Child/Teen Self-Assessment Form

Our ability to draw effective conclusions about you/your child's present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will also assist us to formulate a treatment plan.

Name of child/teen:____ Date:______________

Address:_____________________________________ City:______________ State:________Zip:_________

Home Phone: (______) _____-____________ Birth Date: ______/______/______ Age: __________

Work Phone: (_______) _____-____________ Place of Birth: ___________________________________

Occupation: ___________________________ City or town & country if not US

Referred by: ___________________________ Height: ___' _____" Weight: _________ Sex: _______

Name of person to call in an emergency: ____

Relationship:___________________________ Contact Phone Number: ________________________

Name of person filling out form, if not patient: ____

ALLERGIES:

Medication/Supplement/Food	Reaction
____________________________________	____________________________________
____________________________________	____________________________________
____________________________________	____________________________________
____________________________________	____________________________________

COMPLAINTS/CONCERNS:

1. What do you hope to achieve in your visit with us? _______________________________________
____

2. If you had a magic wand and could help your child/teen in three ways, what would they be?
   a. ____
   b. ____
   c. ____

3. When was the last time you felt your child/teen was well? ______________________________

4. Did something trigger your child/teen's change in health? ____

____

5. Is there anything that makes your child/teen feel worse? ____

____

6. Is there anything that makes your child/teen feel better? ____

____

7. Please list current and ongoing problems in order of priority:

Describe Problem	Mild	Mod.	Severe	Prior Treatment/Approach	Success Excellent	Good	Fair
Example:Difficulty Focusing		X		*Elimination Diet*	X		

MEDICAL HISTORY

8. 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
		CARDIOVASCULAR
		Heart Disease
		Elevated Cholesterol
		Hypertension (high blood pressure)
		Rheumatic Fever
		Mitral Valve Prolapse
		Other
		METABOLIC/ENDOCRINE
		Type 1 Diabetes
		Type 2 Diabetes

PAST	CURRENT	METABOLIC CONT'D
		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 Fluctuation
		Bulimia
		Anorexia
		Binge Eating Disorder
		Night Eating Syndrome
		Eating Disorder (non-specific)
		Other

PAST	CURRENT	**GENITAL & URINARY SYSTEMS**
		Kidney Stones
		Urinary Tract Infections
		Yeast Infections
		Other
		MUSCULOSKELETAL/PAIN
		Arthritis
		Fibromyalgia
		Chronic Pain
		Other
		INFLAMMATORY/AUTOIMMUNE
		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
		Frequent Ear Infections
		Frequent Upper Respiratory Infections
		Asthma
		Chronic Sinusitis
		Bronchitis
		Sleep Apnea
		Other
		SKIN DISEASES
		Eczema
		Psoriasis
		Acne
		Other

PAST	CURRENT	**NEUROLOGIC/MOOD**
		Depression
		Anxiety
		Bipolar Disorder
		Schizophrenia
		Headaches
		Migraines
		ADD/ADHD
		Sensory Integrative Disorder
		Autism
		Mild Cognitive Impairment
		Multiple Sclerosis
		ALS
		Seizures
		Other Neurological Problems

PREVIOUS EVALUATIONS

Check box if yes and provide date.

	YES	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		
Physical Therapy		
Occupational Therapy		
Sensory Integration Therapy		
Language Classes		
Sign Language		
Homeopathic		
Naturopathic		
Craniosacral		
Chiropractic		
MRI		
CT Scan		

	YES	DATE
Upper Endoscopy		
Upper GI Series		
Ultrasound		
INJURIES		
Back Injury		
Neck Injury		
Head Injury		
Broken Bones		
Other		

SURGERIES	YES	DATE
Appendectomy		
Circumcision		
Hernia		
Tonsils		
Adenoids		
Dental Surgery		
Tubes in Ears		
Other		

BLOOD TYPE: A B AB 0
Rh+ Unknown

HOSPITALIZATIONS ☐None

9. Date	Reason

IMMUNIZATIONS

10. Is your child up to date with immunizations? Yes ___ No ___
11. Do you feel immunizations have had an impact on your child's health? Yes ___ No ___
12. If relevant, attach a copy of your child's immunization record or see addendum.

