

PERSONAL INFORMATION

Date of Initial Consultation: ____ / ____ / ____

Child's Name: First: _____ Last: _____ Middle Initial: _____

Parent(s) Name(s): _____

Address: Street: _____ City: _____

State: _____ Zip: _____ Phone: () _____

Work Phone: () _____ Cell : () _____

EMAIL : _____ Fax: () _____

Child's birth date: Month: _____ Day: _____ Year: _____ Child's Sex (Circle One): Male/Female

Primary Care Physician: Name: _____ City: _____

State: _____ Zip: _____ Phone #: () _____

Health insurance: _____ ID No.: _____

Referred by: _____

Siblings: Name:	Sex: (Circle One)	Birth Date:		
	Male/Female	Month:	Day:	Year:
	Male/Female	Month:	Day:	Year:
	Male/Female	Month:	Day:	Year:

Parent's occupation(s): _____

Diagnoses or explanation given to you about your child (Date of diagnoses: ____ / ____ / ____) : _____

Other concerns to be addressed: _____

PERSONAL INFORMATION (Continued)

Describe your child to me, including his/her history. Please be as detailed as possible.

When did you first become concerned about your child ?

What did you first notice?

Was the onset sudden or gradual?

Was there any event or illness that you or others think brought on your child's symptoms?

Please make notation of any other event, action, etc. that you think may have some bearing/ relationship to your child's condition. Again, be as detailed as possible and do not hesitate to mention anything, no matter how small or insignificant, that you believe is related to your child's problem(s):

CHILD'S MEDICAL HISTORY

PRIMARY DOCTOR (S)

Name	Phone Numbers	City

THERAPIST(S)

Speech - Occupational - Physical - Other

Name	Type of Therapist	Phone	City	Hours/Week

Specialist(s)

Name	Phone	City	Date of Evaluation

PRENATAL HISTORY

Maternal age at delivery: _____ years

Illnesses during pregnancy:

Medication during pregnancy:

Other complications during pregnancy:

PRENATAL HISTORY Continued

Complications during labor and delivery:

Mode of delivery: C-section/vaginal? If C-section, explain why:

If vaginal delivery, did you have forceps/vacuum?

Medication(s) during labor and delivery?

Full term/premature? (Circle one)

How many weeks? _____ weeks

Complications after delivery?

Medications given to child during hospital stay?

DIETARY/NUTRITIONAL HISTORY

Breast-fed? Yes/No (Circle One): If yes, how long?

Bottle-fed? Brand of formula?

Begun at what age?

For how long?

Foods? Begun at what age?

First foods?

Whole milk? Yes/No (Circle One)

If yes, begun at what age?

Known allergies to food? (Please list):

Suspected sensitivities to foods? (Please list):

Food cravings? (Please list):

DIETARY/NUTRITIONAL HISTORY (Continued)

Foods my child eats: (Place X in appropriate column)

Food	Daily	3 - 5 times/week	1 - 3times/ week	Never or almost never	Used to eat a lot but no longer does
Cookies					
Candy					
Sweet foods					
Caffeine (soda, tea, etc.)					
Chocolate					
Milk: Whole					
2 %					
1 %					
Skim					
Cheese					
Ice Cream					
Salty Foods					
Meat					
Pasta					
Bread: White					
Wheat					
Other					

Check (X) the most appropriate description below of your child's diet:

- Mostly baby foods**
- Mostly carbohydrates (bread, pasta, etc.)**
- Mostly dairy (milk, cheese, etc.)**
- Mostly meat**
- Mostly vegetarian (vegetables, fruits, grains, etc.)**
- Other. Describe:**

Please describe your child's stool pattern (Examples: daily, foul, large, mushy, etc.):

DIETARY/NUTRITIONAL HISTORY (Continued)

Please list the foods and beverages normally consumed by your child for three typical days:

DAY 1

Breakfast:

Morning snack(s):

Lunch:

Afternoon snack(s):

Dinner:

Beverages:

Other:

DAY 2

Breakfast:

Morning snack(s):

Lunch:

Afternoon snack(s):

Dinner:

Beverages:

Other:

DAY 3

Breakfast:

Morning snack(s):

Lunch:

Afternoon snack(s):

Dinner:

Beverages:

Other:

FAMILY HISTORY

List any allergies, major illnesses, genetic diseases or problems for each of the following family members of your child:

Mother:

Father:

Siblings:

Maternal Grandparents:

Paternal Grandparents:

SOCIAL HISTORY

Who lives in the home with your child:

Are any children in your family adopted?

Pets in the house:

Caregivers besides parents:

List the people most important in your child's life:

Recent changes, losses, births, deaths, divorce, remarriage or moves:

Recent travel:

Child's response to these changes:

Is your child involved in any sports, music or other activities? Please describe:

How does your child interact with other children?

With adults:

ENVIRONMENTAL HISTORY

Do you, your child, or any family members practice any relaxation/stress management techniques? Please describe:

CIRCLE THE APPROPRIATE ANSWERS TO THE FOLLOWING QUESTIONS:

Location of home: City/Suburban/Wooded/Farm **Other (describe):**

Water: City/well **Purification system:** Yes/No **If yes, please describe:**

Do you live near: Power lines/woods/industrial areas/water?

