AMY MYERS, MD
Austin UltraHealth
Westlake Medical Center
5656 Bee Cave Road Suite D-203
Austin, Texas 78746
Phone: 512-383-5343
Fax: 512-721-0348

NEW PATIENT INTAKE FORMS PEDIATRIC

For ages 0-13 years

THESE FORMS MUST BE SUBMITTED TO OUR OFFICE
AT LEAST 7 DAYS PRIOR
TO YOUR FIRST APPOINTMENT

Due to sensitivities, our office is fragrance free. We ask that you DO NOT wear scented products to our office. This includes perfumes, colognes, lotions, deodorants, soaps and shampoos.

GENERAL INFORMATION

Name: ***First*** ***Middle*** ***Last***

Preferred Name:

Date of Birth: **Age:**

Gender: ○ Male ○ Female

Genetic Background: ○ African ○ European ○ Native American ○ Mediterranean ○ Asian ○ Ashkenazi ○ Middle Eastern

Person completing this questionnaire ○ ○ ○

Mother's Name Occupation

Father's Name Occupation

Primary Address:

Street *Apt. No.*

City *State* *Zip*

Alternate Address:

Street *Apt. No.*

City *State* *Zip*

Home Phone 1:

Home Phone 2:

Parent's Work Phone:

Parent's Cell Phone:

Fax:

E-mail:

Emergency Contact:

Name *Phone*

Address *Apt. No.*

City *State* *Zip*

Physician's Name:

Phone Fax

Referred by:

○ Google (please list the search words you used to find us) _____

○ Media (please indicate source)_____

○ Family Member (please list) _____

○ Friend (please list) _____

○ Other _____

PHARMACY INFORMATION

Primary Pharmacy:

Name *Phone*

Address

City *State* *Zip*

E-mail *Fax**

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

Compounding/Supplement Pharmacy:

Name *Phone*

Address

City *State* *Zip*

E-mail *Fax**

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

PEDIATRIC MEDICAL QUESTIONNAIRE

ALLERGIES

Medication/Supplement/Food	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 feel 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**	Excellent	Good	Fair
Example: Difficulty Maintaining Attention		*X*		*Elimination Diet*	*X*		

MEDICAL HISTORY

DISEASES/ DIAGNOSIS/ CONDITIONS *Check appropriate box and provide date of onset*

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

Past	Current	**CARDIOVASCULAR**
☐	☐	Heart Disease _____
☐	☐	Elevated Cholesterol _____
☐	☐	Hypertension (high blood pressure) _____
☐	☐	Rheumatic Fever _____
☐	☐	Mitral Valve Prolapse _____
☐	☐	Other _____

Past	Current	**METABOLIC/ ENDOCRINE**
☐	☐	Type 1 Diabetes _____
☐	☐	Type 2 Diabetes _____
☐	☐	Hypoglycemia _____
☐	☐	Metabolic Syndrome (Pre-Diabetes) _____
☐	☐	Hypothyroidism (low thyroid) _____
☐	☐	Hyperthyroidism (overactive thyroid) _____
☐	☐	Endocrine Problems _____
☐	☐	Polycystic Ovarian Syndrom (PCOS) _____
☐	☐	Weight Gain _____
☐	☐	Weight Loss _____
☐	☐	Frequent Weight Fluctuations _____
☐	☐	Bulimia _____
☐	☐	Anorexia _____
☐	☐	Binge Eating Disorder _____
☐	☐	Night Eating Syndrome _____
☐	☐	Eating Disorder (non-specific) _____
☐	☐	Other _____

Past	Current	**CANCER**
☐	☐	_____

Past	Current	**GENITAL AND URINARY SYSTEMS**
☐	☐	Kidney Stones _____
☐	☐	Urinary Tract Infection _____
☐	☐	Yeast Infections _____
☐	☐	Other _____

Past	Current	**MUSCULOSKELETAL/ PAIN**
☐	☐	Arthritis _____
☐	☐	Fibromyalgia _____
☐	☐	Chronic Pain _____

