textures are a problem)
14. Y__ N__ Gets overwhelmed by crowds, Wal-Mart, the mall, parties, etc.
15. Y__ N__ High pain tolerance Describe: _____

Vision Therapy Screening Section:

1. Y__N__ Good eye contact Circle one: Excellent Good Fair Poor None (1a)
2. Y__N__ Finger stimming/flapping right in front of eyes
3. Y__N__ Does he or she do any sideways glancing?
4. Y__ N__ Holds toys up very close to eyes, or just above or to the side of eyes
5. Y__ N__ Head frequently tilted to one side
6. Y__ N__ History of Lazy Eye Which eye? Circle: R L
7. Y__ N__ Has had the lazy eye corrected with surgery
8. Y__ N__ Are eyes crossed? (Strabismus)
9. Y__ N__ Has dyslexia
10. Y__ N__ Other visual impairments List: _____
11. Y__ N__ Avoids homework, has been called “lazy”
12. Y__ N__ Is very intelligent, but makes poor grades in school
13. Y__ N__ Skips over lines when reading
14. Y__ N__ Dislikes or avoids reading
15. Y__ N__ Dislikes movies in 3-D
16. Y__ N__ Is careful on the stairs, holds the rail, one foot at a time, sits down to do stairs, etc.

17. Y__ N__ Catches a ball easily and accurately
18. Y__ N__ Sometimes trips or stumbles over nothing; tends to be clumsy
19. Y__ N__ Sometimes bumps into the door frame when going through a doorway
20. Y__ N__ Has had prism lenses or Vision Therapy? When? _____

GI and Immune:

1. Y__N__ Skin is very pale
2. Y__N__ Dark under-eye circles Circle: mild moderate dark very dark
3. Y__ N__ Puffiness under lower lashes
4. Y__ N __ Frequent runny nose / Seasonal allergies
5. Y__ N__ Frequent, brief grabbing at penis or vaginal area, as if felt a sharp pain
6. Y__ N__ Cheeks and ears sometimes flush bright red for no reason (Not when exercising or has a fever, just at odd random times)
7. Y__ N__ Eats inedible things (pica)
8. Y__ N__ Known or suspected allergies or sensitivities
   Please list: _____
9. Y__ N__ Celiac disease
10. Y__ N__ Never gets sick
11. Y__ N__ Catches every cold “coming and going”
12. Y__ N__ Sinus infections How many? ___ Antibiotics: Y__ N__
13. Y__ N__ Ear infections over the age of 2? Y
14. Y__ N__ Do any smokers live in the home? How many? _____
15. Y__ N__ Does your child seem less autistic when they have a fever?
16. Y__ N__ Strep infections
17. Y__ N__ Currently has some warts
18. Y__ N__ Molluscum contagiosum
19. Y__ N__ Cold sores (fever blisters)
20. Y__ N__ Asthma
21. Y__ N__ Eczema
22. Y__ N__ Rashes
23. Y__ N__ Hives
24. Y__ N__ Dermatographism
25. Y__ N__ Ringworm

Yeast Screening:

1. Y__ N__ Silly, "drunken" laughter that is inappropriate
2. Y__ N__ Cheeks have bumpy red patches.
3. Y__ N__ Red ring right around the anus
4. Y__ N__ Rectal or vaginal itching
5. Y__ N__ Cracking or peeling hands or feet
6. Y__ N__ Ridged, discolored nails or toenails
7. Y__ N__ Jock itch or athlete’s foot
8. 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
9. Y__ N__ Geographic tongue (map-like)

10. Y__ N__ Toe-walking
11. Y__ N__ Urinary tract infections How many? ___
12. Y__ N__ Kidney infections
13. Y__ N__ Frequently grabs penis or vaginal area
14. _____ How many rounds of antibiotics has your child had in their entire life?
15. Y__ N__ Has used Diflucan, Nystatin or other antifungals. How many times? _____
16. Y__ N__ Spaced out, foggy, in a different world
17. Y__ N__ Cravings for desserts and sugary foods
18. Y__ N__ Depression or irritability
19. Y__ N__ Poor memory
20. Y__ N__ Lethargy or tiredness
21. Y__ N__ Strong Foot or body odor

Tics and Obsessive Tendencies:

1. Y__ N__ Sudden, brief involuntary muscle movements or jerks
2. Y__ N Repetitive blinking, snorting or coughing, touching the nose, smelling objects
3. Y__ N__ Picking at skin until it is raw
4. Y__ N__ Sudden, brief involuntary vocalizations or sounds
5. Y__ N__ Has a known tic disorder such as Tourette syndrome, for example
6. Y__ N__ Has rigid, inflexible routines
   - Routines are functional (Useful but rigid routines) _____
   - Routines are non-functional. (Strange obsessive/compulsive type) _____

Mitochondrial screening section:

1. Y__ N__ Poor muscle tone
2. Y__ N__ Curved back, "C" shape when sitting Y__ N__ Difficulty knowing self in space
3. Y__ N__ Tires easily
4. Y__ N__ Eye-hand coordination is poor
5. Y__ N__ Joints are hyper-flexible
6. Y__ N__ Expressive and Receptive speech is poor
7. Y__ N__ "Crashes" when they get sick. Gets dehydrated or even hospitalized?

Miscellaneous:

1. What is your child's exercise level?
   Y__ N__ Completely sedentary
   Y__ N__ Not much exercise
   Y__ N__ Moderate level of exercise
   Y__ N__ High level of exercise
   Y__ N __ Plays on a sports team Which sport? _____
2. Y__ N__ History of being sexually, physically or verbally abused (Circle all that apply)
3. Y__ N__ Headaches Describe: _____
4. Y__ N__ Visual Hallucinations
5. Y__ N__ Auditory Hallucinations

Sleep Patterns: (check all that apply)

Usual Bedtime: _____
Wake-up Time: _____

__ Falls asleep easily

__ Difficulty falling asleep most of the time
__ Difficulty falling asleep occasionally
__ 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 maybe once a night, and 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

1. Y__ N__ Moans or cries in sleep
2. Y__ N__ Sweat at night
3. Y__ N__ Nightmares
4. Y__ N__ Night terrors
5. Y__ N__ Sleep walks
6. Y__ N__ Takes melatonin How much? _____
7. Y__ N__ Takes Clonidine or medication for sleep
8. How many caffeinated drinks are consumed each day? _____

Dietary History: ☐ Organic Foods ☐ Non-organic Foods ☐ Partially organic diet

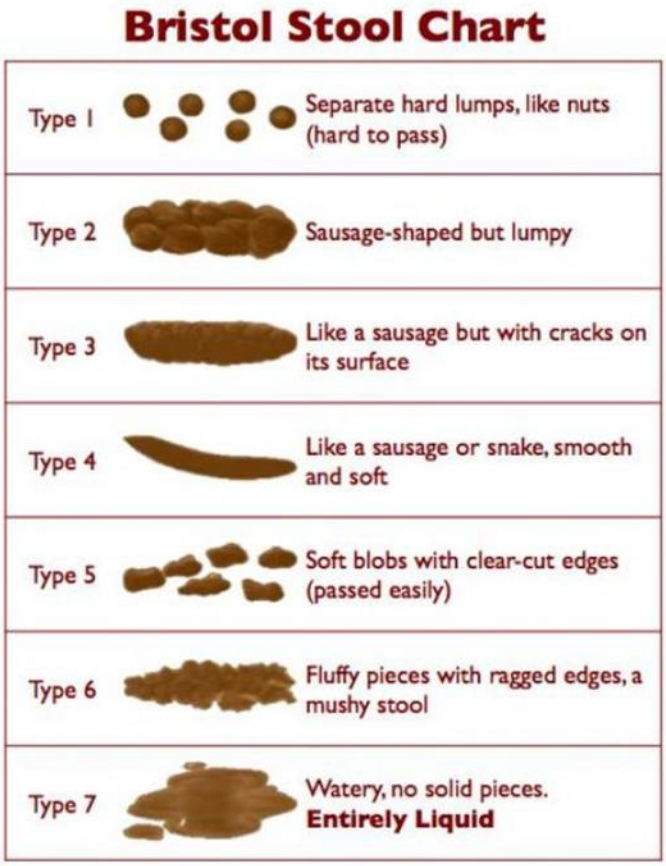
Vegetables: _____ Fruits: _____
_____ _____
_____ _____
Dairy: _____ Meats: _____
_____ _____
_____ _____
Snacks: _____ Other: _____
_____ _____
_____ _____

