U2000-032110

928 Brodhead Road

Moon Township, PA 15108

Ph-724.457.6258

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D’Eramo Family Medicine

Pediatric

Patient

Information

General Information

Preferred Name

Date of Birth

Age

Gender Male Female

Genetic Background African European Native American Mediterranean

Asian Ashkenazi Middle Eastern 

|  |  |  |  |
| --- | --- | --- | --- |
| Mother’s Name  Father’s Name |  | Occupation |  |
|  | Occupation |  |
| *Person completing this questionnaire* |  |  |
| Primary Address | *Number, Street* |  | *Apt. No.* |
| *City* | *State* | *Zip* |
| Alternate Address | *Number, Street* |  | *Apt. No.* |
| *City* | *State* | *Zip* |
| Home Phone 1  Home Phone 2  Parent’s Work Phone  Parent’s Cell Phone  Fax  Email |  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| Emergency Contact | *Name* | *Phone Number* |  |
| *Address* |  | *Apt. No.* |
| *City* | *State* | *Zip* |
| Physician | *Name* | *Phone Number* |  |
| *Fax* |  |  |

Referred by Book Website

Media Friend or Family Member Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| PHARMACY INFORMATION | |  |
| Primary Pharmacy | *Name* | *Phone Number* |
| *Address* |  |
| *City* | *State Zip* |
| *E-mail* | **Fax\*** |
|  | ***\* It is extremely important that you list the pharmacy’s fax number.*** |
| Compounding/  Supplement Pharmacy | *Name* | *Phone Number* |
| *Address* |  |
| *City* | *State Zip* |
| *E-mail* | **Fax\*** |
|  | ***\* It is extremely important that you list the pharmacy’s fax number.*** |
| CREDIT CARD INFORMATION | |

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Method of Payment *(please circle one)*: Cash / Check / Credit Card If paying by credit card, we accept VISA, MasterCard and Discover\*.

*\*Note: If Discover is your primary card, please provide another card (i.e., MC or Visa) for transactions*

*(i.e., supplement orders, etc.) that we may need to process. Some pharmacies do not accept Discover.*

##### PRIMARY CARD

Name on Card \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Type Visa MasterCard Discover

Account Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date (mm/yy) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CVV# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SECONDARY CARD**

Name on Card \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Type Visa MasterCard Discover

Account Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date (mm/yy) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CVV# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pediatric Medical Questionnaire**

3.

When was the last time you felt 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

Success

*Example: Difficulty Maintaining Attention*

*X*

*Elimination Diet*

*X*

|  |  |
| --- | --- |
| **ALLERGIES** |  |
| **Medication/Supplement/Food** | **Reaction** |

What do you hope to achieve in your visit with us?

**COMPLAINTS/CONCERNS**

If you had a magic wand and could help your child in three ways, what would they be?

1.

2.