Past	Current	**MUSCULOSKELETAL/ PAIN (Cont.)**
☐	☐	Other _____

Past	Current	**INFLAMMATION/ AUTOIMMUNE**
☐	☐	Chronic Fatigue Syndrome _____
☐	☐	Autoimmune Disease _____
☐	☐	Rheumatoid Arthritis _____
☐	☐	Lupus SLE _____
☐	☐	Immune Deficiency Disease _____
☐	☐	Severe Infectious Disease _____
☐	☐	Poor Immune Function _____
☐	☐	(frequent infection)
☐	☐	Food Allergies _____
☐	☐	Environmental Allergies _____
☐	☐	Multiple Chemical Sensitivities _____
☐	☐	Latex Allergy _____
☐	☐	Other _____

Past	Current	**RESPIRATORY DISEASES**
☐	☐	Frequent Ear Infections _____
☐	☐	Frequent Upper Respiratory Infections _____
☐	☐	Asthma _____
☐	☐	Chronic Sinusitis _____
☐	☐	Bronchitis _____
☐	☐	Sleep Apnea _____
☐	☐	Other _____

Past	Current	**SKIN DISEASES**
☐	☐	Eczema _____
☐	☐	Psoriasis _____
☐	☐	Acne _____
☐	☐	Other _____

Past	Current	**NEUROLOGIC/ MOOD**
☐	☐	Depression _____
☐	☐	Anxiety _____
☐	☐	Bipolar Disorder _____
☐	☐	Schizophrenia _____
☐	☐	Headaches _____
☐	☐	Migranes _____
☐	☐	ADD/ ADHD _____
☐	☐	Sensory Integrative Disorder _____
☐	☐	Autism _____
☐	☐	Mild Cognitive Impairment _____
☐	☐	ALS _____
☐	☐	Seizures _____
☐	☐	Arthritis _____
☐	☐	Other Neurological Problems _____

MEDICAL HISTORY (CONTINUED)

PREVIOUS EVALUATIONS

Check box if yes and provide date

- ☐ Full Physical Exam _____
- ☐ 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 _____
- ☐ Occupational Therapy _____
- ☐ Sensory Integration Therapy _____
- ☐ Language Classes _____
- ☐ Sign Language _____
- ☐ Homeopathic _____
- ☐ Naturopathic _____
- ☐ Craniosacral _____
- ☐ Chiropractic _____
- ☐ MRI _____
- ☐ CT Scan _____
- ☐ Upper Endoscopy _____
- ☐ Upper GI Series _____
- ☐ Ultrasound _____

INJURIES

Check box if yes and provide date

- ☐ Back Injury _____
- ☐ Neck Injury _____
- ☐ Head Injury _____
- ☐ Broken Bones _____
- ☐ Other _____
- ☐ Head Injury _____
- ☐ Broken Bones _____
- ☐ Other _____

SURGERIES

Check box if yes and provide date

- ☐ Appendectomy _____
- ☐ Circumcision _____
- ☐ Hernia _____
- ☐ Tonsils _____
- ☐ Adenoids _____
- ☐ Dental Surgery _____
- ☐ Tubes in Ears _____
- ☐ Other _____

BLOOD TYPE: ○ A ○ B ○ AB ○ O ○ Rh+ ○ Unknown

HOSPITALIZATIONS ☐ None If yes, please list:

Date	Reason

MEDICAL HISTORY (CONTINUED)

IMMUNIZATIONS

Is your child up to date with immunizations? ..... ○ Yes ○ No

Do you feel immunizations have had an impact on your child's health? ..... ○ Yes ○ No

If relevant, attach a copy of your child's immunization record or see addendum.

PSYCHOSOCIAL

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

Has your child ever experienced any major losses? ..... ○ Yes ○ No

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 (please describe) _____

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 at night: ○ >12 ○ 10-12 ○ 8-10 ○ <8

Does your child have trouble falling asleep? ..... ○ Yes ○ No

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

Does your child snore? ..... ○ Yes ○ No

ROLES/RELATIONSHIP

List Family Members:

Family Member and Relationship	Age	Gender

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

Their Employment/Occupation: _____

Resources for emotional support?