Breads, pastas, pizzas, etc: _____
_____
_____

1. Y__ N__ Difficulty swallowing
2. Y__ N __ Difficulty chewing
3. Y__ N__ Picky eater
4. Y__ N__ Artificial sweeteners
5. Y__ N__ Attitude or mood changes after meals
6. Foods that are demanded or wanted every day: _____
7. If your child were on a desert island, which 3 foods would he take with him?
8. Y__ N__ Drinks a lot of milk. (white / chocolate / strawberry) # of glasses per day: _____
   How much would he/she drink if you let him have all he wanted?_____
9. Y__ N__ Ever been on the Gluten-free/Casein-free Diet For how long?_____
   Was it done strictly? _____ What happened?_____
10. Y__ N__ Any other diets? (Specific Carbohydrate, Feingold Diet, Low Oxalate Diet, Candida)

Bowel Habits:

Use the following chart to describe your child's stools: **Circle all that apply.**



11. 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 toilet paper

12. Y__ N__ Do you give any enemas, suppositories, laxatives, etc?
13. Y__ N__ Does your child have to crouch/perch on the toilet seat to have a bowel movement?
14. How often does he or she have a bowel movement? _____
15. Y__ N__ Foul-smelling bowel movements (more than "normal")
16. Y__ N__ Gassiness
17. Y__ N__ Foul-smelling gas
18. What does his/her breath smell like? __ Not bad
__ Like freshly baked bread
__ Stinky, bad
__ Just like poop

19. Y__ N__ Abdominal bloating?
20. Y__ N__ Does he/she drape their tummy or lean over tables, chairs, or arms of couches?
21. Y__ N__ Presses tummy up against the edges of tables or stands?
22. Y__ N__ Self-injuring behavior___Only when angry___ Random, no reason
23. Y__ N__ Random sadness or crying, or unexplained tantrums
24. Y__ N__ Head-banging ___Only when angry ___ Random, no reason
25. Y__ N__ Has inflammation of the esophagus, stomach or intestinal tract
    How was this confirmed? _____
26. Y__ N__ Does he/she grind her teeth at night?
27. 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?
28. Y__ N__ Spotting of feces in underwear
29. Y__ N__ Potty-trained At what age?_____
30. Y__ N__ Stays dry at night
31. Y__ N__ Seems to urinate excessively

Reflux screening section:

Y__ N__ Has known reflux
Y__ N__ Swallows or clears throat frequently
Y__ N__ Has the tooth enamel been eroded by gastric acid?
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

Seizures:

1. Y__ N__ Staring spells
2. Y__ N__ Seizures
   Type of seizures: _____
   Frequency of seizures: _____
   Date of last seizure: _____
   Do you carry the Diastat suppository?___Y___N

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

Signs of an essential fatty acid deficiency:

Y__ N__ Keratosis pilaris
Y__ N__ Dry, coarse hair

Signs of a magnesium deficiency:

Y__ N__ Muscle twitches/tingling
Y__ N__ Sighing

Y__ N__ Salt craving
Y__ N__ Chews on toys, objects, clothing

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

___ Speech ___Son Rise
___ Physical Therapy ___Vision Therapy
___ Occupational ___ Social Skills
___ ABA ___Sensory Integration
___ Counseling ___Light Therapy
___ Anger Management ___Music Therapy
___Floor Time ___Listening therapy
___Other ___Relationship Development Intervention

Which therapies have helped the most? _____
_____
_____

Dental:

Y__ N__ Does your child have regular dental visits?
Y__ N__ Does your child tolerate visits to the dentist?
Y__ N__ Does your child have cavities now? How many? _____
Y__ N__ Has your child had cavities in the past? How many? _____
Y__ N__ Has the tooth enamel been eroded by gastric acid?
Y__ N__ Have steel caps been placed on the teeth?
Y__ N__ Is your child sedated for procedures?_____
Y__ N__ Does your child have an unusually large number of cavities?
Y__ N__ Tolerates brushing?
Y__ N__ Brushes his or her own teeth?
Y__ N__ Regular flossing?
Y__ N__ Has had molars sealed?
Y__ N__ Uses xylitol products for the oral/nasal cavity?
Circle the xylitol products used: Toothpaste Mouthwash Gum Candy Nasal spray
Y__ N__ Uses a probiotic toothpaste?