PSYCHOSOCIAL

13. Has your child experienced any major life changes that may have impacted his/her health? Yes ___ No ___
14. Has your child ever experienced any major losses? Yes ___ No ___
    Explain: ____

STRESS/COPING

15. Is your child or family currently in therapy? Yes ___ No ___ Describe: ___________________
16. Have you ever sought counseling for your child? Yes ___ No ___
17. Does your child have a favorite toy or object? Yes ___ No ___
18. Does your child practice stress release methods? Yes ___ No ___ If yes, then check all that apply:
    ☐Yoga ☐ Meditation ☐Imagery ☐Breathing ☐Tai Chi ☐ Prayer ☐Other: ___________________
19. Has your child ever been abused, a victim of a crime, or experienced a significant trauma? Yes ___ No ___

SLEEP/REST

12. Average number of hours your child sleeps per night: ___ >12 ___10-12 ___8-10 ___< 8

13. Does your child/teen…

____Have trouble falling asleep	____ Awaken screaming/crying
____Feel rested upon awakening	____ Wake early
____Snore	____ Have Insomnia
____Sleep in own bed	____ Sleep less than normal
____Sleep with parent(s)	____ Sleep more than normal
____Have daytime sleepiness	____ Jerk during sleep
____Have nightmares	

ROLES/RELATIONSHIP

14. *List family members living in same house:*

Family Member and Relationship	Age	Gender

15. Who are the main people who care for your child? ____

16. Their employment/occupation: ____

17. Resources for emotional support: *Check all that apply*

☐ Spouse ☐ Family ☐Friends ☐ Religious/Spiritual ☐Pets ☐Other: ________________________

GYNECOLOGIC HISTORY *(Females only)*

MENSTRUAL HISTORY

18. Age at first period: ____ Menses Frequency: ____ Length: ____ Pain: Yes No Clotting: Yes No

19. Has their period ever skipped? ____________ For how long? ____________ Last Menstrual Period: _____

20. Does your teen use contraception? (*Please circle)* Yes No Condom Diaphragm IUD

Partner Vasectomy Hormonal contraception such as: Birth Control Pills Patch Nuva Ring

21. How long? ________

GI HISTORY

22. Has your child/teen traveled to foreign countries? Yes ___ No ___ Where? ____________________

23. Wilderness camping? Yes ___ No ___ Where? _____________

24. Ever had severe: ☐ Gastroenteritis ☐ Diarrhea

DENTAL HISTORY

25. *Please check all that apply:*

☐ Silver Mercury Fillings How many? ___________

☐ Gold Fillings ☐ Root Canals ☐ Implants ☐ Tooth Pain ☐ Bleeding Gums

☐ Gingivitis ☐ Trouble with Chewing

Do they floss regularly? Yes ___ No ___

PATIENT BIRTH HISTORY

26**. MOTHER'S PAST PREGNANCIES**

Number of: Pregnancies: ____________ Live births: _________ Miscarriages: _______

27. **MOTHER'S PREGNANCY**

Check box if yes and provide description if applicable

	Difficulty getting pregnant (more than 6 months)		Group B strep infection
	Infertility drugs used (Specify)		Had c-section due to:
	In vitro fertilization		Used induction for labor (ex. Pitocin)
	Drank alcohol		Had anesthesia (specify type)
	Drank coffee		Used oxygen during labor
	Smoked tobacco		Had an x-ray
	Took Progesterone		Had Rhogam, if yes how many shots?
	Took prenatal vitamins		How many when pregnant?
	Took antibiotics; during labor?		Gestational Diabetes
	Took other drugs (Specify)		High blood pressure (pre-eclampsia)
	Excessive vomiting, nausea (>3 weeks)		High blood pressure/toxemia
	Had a viral infection		Had chemical exposure
	Had a yeast infection		Father had chemical exposure
	Had amalgam fillings put in teeth		Moved to a newly built house
	Had amalgam fillings removed from teeth		House painted indoors
	Number of fillings in teeth when pregnant		House painted outdoors
	Had bleeding? If so which months?		House exterminated for insects
	Had birth problems		

