Date of Initial Consultation: _____ Who is present at initial consult: _____
[The above is for office use only]

Name of patient: _____ ____ Male ____ Female _____Wt _____Ht
Date of birth: _____ Age ___
Physician/Pediatrician:_____ Allergies: _____
Who has legal custody?_____

Name of mother: _____ Mother's employer: _____
Mother's home phone: _____ Work: _____ Cell: _____
Email address: _____
Address: _____
_____

Name of Father: _____ Father's employer: _____
Father's home phone: _____ Work: _____ Cell: _____
Address: _____
_____

Emergency contact: (Name and phone)

Name of Specialists: _____ Institution: _____

List any diagnoses or explanations you have been given for your child:
_____

Who provided the diagnosis? _____

Age at time of diagnosis: ___

Do the biological siblings have any diagnoses? _____

What are your goals with us today? _____

Is your child on any time-release, delayed-release, or extended-release medication? _____

Does your child have a Medicaid card? ___Y ___N The Title 19 Waiver Program? ___ Y___N

Is/Was your child in the Birth to Three Program? ___Y ___N

Please bring copies of any tests or lab work that have been done for your child.
Please attach a toddler photo and a current photo if possible.

A. Maternal Health (Biological Mother)

1. Y__ N__ Is this your biological child?
   (*If no, please answer numbers 2-7 for the biological mother if you have the Information; otherwise go on to Section B)*
2. Y__ N__ History of miscarriages. If yes, how many? _____
3. _____ Number of "silver" dental fillings (amalgams) at time of pregnancy
4. Y__ N__ Did you have any new silver fillings put in, or any old ones repaired or removed during the pregnancy?
5. Y__ N__ Did you receive any vaccinations during the pregnancy?
6. Y__ N__ Did you receive any flu shots during the pregnancy? How many? _____
7. _____ Mother's Rh status, if known (+ or -)
8. Y__ N__ Did you ever receive Rhogam shots? How many? _____
9. Y__ N__ Mother's thyroid status: (Circle) Normal Hyperthyroid Hypothyroid (Low)
10. Y__ N__ Diabetic

11. Mother's occupation before and during pregnancy: _____
12. During the pregnancy, did you use any: (All answers are kept strictly confidential)
    Y__ N__ Street Drugs Please list: _____
    Y__ N__ Alcohol
    Y__ N__ Cigarettes How many packs a day? _____
    Y__ N__ Prescription Drugs Which ones: _____
    Y__ N__ Were you on SSRI's? (For depression or anxiety)

B. The Pregnancy

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

C. The Birth

1. __Vaginal
   __C-Section Reason: _____
   __VBAC(Vaginal Birth after C-Section)
2. Y__ N__ Was labor induced?
3. Y__ N__ Medications used during labor:_____
4. Y__ N__ Medications used during delivery: _____
5. Y__ N__ Full term
6. Y__ N__ Premature If yes, how many weeks early? _____
7. ___/___ APGAR Scores (Or do you remember if they were they good or poor? _____)
8. Birth weight: _____
9. Complications: _____
   _____
   _____
10. Y__ N__ Was there any concern for birth trauma?

11. Medications given to baby at the hospital: _____
    _____

12. Y__ N__ Did the baby receive any antibiotics at the hospital?

D. Infancy/Toddler Years Birth to 2 years of age(attach 2 photos if possible)

1. Y__ N__ Breastfed? For how long? _____
2. Y__ N__ Bottle-fed?
3. Y__ N__ Difficulty latching on?
4. Y__ N__ Difficulty swallowing?
5. _____ At what age were foods introduced?
6. Y__ N__ Excessive drooling?
7. Y__ N__ Poor head control - "Floppy baby"? (Low muscle tone)
8. Y__ N__ Colic or reflux
9. Y__ N__ Would "crash" when sick→got dehydrated or even hospitalized.
10. Y__ N__ History of thrush? (White overgrowth in mouth) How many times? ___
11. Y__ N__ History of strep How many times? ___ Antibiotics? Y__ N__
12. Y__ N__ Ear infections How many times? ___ Antibiotics? Y__ N__

13. Y__ N__ Seizures?
14. Y__ N__ Vaccine reactions. Describe: _____
15. Y__ N__ Asthma
16. Y__ N__ Known allergies List: _____
17. Y__ N__ Prone to diaper rash
18. Y__ N__ Prone to body rashes Location: _____
19. Y__ N__ Red ring around the anus/cracking/bleeding

20. Texture of bowel movements:(Age 2 years and younger)

__ hard "rabbit pellets"
__ enormous rock hard bowel movements
__ formed, hard
__ formed, soft (normal)
__ "mashed potatoes"
__ diarrhea
__ diarrhea **and** constipation