Focus, Attention and Impulsivity:

Y__ N__ Has been diagnosed with ADD or ADHD
Y__ N__ Poor self-control
Y__ N__ Impulsive, acts before thinking
Y__ N__ Poor memory for directions and instructions
Y__ N__ Dreamy, distracted type
Y__ N__ Needs special seating in the classroom
Y__ N__ Trouble following directions
Y__ N__ Frequently interrupts
Y__ N__ Is the class clown
Y__ N__ Acts before thinking
Y__ N__ Disorganized
Y__ N__ Poor planning

Activity:

Y__ N__ Restless, roams around
Y__ N__ Fidgety
Y__ N__ Difficulty staying seated
Y__ N__ Hyperactive
Y__ N__ Talks excessively
Y__ N__ Touches everything
Y__ N__ Easily excited
Y__ N__ Lethargic/fatigued

Compliance:

Y__ N__ Has difficulty following the rules
Y__ N__ Argumentative
Y__ N__ Engages in negative behavior to get attention
Y__ N__ Destruction of household items, furniture or walls
Y__ N__ Gets physically aggressive with family members
Y__ N__ Gets physically aggressive with classmates, teachers or aides

Peer Relationships and Behavioral Difficulties:

Y__ N__ Would like to have friends
Y__ N__ Truly prefers to be alone
Y__ N__ Parallel play (plays near other children, not with them)
Y__ N__ Has trouble with group activities
Y__ N__ Blames others
Y__ N__ Is a “provocative victim”
Y__ N__ Bullies or bosses other children
Y__ N__ Teases excessively
Y__ N__ Unpredictable behavior scares other children away
Y__ N__ Is rejected or avoided by others

Unusual Behaviors:

Y__ N__ Opens and closes doors, or sliding doors, for long periods of time
Y__ N__ Plays with parts of toys, not the whole toy (spins the wheels, but doesn't play trains)
Y__ N__ Stares at fans
Y__ N__ Meticulously lines up or stacks toys
Y__ N__ Has imaginary play (makes up storylines, makes car noises, etc.)
Y__ N__ Gets obsessed with certain topics, toys, movies, TV shows, appliances, etc.
Y__ N__ Would play video games all the time, if allowed to do so

Intellectual Status: (Your best estimate)

__ Has a diagnosis of “MR” or Mental Retardation
__ Below average intelligence
__ Average intelligence
__ Above average intelligence
__ Superior intelligence
__ Genius

Female Health:

1. Y__ N__ Regular gynecological visits
2. Age of first menses: _____
3. Y__ N__ Birth Control Type: _____
4. Please describe any premenstrual symptoms: _____
5. Please describe any problems or concerns:_____

Emotional Difficulties:

1. Y__ N__ Has been diagnosed with a mood disorder Specify:
   Y__ N__ Frequent mood swings
   Y__ N__ Irritable
   Y__ N__ Easily frustrated
   Y__ N__ Easily angered
   Y__ N__ Tantrums or outbursts
   Y__ N__ Often anxious
   Y__ N__ Depressed or unhappy

2. Y__ N__ Ever had full psychological testing and evaluation? Please include a copy of the report.
3. Y__ N__ Does he/she ever run away? How often? _____
4. Y__ N__ Ever been in a residential treatment center?

Name of facility _____
Reason: _____

5. Y__ N__ Ever been arrested?

How many times?_____Reason:_____

Maturity:

Y__ N__ Behavior resembles that of a younger child
Y__ N__ Prefers younger relationships
Y__ N__ Prefers the company of adults

Home Situation:

1. How many homes does the child live in, or divide time between? _____
2. In which city was the child born? _____
3. How many times have you moved since his/her birth? _____
4. If more than one home, will both homes be cooperative with treatment plans? _____
5. Please describe any difficult family situations which may hinder treatment:

6. Who lives in the primary home?
   __ Mother __ Grandmother
   __ Father __ Grandfather
   __ Stepmother __ Others List: _____
   __ Stepfather _____
   __ Girlfriend _____
   __ Boyfriend _____
   __ Brothers Ages: _____
   __ Sisters Ages: _____

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

_____

_____

8. What county is the school in? _____

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 Sclerosi
__ Obsessive Compulsive disorder
__ Parkinson's
__ Seizures
__ Tic disorders
__ Thyroid disorders
__ Tourette disorder
__ Ulcerative colitis
__ Wheat (gluten) sensitivity

Medication Log Date:_____

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

Please list any surgeries from the age of 2 and older:

_____

_____

_____