If you live near water, list type: Swamp/river/ocean/other **If other, please describe:**

Does your home have a lot of: Dust/mold/down or feather items (pillows, upholstery, stuffed animals?) **If so, please give details:**

Describe your child's bedroom (Circle appropriate response):

Bedding: Synthetic/down/feather? **Mattress cover:** Yes/No **Crib/Junior Bed/Adult Bed**

Flooring: Carpet: Wall-to-wall or area rug? Wood? Glued down? Synthetic pad?

Window treatment: Shades/blinds/thin curtain/heavy curtain/valance/other? **If other, describe:**

Other items in room including furniture, toys, stuffed animals:

Flooring in other rooms:

Child's bathroom? **Living room?** **Family room/play room?**

Is your child sensitive to or bothered by any of the following? Please check where appropriate and list specific products if

_____ **Perfumes/cosmetics?** _____ **Mold?** _____ **Soaps?** _____ **Animals (dander)?** _____ **Paint?**

_____ **Cleaning products?** _____ **Pollens/grasses?** _____ **Detergents?** _____ **Gasoline?** _____ **Dust?**

Please list known allergies:

DEVELOPMENTAL HISTORY

Please list age when following skills were mastered and any problems associated with these skills:

First words: (Age: _____)

Phrases or sentences: (Age: _____)

Walking: (Age: _____)

Sitting up: (Age: _____)

Crawling: (Age: _____)

Running: (Age: _____)

Walking up/down steps without help: (Age: _____)

Jumping: (Age: _____)

Learned to pedal: (Age: _____)

Rode 2-wheel bicycle: (Age: _____)

Put on clothing: (Age: _____)

MEDICAL HISTORY

Please list all BLOOD tests(CBC,CMP, ferritin, food sensitivities) that have been performed in the past 2 years:

Please list all imaging studies (MRI, CT scan, Ultrasound, colonoscopy) that have been performed in the past 2 years

Please list all other tests (stool cultures, hair analysis) performed in the past 2 years

MEDICAL HISTORY (Continued)

Major surgeries - Please describe and give dates:

SURGERY	DATE(S)	RESULTS

Major injuries - Please describe and give dates:

INJURY	DATE(S)	RESULTS

Illnesses - Please list appropriate dates and any complications:

ILLNESS	DATE(S)	COMPLICATIONS
Ear infections		
Sinus infections		
Bronchitis		
Pneumonia		
Thrush		
Yeast Infections		
Chicken Pox		
Seizures		
Measles		
Mumps		
Rubella		
Tuberculosis		
Mono		
Other: (Please list):		

Immunizations

Please indicate date and any reactions for those immunizations that your child has received. If the exact date isn't known, please approximate. Please include any side effects/negative reactions to the vaccine.

Vaccination	Date(s)	Side Effects/Negative Reactions
Diphtheria/Pertussis/Tetanus (DTaP,DPT)		
H Influenza Type B (Hib)		
Polio (IPV)		
Measles/Mumps/Rubella (MMR)		
Hepatitis b Vaccine		
Pnemococcal (Pevnar)		
Chicken Pox (Varivax)		
Flu Vaccine		
Other:		

Medications/Supplements

Please list all past prescription medications and any side effects your child may have experienced

Please list all current prescription medications and any side effects your child is/has experienced

Medications/Supplements continued

Please list all past supplements(herbal, vitamins, minerals) and any side effects your child may have experienced

Please list all current supplements(herbal, vitamins, minerals) and any side effects your child is/has experienced

Therapies and Diets

Please list all therapies you have used and/or are using

Please list all diets you have used and/or are using

SIGNS AND SYMPTOMS

Please indicate the severity of the follow signs and symptoms(mild, moderate, severe) and any unique details

Stimmng (repetitive actions or movements)

Rocking

Head banging

Self-mutilation

Nail biting

Hand/arm biting

Nail/skin picking

Aggressiveness(hitting, kicking, biting others)

Mood swings

Irritability/tantrums

Fears/Anxiety

Hyperactivity

Inability to concentrate/focus

Fidgeting

Impulsiveness

Breath holding

Dizziness

Poor coordination

Problems with buttons, ties, snaps

Processing issues(visual, motor, language)

Sensitive to crowds

Memory issues

Low self-esteem

Fatigue

Cold hands/feet

Cold intolerance

SIGNS AND SYMPTOMS (Continued)

Heat intolerance
Recurrent/chronic fevers
Flushing
Difficulty falling asleep
Difficulty staying asleep
Night walking
Nightmares
Difficulty waking
Bed wetting
Day time wetting/soiling
Numbness/tingling in hands/feet
Headaches
Blinking
Tics
Eye discharge
Dark circles/puffiness under eyes
Congestion
Dripping nose
Sensitivity to light
Earaches
Ringing in ears
Sensitivity to noise
Bad breath
Nose bleeds
Acute sense of smell
Sore throats
Hoarseness

SIGNS AND SYMPTOMS (Continued)

- Cough
- Wheezing
- Swollen gums
- Canker sores
- Dry lips/mouth
- Diarrhea
- Constipation
- Blood/mucous in stool
- Bloating
- Passing gas
- Belching
- Stomach ache
- Refusal to eat
- Sensitive to texture of food
- Difficulty swallowing
- Food cravings
- Grinding teeth
- Muscle cramping
- Tremors
- Weakness
- Eczema
- Psoriasis
- Hives
- Acne
- Cradle cap
- Easy bruising
- Itchy scalp