MEDICAL HISTORY

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

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PAS | T C  URRENT                 | | **GASTROINTESTINAL** |  | PAS | T C | URRENT | **GENITAL AND URINARY SYSTEMS** |
|                | Irritable Bowel Syndrome \_\_\_\_\_\_\_\_\_\_\_\_  Inflammatory Bowel Disease \_\_\_\_\_\_\_\_\_  Crohn’s \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ulcerative Colitis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gastritis or Peptic Ulcer Disease \_\_\_\_\_\_\_\_  GERD (reflux) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Celiac Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |        |        | Kidn  Urin  Yeast  Othe | ey Stones \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ary Tract Infections \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Infections \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ r \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| PAS | T C | URRENT | **MUSCULOSKELETAL/PAIN** |
|        |        | Arth  Fibr  Chro  Othe | ritis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ omyalgia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ nic Pain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ r \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| PA | ST | CURRENT | **CARDIOVASCULAR** |
|            |            | Heart  Eleva  Hype  Rheu  Mitra  Other | Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ted Cholesterol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ rtension (high blood pressure) \_\_\_\_\_\_\_\_\_ matic Fever \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ l Valve Prolapse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| PAS | T C | URRENT | **INFLAMMATORY/AUTOIMMUNE** |
|                          |                          | Chro Auto  Rheu  Lupu  Imm  Seve  Poor  (freq  Other | nic Fatigue Syndrome \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ immune Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ matoid Arthritis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ s SLE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ une Deficiency Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ re Infectious Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Immune Function \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ uent infections)  Food Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Environmental Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Multiple Chemical Sensitivities \_\_\_\_\_\_\_\_\_\_\_\_\_  Latex Allergy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| PA | ST | CURRENT | **METABOLIC/ENDOCRINE** |
|                                    |                                    | Type  Type  Hypo  Meta  (  Weight Loss  Bulimia  Anorexia  Other | 1. Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ glycemia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ bolic Syndrome \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insulin Resistance or Pre-Diabetes)   Hypothyroidism (low thyroid) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hyperthyroidism (overactive thyroid) \_\_\_\_\_\_\_\_ Endocrine Problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Polycystic Ovarian Syndrome (PCOS) \_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Weight Gain  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Frequent Weight Fluctuations \_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Binge Eating Disorder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Night Eating Syndrome \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Eating Disorder (non-specific) \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| PA | ST | CURRENT **RESPIRATORY DISEASES** | |
|              |              | Frequent Ear Infections \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequent Upper Respiratory Infections \_\_\_\_\_\_\_\_ Asthma\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Chronic Sinusitis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bronchitis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Sleep Apnea \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| PAS | T C | URRENT **SKIN DISEASES** | |
|        |        | Eczema \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Psoriasis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Acne \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| PA | ST | CURRENT **CANCER** | |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  |

#### MEDICAL HISTORY (CONTINUED)

##### 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*

* 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### HOSPITALIZATIONS  None

Date

Reason

* 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### SURGERIES

*Check box if yes and provide date*

 Appendectomy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Circumcision \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Hernia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Tonsils \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Adenoids \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Dental Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Tubes in Ears \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **BLOOD TYPE:** A B AB 0

Rh+ Unknown

###### 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

Does your child practice stress release methods? Yes No If yes, then check all that apply:  Yoga  Meditation  Imagery  Breathing   Tai Chi  Prayer  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 per 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

Family Member and Relationship

Age

Gender

**ROLES/RELATIONSHIP**

*List Family Members:*

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GYNECOLOGIC HISTORY** *(for females only)*

###### MENSTRUAL HISTORY

Age at first period:\_\_\_\_\_\_ Menses Frequency:\_\_\_\_\_\_ Length:\_\_\_\_\_\_ Pain: Yes No Clotting: Yes No Has your period ever skipped?\_\_\_\_\_\_ For how long?\_\_\_\_\_\_

Last Menstrual Period:\_\_\_\_\_\_\_\_\_\_\_

Does your child use contraception? Yes No   Condom   Diaphragm   IUD   Partner Vasectomy Use of hormonal contraception such as:  Birth Control Pills  Patch  Nuva Ring How long?\_\_\_\_\_\_

#### GI HISTORY

Has your child traveled to foreign countries? Yes No Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Wilderness Camping? Yes No Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ever had severe: Gastroenteritis Diarrhea

**DENTAL HISTORY**

* Silver Mercury Fillings 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 description if applicable*

|  |  |
| --- | --- |
| * Difficulty getting pregnant (more than 6 months) \_\_\_\_ * Infertility drugs used Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * In vitro fertilization \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Drink alcohol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Drink coffee \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   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? If so which months? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Group B strep infection \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Have c-section because of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Use induction for labor (such as Pitocin) \_\_\_\_\_\_\_ * Have anesthesia, if so list type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Use oxygen during labor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Have an x-ray \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * 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 a newly built house \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   House painted indoors \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   House painted outdoors \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   House exterminated for insects \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

  Have birth problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### PREGNANCY

Total weight gain during pregnancy: \_\_\_\_\_\_\_\_lb Total weight loss during pregnancy: \_\_\_\_\_\_\_\_ lb

Please describe diet during pregnancy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please describe labor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### PATIENT BIRTH HISTORY (CONTINUED)