PREGNANCY

28. Total weight gain during pregnancy: _______ lbs Total weight loss during pregnancy: ______lbs

29. Please describe diet during pregnancy: ____

____

____

30. Please describe labor: ____

____

____

PERINATAL

31. Pregnancy duration: *(Please circle at what week your baby was born)*

24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 (full term) 41 42 43 44

31. Very active before birth? Yes ___ No ___ Hospital/Birthing Center? Yes ___ No ___
32. Needed Newborn Special Care? Yes __ No ___ Appeared healthy? Yes ___ No ___
33. Easily consoled during first month? Yes ___ No ___
34. Experienced complications during first month of life? Yes ___ No ___

BIRTH WEIGHT AND APGAR

35. Weight at birth: ____ lbs Apgar score at 1 minute: ______ Apgar score at 5 minutes: _______

EARLY CHILDHOOD ILLNESSES

36. Number of earaches in the first two years: _________
37. Number of other infections in the first two years: __________
38. Number of times your child had antibiotics in the first two years of life: ____________
39. Number of courses of prophylactic antibiotics in first two years of life: ___________________

First antibiotic at _____ months. First illness at ________ months.

DESCRIPTION OF DEVELOPMENTAL PROBLEMS

40. If your child has developmental problems, at what age did they occur? *(Please circle appropriate answer)*

0-1 months 2-6 months 7-15 months 16-24 months After 24 months

41. Is this impression shared among parents and others caring for the child? Yes ___ No ___
42. Does this impression differ among parents and others caring for the child? Yes ___ No ___
43. Is this impression weak? Yes ___ No ___
44. Or is this impression strong? Yes ___ No ___

DEVELOPMENTAL HISTORY

45. *Please indicate the approximate age in months for the following milestones: (ex. Walking 14 months)*

	Months	Never		Months	Never
Sitting up			Dry at night		
Crawling			First words		
Pulled to stand			Spoke clearly		
Potty trained			Lost language		
Walked alone			Lost eye contact		

MEDICATIONS

46. **Current Medications:**

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

47. **Previous Medications:** (*Last 10 years*)

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

48. **Nutritional Supplements (Vitamins/Minerals/Herbs/Homeopathy)**

Supplement and Brand | Dose | Frequency | Start Date (month/yr) | Reason For Use

49. Have medications or supplements ever caused your child unusual side effects or problems? Yes ___ No ___
Describe: ___
50. Has your child had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, or Aspirin? Yes ___ No ___
51. Has your child had prolonged or regular use of Tylenol? Yes ___ No ___
52. Has your child had prolonged or regular use of Acid Blocking Drugs (Zantac, Prilosec, etc.)? Yes ___ No ___
53. Frequent antibiotics (over 3 times/year)? Yes ___ No ___ Long term antibiotics? Yes ___ No ___
54. Use of steroids (prednisone, nasal allergy inhalers) in the past? Yes ___ No ___
55. Use of oral contraceptives? Yes ___ No ___

FAMILY HISTORY

56. *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												
Cancers												
Colon Cancer												

	Mother	Father	Brother(s)	Sister (s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Sondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Diseases (ex. 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 (ex. Alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												

NUTRITION HISTORY

57. Has your child ever had a nutrition consultation? Yes ___ No____

58. Have you made any changes in your child’s diet because of health problems? Yes ___ No ___

Describe: ____

59. Does your child follow a special diet or nutritional program? Yes ___ No ___

Circle 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 (Peanuts, Eggs, etc.): ____

60. Height (feet/inches): ____________ Current Weight: ________________

Longest Weight Fluctuations: ____

61. Does your child avoid any particular foods? Yes ____ No ____ If yes, types and reason: ______________________

____

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

____

63. Who does the shopping in your household? ____

64. Who does the cooking in your household? ____

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

66. Check all the factors that apply to your child's current lifestyle and eating habits:

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

BREASTFEEDING HISTORY

67. Breastfed? Yes ___ No ___ How long? _________ Problems latching on? Yes ___ No ___

Sucking quality? _____Very Good _____Good _____Poor Exclusively breastfed for ____________ months

BOTTLEFEEDING HISTORY

68. Bottle fed? Yes ___ No ___ Type of formula: _____Soy _____Cow's Milk _____Low Allergy

69. 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.