Check all that apply:

☐ Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual

☐ Pets ☐ Other (please list) _____

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? ..... ○ Yes ○ No

For how long? _____

Last Menstrual Period: _____

Use of hormonal contraception such as: ☐ Birth Control Pills ☐ Patch ☐ Nuva Ring

How long? _____

Do you use contraception? ..... ○ Yes ○ No

If yes, which type? ☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner Vasectomy

GI HISTORY

Has your child traveled to foreign countries? ..... ○ Yes ○ No

If yes, where?_____

Wilderness Camping? ..... ○ Yes ○ No

If yes, where?_____

Ever had severe: ☐ Gastroenteritis ☐ Diarrhea

DENTAL HISTORY

☐ Silver Mercury Fillings If yes, 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 date

☐ Difficulty getting pregnant (more than 6 months) _____

☐ Infertility drugs used Specify:_____

☐ In vitro fertilization _____

☐ Drink alcohol _____

☐ 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 step infection _____

☐ Have c-section because of _____

☐ Use induction for labor (such as Pitocin)_____

☐ Have anaesthesia – what was used?_____

☐ Use oxygen during labor_____

☐ 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 newly built house_____

☐ House painted indoors _____

☐ House painted outdoors _____

☐ House exterminated for insects _____

PATIENT BIRTH HISTORY (CONTINUED)

PREGNANCY

Total weight gain during pregnancy: _____ lbs. Total weight loss during pregnancy: _____ lbs.

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 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 this 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	Dry at night	_____ months	☐ Never
Crawl	_____ months	☐ Never	First words (e.g., mama, dada)	_____ months	☐ Never
Pulled to stand	_____ months	☐ Never	Spoke clearly	_____ months	☐ Never
Potty trained	_____ months	☐ Never	Lost language	_____ months	☐ Never
Walked alone	_____ months	☐ Never	Lost eye contact	_____ months	☐ Never

MEDICATIONS

CURRENT MEDICATIONS

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

PREVIOUS MEDICATIONS: *Last 10 years*

Medications	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 (e.g., Advil, Aleve), Motrin, Aspirin? .... ○ Yes ○ No

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

Have you had prolonged or regular use of Acid Blocking Drugs (e.g., Tagamet, Zantac, Prilosec) ..... ○ 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

FAMILY HISTORY

Check family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at death (if diseased)												
Cancers	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Breast or Ovarian Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Sondylitis)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Inflammatory Bowel Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Auto Immune Diseases (such as Lupus)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Irritable Bowel Syndrome	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Celiac Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

NUTRITION 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

- ☐ Dairy Free
- ☐ Diabetic
- ☐ Feingold
- ☐ Gluten Restricted
- ☐ Gluten/Casein Free
- ☐ Ketogenic
- ☐ Low Oxalate
- ☐ Specific Carbohydrate
- ☐ Vegan
- ☐ Vegetarian
- ☐ Weight Management
- ☐ Wheat Free
- ☐ Yeast Free
- ☐ Food Allergy (e.g., *peanuts, eggs):* _____

Height (feet/inches) _____ Current Weight _____

Longest 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 child's 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
- ☐ Gestational
- ☐ High blood pressure(pre-
- ☐ High blood
- ☐ Have chemical exposure

BREASTFED HISTORY

Breastfed? ..... ○ 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.

NUTRITION HISTORY (CONTINUED)

BREASTFED HISTORY, (Cont.)

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 you have regarded with your child:

_____

_____

ACTIVITY

List type and amount of activity daily.

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.

Past	Current	EXPOSURES	Past	Current	EXPOSURES
☐	☐	Mold in bathroom	☐	☐	Mold in cellar, crawl space, or basement
☐	☐	Damp cellar	☐	☐	Moldy, musty school/daycare
☐	☐	Pest extermination – Inside	☐	☐	Tobacco smoke
☐	☐	Pest extermination – Outside	☐	☐	Well water
☐	☐	Forced hot air heat	☐	☐	Carpet in bedroom
☐	☐	Had water in basement	☐	☐	Carpet in most parts of the house
☐	☐	Mold visible on exterior of house	☐	☐	Feather or down bedding
☐	☐	Heavily wooded or damp surroundings			