###### PERINATAL

Pregnancy duration: *(Please indicate at what week was your baby born)*

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 1 minute: \_\_\_\_\_\_\_\_ Apgar score at 5 minutes: \_\_\_\_\_\_\_\_

###### 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?

0-1months 2-6 months 7-15 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 to 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 the 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

Crawl \_\_\_\_\_\_\_\_ months Never

Pulled to stand \_\_\_\_\_\_\_\_ months Never

Potty trained \_\_\_\_\_\_\_\_ months Never

Walked alone \_\_\_\_\_\_\_\_ months Never Dry at night \_\_\_\_\_\_\_ months Never

First words (“mamma”, “dada”, etc.) \_\_\_\_\_\_ months Never

Spoke clearly \_\_\_\_\_\_\_ months Never

Lost language \_\_\_\_\_\_\_ months Never

Lost eye contact \_\_\_\_\_\_\_ months Never

#### MEDICATIONS

##### CURRENT MEDICATIONS

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication | Dose | Frequency | Start Date (month/year) | Reason For Use |
|  |  |  |  |  |
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##### PREVIOUS MEDICATIONS: *Last 10 years*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication | 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 |
|  |  |  |  |  |
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Have medications or supplements ever caused your child unusual side effects or problems? Yes No

Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? Yes No

Has your child had prolonged or regular use of Tylenol? Yes No

Has your child had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.) 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*

Age (if still alive)

Age at death (if deceased)

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 (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 (such as alcoholism)

Psychiatric Disorders

Depression

Schizophrenia

ADHD

Autism

Bipolar Disease

Other

Mother

Father

Brother(s)

Sister(s)

Maternal

Grandmother

Maternal

Grandfather

Paternal

Grandmother

Paternal

Grandfather

Aunts

Uncles

Children

#### 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:*

* 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.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Height (feet/inches)\_\_\_\_\_\_\_\_\_\_  Longest Weight Fluctuations Yes No |  | Current Weight \_\_\_\_\_\_\_\_\_\_ |

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 * Drinks soda or diet soda * Cow’s Milk 1 2 3+ * Caffeine intake * TV or videos with meals * Challenges with food served outside the home   (Ex. childcare, friend’s home) |

##### BREASTFED HISTORY

Breastfed? Yes No How long? \_\_\_\_\_\_\_\_ Problems latching on? Yes No

Sucking quality? Very Good Good Poor Exclusively breastfed for \_\_\_\_\_\_\_\_ months

##### BOTTLE FED HISTORY

Bottle fed? 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.

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 that you have regarding your child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### ACTIVITY

**Type**

**Amount Daily**

*Li*

*st type and amount of activity 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** | | |
|  |  | Mold in bathroom |
|  |  | Damp cellar |
|  |  | Pest extermination - Inside |
|  |  | Pest extermination - Outside |
|  |  | Forced hot air heat |
|  |  | Had water in basement |
|  |  | Mold visible on exterior of house |
|  |  | Heavily wooded or damp surroundings |

*  Mold in cellar, crawl space, or basement
*  Moldy, musty school/daycare
*  Tobacco smoke
*  Well water
*  Carpet in bedroom
*  Carpet in most parts of house   Feather or down bedding

##### 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 peoples feelings
* OK if parents leave
* Answers parent
* Follows instructions
* Pronounces words well
* Unusual memory
* Perfect musical pitch
* Good with math
* Good with computer
* Good with fine work
* Good throwing and catching
* Good climbing
* Strong desire to do things
* Swimming
* Bold, free of fear
* Likes to be held
* Likes 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 unusually large
* Unusually long eye lashes
* Pupils unusually small
* Dark circles under eyes
* Red lips
* Red fingers
* Red toes
* Webbed toes
* Red ears
* Double jointed
* High arched palate
* Lymph nodes enlarged neck
* Head warm
* Head sweats
* Night sweats
* Abnormal fatigue
* Failure to thrive
* Cold all over
* Cold hands and feet
* Cold intolerance
* Hands/feet - very sweaty
* Head very hot/sweaty
* Night sweats
* 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
* Strong body odor
* Acne
* Dark circle 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 or lines in nails
* Dry skin in general
* Feet cracking
* Feet peeling
* Hands cracking
* 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
* Abdominal bloating
* Lower abdominal bloating
* Colic
* Abdomen distended
* Abdominal pain
* Intestinal parasites
* Pinworms
* Crampy pain with pooping
* Constipation
* Diarrhea
* 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 intol.
* 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 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 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/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
* Eye contact poor
* Isolates
* Negative
* Fright without cause
* Always frightened
* Anguish
* Discontented
* Does not want to be touched
* Inconsolable crying
* Irritable
* Looks like in pain
* Moaning, groaning
* Phobias
* Restless
* Severe mood swings
* Unhappy
* Agitated
* Anxious