70. Choke/Gas/Vomit on milk? Yes ___ No ___ Refused to chew solids? Yes ___ No ___

71. List mother's known food allergies or sensitivities: ____

72. Please describe any other eating concerns that you have regarding your child: ___________________________

____

ACTIVITY

73. *List type and amount of activity daily.*

Type	**Amount Daily**

74. How much time does your child spend watching tv? ______________

75. How much time does your child spend on the computer or playing video games? ________________________

ENVIRONMENTAL HISTORY

76. *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
		Water in basement			Carpet in most parts of house
		Mold visible on house exterior			Feather or down bedding
		Heavily wooded or damp surroundings			

78. MOTHER - PERSONAL

Age at your birth ___________________

Education _________________________

Ethnicity __________________________

Blood type ________________________

79. FATHER – PERSONAL

Age at your birth ___________________

Education _________________________

Ethnicity __________________________

Blood type ________________________

SYMPTOM REVIEW

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

	STRENGTHS				
	Especially attractive		Good climbing		Double jointed
	Accepts new clothes		Strong desire to do things		High arched palate
	Cuddly		Swimming		Lymph nodes enlarged neck
	Physically coordinated		Bold, free of fear		Head warm
	Happy		Likes to be held		Head sweats
	Pleasant/easy to care for		Likes to be swaddled		Night sweats
	Sensitive/affectionate				Abnormal fatigue
	Wants to be liked		**PHYSICAL**		Failure to thrive
	Responsible		Looks sick		Cold all over
	Draws accurate pictures		Glazed look		Cold hands and feet
	Sensitive to peoples' feelings		Overweight		Cold intolerance
	Okay if parents leave		Underweight		Hands/feet very sweaty
	Answers parent		Unusually long eyelashes		Head very hot/sweaty
	Follows instructions		Unusually small pupils		Night sweats
	Pronounces words well		Unusually large pupils		Perspiration odd odor
	Unusual memory		Dark circles under eyes		Seizures – focal
	Perfect musical pitch		Red lips		Seizures – generalized
	Good with math		Red fingers		Seizures – grand mal
	Good with computers		Red toes		Seizures – petit mal
	Good with fine work		Red ears		Unusually fast heart beat
	Good throwing and catching		Webbed toes		Heart murmur

	Headaches
	Joint pains
	SKIN
	Paleness, severe
	Fingernail fungus
	Toenail fungus
	Dandruff
	Chicken skin
	Oily skin
	Patchy dullness
	Seborrhea on face
	Thick calluses
	Athletes foot
	Stinky feet
	Diaper rash
	Odd body odor
	Strong body odor
	Acne
	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)
	Light birth mark(s)
	Easy bruising
	Inability to tan
	Ragged cuticles
	Thickening fingernails
	Thickening toenails
	Vitiligo
	White spots of lines in nails
	Dry skin in general
	Feet cracking
	Feet peeling
	Hands cracking

	Leg pains
	Muscle pains
	Hands peeling
	Lower legs dry
	Skin lackluster
	Itchy skin in general
	Itchy scalp
	Itchy ear canals
	Itchy eyes
	Itchy nose
	Itchy roof of mouth
	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
	Upper abdominal bloating
	Lower abdominal bloating
	Abdomen distended
	Abdominal pain
	Colic
	Intestinal parasites
	Pinworms