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 _____

Ethnicity _____

Education _____

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

- ☐ Especially attractive
- ☐ Accepts new clothes
- ☐ Cuddly
- ☐ Physically coordinated
- ☐ Happy
- ☐ Pleasant/ easy to care for
- ☐ Sensitive/ affectionate
- ☐ Wants to be liked
- ☐ Responsible
- ☐ Draws accurate pictures
- ☐ Sensitive to people's feelings
- ☐ Okay if parents leave
- ☐ Answers parent
- ☐ Follows instructions
- ☐ Pronounces words well
- ☐ Good with math
- ☐ Good with computers
- ☐ Good with fine work
- ☐ Good throwing and catching
- ☐ Good climbing
- ☐ Strong desire to do things
- ☐ Swimming
- ☐ Bold, free of fear
- ☐ Likes to be held
- ☐ Like to be swaddled

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 usually large
- ☐ Unusually long eyelashes
- ☐ Pupils unusually small
- ☐ Dark circles under eyes
- ☐ Red lips
- ☐ Red fingers
- ☐ Red toes
- ☐ Webbed toes
- ☐ Red ears
- ☐ Double jointed
- ☐ Lymph nodes enlarged in neck
- ☐ Head warms
- ☐ Head sweats
- ☐ Night sweats
- ☐ Abnormal fatigue
- ☐ Failure to thrive
- ☐ Cold all over
- ☐ Cold hands and feet
- ☐ Cold intolerance
- ☐ Hands/ feet – very sweaty
- ☐ Perspiration – odd odor

SKIN

- ☐ Paleness, severe
- ☐ Fungus/ fingernails
- ☐ Fungus/ toenails
- ☐ Dandruff
- ☐ Chicken skin
- ☐ Oily skin
- ☐ Patchy dullness
- ☐ Seborrhea on face
- ☐ Thick calluses
- ☐ Athletes foot
- ☐ Feet – stinky
- ☐ Diaper rash
- ☐ Odd body odor

SKIN, Continued

- ☐ Strong body odor
- ☐ Acne
- ☐ Dark circles under eyes
- ☐ Ears get red
- ☐ Eczema
- ☐ Flushing
- ☐ Red face
- ☐ Sensitive to insect bites
- ☐ Stretch marks
- ☐ Blotchy skin
- ☐ Bugs love to bite you
- ☐ 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 fingernails
- ☐ Thickening toenails
- ☐ Vitiligo
- ☐ White spots of lines in nails
- ☐ Dry skin in general
- ☐ Feet cracking
- ☐ Hand peeling
- ☐ Lower legs dry
- ☐ Skin lackluster
- ☐ Itchy skin in general
- ☐ Itchy scalp
- ☐ Itchy ear canals
- ☐ Itchy eyes
- ☐ Itchy nose

SYMPTOM REVIEW (CONTINUED)

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

SKIN, Continued

- ☐ Itchy roof of mouth
- ☐ Itchy arms
- ☐ Itchy hands
- ☐ 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
- ☐ Cancer 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
- ☐ Lower abdominal bloating
- ☐ Colic
- ☐ Abdomen distended
- ☐ Abdominal pain
- ☐ Intestinal parasites
- ☐ Pinworms
- ☐ Cramping pain with pooping
- ☐ Constipation
- ☐ Diarrhea

DIGESTIVE, Continued

- ☐ Farting – regular
- ☐ 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
- ☐ Flatulence
- ☐ Stool odor foul
- ☐ Stool odor yeasty
- ☐ Stools pale
- ☐ Stools slimy
- ☐ 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
- ☐ intolerance
- ☐ Sugar intolerance
- ☐ Salicylate intolerance
- ☐ Oxalate intolerance
- ☐ Phenolics intolerance
- ☐ MSG intolerance
- ☐ Food coloring intolerance
- ☐ Gluten intolerance
- ☐ Casein intolerance

EATING, Continued

- ☐ 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
- ☐ Doesn't do for self
- ☐ 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 TV for a 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
- ☐ Melts down
- ☐ 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

SYMPTOM REVIEW (CONTINUED)

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

BEHAVIOR, Continued

- ☐ Falls, gets hurt running climbing
- ☐ Does opposite of asked
- ☐ Silly
- ☐ Shrieks
- ☐ Holds hands in strange pose
- ☐ Spends time with 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 finder side of face
- ☐ Bites or chews fingers
- ☐ Bites wrist or back of hands
- ☐ Chews on things