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##### 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’ feelings
* Unaware of self as person
* Upset if things change
* Upset of 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 held 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
* 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
* Occas. 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 @ 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
* Breath holding
* Bronchitis
* Congestion chg. 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 urgency
* Dry at night
* Seizures - focal
* Seizures - generalized
* Seizures - grand mal
* Seizures - petit mal
* Unusually 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 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*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, e-mail correspondence) from our professional staff would be helpful to you as you implement your childs health program? - 5 4 3  2 1 Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## 3-DAY 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 e.g., milk - what kind? (whole, 2%, nonfat); toast (whole wheat, white, buttered); chicken (fried, baked, breaded), coffee (decaffeinated, with sugar, ½ & ½).
* Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, 1/2 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 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TIME**

**FOOD/BEVERAGE/AMOUNT**

**COMMENTS**

DAY 2

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** 2 = Occasionally have, effect is severe

0 = Never or almost never have the symptom 3 = Frequently have it, effect is not severe 1 = Occasionally 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, ear infections  \_\_\_ Drainage from ear  \_\_\_ Ringing in ears, hearing loss *Total* \_\_\_\_\_\_\_  **EMOTIONS**  \_\_\_ Mood swings  \_\_\_ Anxiety, fear or nervousness  \_\_\_ Anger, irritability or aggressiveness  \_\_\_ 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 under eyes \_\_\_ Blurred or tunnel vision (does not include near- or far-sightedness)  *Total* \_\_\_\_\_\_\_ | **HEAD**  \_\_\_ Headaches \_\_\_ Faintness  \_\_\_ Dizziness \_\_\_ Insomnia  *Total* \_\_\_\_\_\_\_  **HEART**  \_\_\_ Irregular or skipped heartbeat  \_\_\_ Rapid or pounding heartbeat  \_\_\_ Chest pain  *Total* \_\_\_\_\_\_\_  **JOINTS/MUSCLES**  \_\_\_ Pain or aches in joints  \_\_\_ Arthritis  \_\_\_ Stiffness or limitation of movement \_\_\_ Pain or aches in muscles  \_\_\_ Feeling of weakness or tiredness *Total* \_\_\_\_\_\_\_  **LUNGS**  \_\_\_ Chest congestion  \_\_\_ Asthma, bronchitis  \_\_\_ Shortness of breath  \_\_\_ Difficult breathing *Total* \_\_\_\_\_\_\_  **MIND**  \_\_\_ Poor memory  \_\_\_ Confusion, poor comprehension  \_\_\_ Poor concentration  \_\_\_ Poor physical coordination  \_\_\_ Difficulty in making decisions  \_\_\_ Stuttering or stammering  \_\_\_ Slurred speech  \_\_\_ Learning disabilities  *Total* \_\_\_\_\_\_\_ | **MOUTH/THROAT**  \_\_\_ Chronic coughing  \_\_\_ Gagging, frequent need to clear throat \_\_\_ Sore throat, hoarseness, 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, or dry skin \_\_\_ Hair loss  \_\_\_ Flushing or hot flushes  \_\_\_ 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 TO QUESTIONNAIRE

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

• Optimal is less than 10 • Mild Toxicity: 10-50 • Moderate Toxicity: 51-100 • Severe Toxicity: over 100