	Crampy pain with pooping
	Constipation
	Diarrhea
	Farting – regular
	Farting – stinky
	Anal fissures
	Red ring around anus
	Stools bulky
	Stools light colored
	Stools very stinky
	Stools with blood
	Stools with mucous
	Stools with undigested food
	Stool odor foul
	Stool odor yeasty
	Stools pale
	Stools slimy
	Stools slimy
	Stools watery
	EATING
	Poor appetite
	Thirst
	Extreme water drinking
	Bingeing
	Bread craving
	Carb. craving
	Juice craving
	Salt craving
	Diet soda craving
	Pica (eating non-edibles)
	Abnormal food cravings
	Carb. intolerance
	Starch/disaccharide intolerance
	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 adult's 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 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 of asked
	Teases others
	Silly
	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
	Poor eye contact
	Isolates
	Negative
	Fright without cause
	Always frightened
	Anguish
	Discontented
	Doesn't 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
	Examines by smell
	Intensely aware of odors
	Blinking
	Bothered by bright lights
	Distorted vision
	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' feeling
	Unaware of self as person
	Upset by 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
	Sensitive 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
	NEUROMUSCULAR
	Clumsiness
	Coordination

	Poor fine motor skills
	Poor gross motor skills
	Holds bizarre posture
	Hyperactivity
	Physically awkward
	Rocking
	Stiffens body when held
	Calf cramps
	Foot cramps
	Muscle pain
	Muscle tone tense
	Muscle twitches
	Fist clenching
	Jaw clenching
	Poor muscle tone/limp
	Tics
	Muscle tone low - trunk
	Muscle tone low - all over
	Muscle weakness, atrophy
	Tremors
	Cognitive delays
	Poor memory
	Poor attention, focus
	Slow and sluggish
	Expressive language delay
	SPEECH
	Never spoke
	Occas. words when excited
	Poor expressive language
	No answers to simple questions
	Points to objects/can’t name
	Speech apraxia
	Does not ask questions
	Babbling
	Asks using “you” not “I”
	Says “I”
	Says “no”
	Says “yes”
	Answers by repeating question
	Receptive language poor
	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
	Holds breath
	Bronchitis
	Congestion w/ changing 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
	Early breast development
	Vaginal odor
	Boys: Large testicles
	Early pubic hair
	URINARY
	Frequent urination
	Bed wetting after age 4
	Odd urinary odor
	Urinary hesitancy
	Urinary tract infections
	Urinary urgency
	Dry at night

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. school/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
Having 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, email correspondence, etc.) 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 FOOD DIET DIARY 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. For example: Milk – what kind? Whole, 2%, nonfat? Toast – whole wheat, white, buttered? Chicken – fried, baked, breaded?
- Record the amount of each food or beverage consumed using standard measurements such as 8 oz., ½ cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 tsp. honey, potato with 2 tsp. butter, etc.
- Record all beverages, including water, coffee, tea, sports/energy 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/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 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.

POINT SCALE:

0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have it, 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 _______
Earaches, infections _______
Drainage from ear _______
Ringing in ears, hearing loss ______
Total: _________

EMOTIONS
Mood swings _______
Anxiety, fear or nervousness ______
Anger, irritability or aggression _______
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 _______
Blurred or tunnel vision (not including near- or far-sightedness) _______
Total: _________

HEAD
Headaches _______
Faintness _______
Dizziness _______
Insomnia _______
Total: _________

JOINTS/MUSCLES
Pain or aches in joints _______
Arthritis _______
Stiff or limited movement _______
Pain or aches in muscles _______
Feeling weak or tired _______
Total: _________

LUNGS
Chest congestion _______
Asthma, bronchitis _______
Shortness of breath _______
Difficult breathing _______
Total: _________

MIND
Poor memory _______
Confusion, poor comprehension _______
Poor concentration _______
Poor physical coordination _______
Difficulty making decisions ______
Stuttering or stammering _______
Slurred speech _______
Learning disabilities _______
Total: _________

MOUTH/THROAT
Chronic coughing _______
Gagging, frequently clearing throat _______
Sore throat, hoarse, 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, dry skin _______
Hair loss _______
Flushing or hot flashes _______
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: Optimal is 10, Mild toxicity: 10-50, Moderate 51-100, Severe: >100