MOOD

- ☐ Apathy
- ☐ Blank look
- ☐ Depression
- ☐ Detached
- ☐ Disinterest
- ☐ Eye contact poor
- ☐ Isolates
- ☐ Negative fright without cause
- ☐ Always frightened
- ☐ Anguish
- ☐ Disconnected

MOOD, Continued

- ☐ 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 sound
- ☐ Ear pain
- ☐ Ear ringing
- ☐ Hearing acute
- ☐ Hearing loss
- ☐ Likes certain sounds
- ☐ Sensitive to loud noise
- ☐ Sounds seem painful
- ☐ Tinnitus
- ☐ Acute sense of smell
- ☐ Examines by smell
- ☐ Intensely aware of odors
- ☐ Blinking
- ☐ Bother by bright lights
- ☐ Distorted vision
- ☐ Conjuctivitis
- ☐ Eye crusting
- ☐ Eye problem
- ☐ Lid margin redness
- ☐ Examines by sight
- ☐ Fails to blink at bright light
- ☐ Likes fans
- ☐ Likes flickering lights
- ☐ Looks out of the corner of eye
- ☐ Poor vision
- ☐ Puts eye to bright light or sun

SENSORY, Continued

- ☐ Strabismus (crossed eye)
- ☐ Fearful of harmless object
- ☐ Fearful of unusual events
- ☐ Unaware of danger
- ☐ Unaware of peoples' feelings
- ☐ Unaware of self as person
- ☐ Upset if things change
- ☐ Upset if things aren't right
- ☐ 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 help 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
- ☐ Holds bizarre posture
- ☐ Hyperactivity
- ☐ Physically awkward
- ☐ Rocking
- ☐ Stiffens body when held
- ☐ Calf cramps
- ☐ Foot cramps

SYMPTOM REVIEW (CONTINUED)

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

NEUROMUSCULAR, Continued

- ☐ Muscle pain
- ☐ Muscle tone tense
- ☐ Muscle twitches
- ☐ Fist clenching
- ☐ 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
- ☐ Occasional 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 at 12-24 months
- ☐ Lost language after 24 months
- ☐ Scripting
- ☐ Stuttering
- ☐ Talks to self
- ☐ Poor auditory processing

SPEECH, Continued

- ☐ Unusual sound of cry
- ☐ Uses one word for another
- ☐ Rigid behaviors
- ☐ Poor confidence
- ☐ Timid
- ☐ Corrects imperfections

RESPIRATORY

- ☐ Pneumonia
- ☐ Bad odor in nose
- ☐ Breath holding
- ☐ Bronchitis
- ☐ Congestion change with
- ☐ season
- ☐ Congestion in the fall
- ☐ Congestion in the spring
- ☐ Congestion in the summer
- ☐ Congestion in the winter
- ☐ Cough
- ☐ Post nasal drip
- ☐ Runny nose
- ☐ Sighing
- ☐ Sinus fullness
- ☐ 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, Continued

- ☐ Urinary urgency
- ☐ Dry at night
- ☐ Seizures – focal
- ☐ Seizures – generalized
- ☐ Seizures – grand mal
- ☐ Seizures – petit mal
- ☐ Usual fast heart beat
- ☐ Heart murmur
- ☐ Headaches
- ☐ Joint pains
- ☐ Leg 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 are you to:

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

Significantly modify your diet	○ 5	○ 4	○ 3	○ 2	○ 1
Take several nutritional supplements each day	○ 5	○ 4	○ 3	○ 2	○ 1
Keep a record of everything you eat each day	○ 5	○ 4	○ 3	○ 2	○ 1
Modify your lifestyle (e.g., work demands, sleep habits)	○ 5	○ 4	○ 3	○ 2	○ 1
Practice a relaxation technique	○ 5	○ 4	○ 3	○ 2	○ 1
Engage in regular exercise	○ 5	○ 4	○ 3	○ 2	○ 1
Have periodic lab tests to assess your progress	○ 5	○ 4	○ 3	○ 2	○ 1

Comments:

_____

_____

_____

Your ability to organize and follow through on the above health related activities: ..... ○ 5 ○ 4 ○ 3 ○ 2 ○ 1

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

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?

_____

_____

_____

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

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

Comments:

_____

_____

_____

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

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

Comments:

_____

_____

_____

3-DAY DIET DIARY INSTRUCTIONS

PLEASE SUBMIT WITH THE ENTIRE INTAKE FORM. DO NOT WAIT AND BRING WITH YOU TO THE APPOINTMENT. WE NEED TO REVIEW PRIOR TO YOUR APPOINTMENT.

It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan.

Please complete this Diet Diary for 3 consecutive days including one weekend day.

- Do not change your eating behavior at this time, as the purpose of this food record is to analyze your 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, ½ 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 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/BEVERAGE/AMOUNT	COMMENTS

Bowel Movements (#, form, color): _____
Stress/Mood/Emotions: _____
Other Comments: _____

DAY 2

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel Movements (#, form, color): _____
Stress/Mood/Emotions: _____
Other Comments: _____

DAY 3

TIME	FOOD/BEVERAGE/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 you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are completing this after your first time, then record your symptoms for *ONLY* the last 48 hours.

POINT SCALE

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

KEY TO QUESTIONNAIRE

Add individual scores and total each group. Add each group score and give a grand total.

• Optimal is less than 10 • Mild Toxicity: 10-50 • Moderate Toxicity: 50-100 • Severe Toxicity: over 100

DIGESTIVE TRACT
_-___ Nausea or vomiting
_-___ Diarrhea
_-___ Constipation
_-___ Bloated feeling
_-___ Belching or passing gas
_-___ Heartburn
_-___ Intestinal/Stomach pain
Total ___0___

EARS
_-___ Itchy ears
_-___ Earaches, ear infections
_-___ Drainage from ear
_-___ Ringing in ears, hearing loss
Total ___0___

EMOTIONS
_-___ Mood swings
_-___ Anxiety, fear or nervousness
_-___ Anger, irritability or aggressiveness
_-___ Depression
Total ___0___

ENERGY/ACTIVITY
_-___ Fatigue, sluggishness
_-___ Apathy, lethargy
_-___ Hyperactivity
_-___ Restlessness
Total ___0___

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 ___0___

HEAD
_-___ Headaches
_-___ Faintness
_-___ Dizziness
_-___ Insomnia
Total ___0___

HEART
_-___ Irregular or skipped heartbeat
_-___ Rapid or pounding heartbeat
_-___ Chest pain
Total ___0___

JOINTS/MUSCLES
_-___ Pain or aches in joints
_-___ Arthritis
_-___ Stiffness or limitation of movement
_-___ Pain or aches in muscles
_-___ Feeling of weakness or tiredness
Total ___0___

LUNGS
_-___ Chest congestion
_-___ Asthma, bronchitis
_-___ Shortness of breath
_-___ Difficult breathing
Total ___0___

MIND
_-___ Poor memory
_-___ Confusion, poor comprehension
_-___ Poor concentration
_-___ Poor physical coordination
_-___ Difficulty in making decisions
_-___ Stuttering or stammering
_-___ Slurred speech
_-___ Learning disabilities
Total ___0___

MOUTH/THROAT
_-___ Chronic coughing
_-___ Gagging, frequent need to clear throat
_-___ Sore throat, hoarseness, loss of voice
_-___ Swollen/discolored tongue, gum, lips
_-___ Canker sores
Total ___0___

NOSE
_-___ Stuffy nose
_-___ Sinus problems
_-___ Hay fever
_-___ Sneezing attacks
_-___ Excessive mucus formation
Total ___0___

SKIN
_-___ Acne
_-___ Hives, rashes or dry skin
_-___ Hair loss
_-___ Flushing or hot flushes
_-___ Excessive sweating
Total ___0___

WEIGHT
_-___ Binge eating/drinking
_-___ Craving certain foods
_-___ Excessive weight
_-___ Compulsive eating
_-___ Water retention
_-___ Underweight
Total ___0___

OTHER
_-___ Frequent illness
_-___ Frequent or urgent urination
_-___ Genital itch or discharge
Total ___0___

GRAND TOTAL: ___0___

SPACE FOR ADDITIONAL NOTES