21. Describe sleep habits as an infant and as a toddler:
_____

22. How often were the bowel movements as an infant? _____
23. Y__ N__ Had to use laxatives or stool softeners
24. Y__ N__ Hospitalized for constipation at age 2 years or younger
25. Y__ N__ Bowel movements were very foul smelling
26. Y__ N__ Excessively gassy
27. Y__ N__ Gas was very foul-smelling
28. Y__ N__ Caught a lot of colds as an infant

29. List any surgeries or procedures, age 2 or younger: _____

30. CDC's Developmental Health Watch (by 12 months) **Circle all that apply.**

- Does not crawl
- Drags one side of body while crawling (for over one month)
- Cannot stand when supported
- Does not search for objects that are hidden while he or she watches
- Says no single words ("mama" or "dada")
- Does not learn to use gestures, such as waving or shaking head
- Does not point to objects or pictures
- Experiences a dramatic loss of skills he or she once had.

31. CDC's Developmental Health Watch (by 24 months) **Circle all that apply.**

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

32. Choose from the following three scenarios:
    ____ Your child hit milestones and spoke on time, then abruptly changed and was "lost".
    ____ Your child was never really right from birth, didn't hit milestones or speak on time.
    ____ Your child was developing normally, and then just hit a plateau. (no abrupt change)
    ____ Other: _____

33. Y__ N__ If your child had speech and then lost it at some point
    Age when speech was lost: _____
    Describe: _____

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

35. Y__ N__ Good eye contact? Circle one: Excellent Good Fair Poor None
36. Y__ N__ Known genetic disorders
37. Y__ N__ Known metabolic disorders

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

1. What is your child's primary form of communication? (Example: Speaking, Proloquo2Go, PECS, etc.)
   _____

2. Please check all that apply:
   __ Does your child speak now?
   __ Does your child understand what is being said to him?
   __ Does he/she express needs and wants?
   __ Does he use "I want" statements?
   __ Will he/she go get items that you ask for?
   __ Does he answer by repeating your question?
   __ Does he/she initiate conversations?

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

   __ 0 words, mumbles, makes some noises
   __ 1-2 words in a row
   __ 3-4 words in a row
   __ 1 sentence at a time
   __ 2-3 sentences in a row
   __ Many sentences in a row
   __ Language is highly developed, and appropriate
   __ A "wall" of one-way conversation, always talking, doesn't need you to answer
   __ Can sustain a back-and-forth conversation, not just reply to questions

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

Sensory:

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

Vision Therapy Screening Section:

1. Y__ N__ Good eye contact Circle one: Excellent Good Fair Poor None (1a)
2. Y__ N__ Finger stimming/flapping right in front of eyes
3. Y__ N__ Does he or she do any sideways glancing?
4. Y__ N__ Holds toys up very close to eyes, or just above or to the side of eyes
5. Y__ N__ Head frequently tilted to one side
6. Y__ N__ History of Lazy Eye Which eye? Circle: R L
7. Y__ N__ Has had the lazy eye corrected with surgery
8. Y__ N__ Are eyes crossed? (Strabismus)
9. Y__ N__ Has dyslexia
10. Y__ N__ Other visual impairments List: _____
11. Y__ N__ Avoids homework, has been called “lazy”
12. Y__ N__ Is very intelligent, but makes poor grades in school
13. Y__ N__ Skips over lines when reading
14. Y__ N__ Dislikes or avoids reading
15. Y__ N__ Dislikes movies in 3-D
16. Y__ N__ Is careful on the stairs, holds the rail, one foot at a time, sits down to do stairs, etc.
17. Y__ N__ Catches a ball easily and accurately
18. Y__ N__ Ball Refusal - Turns away from the ball to avoid being hit by it
19. Y__ N__ Sometimes trips or stumbles over nothing; tends to be clumsy
20. Y__ N__ Sometimes bumps into the door frame when going through a doorway
21. Y__ N__ Has had prism lenses or Vision Therapy? When? _____

Learning:

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

GI and Immune:

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

Dysbiosis Screening:

1. Y__ N__ Silly, "drunken" laughter when nothing is funny
2. Y__ N__ Cheeks have bumpy red patches.
3. Y__ N__ Red ring around the anus
4. Y__ N__ Rectal or vaginal itching
5. Y__ N__ Cracking or peeling hands or feet
6. Y__ N__ Ridged, discolored nails or toenails
7. Y__ N__ Jock itch or athlete's foot

8. Check all that apply:
   ___ Wet hair smells funny or like a wet dog
   ___ Scalp is crusty or flaky
   ___ Dry flaky skin around the ears, eyebrows or nose
   ___ Persistent cradle cap

9. Y__ N__ Urinary tract infections How many? ___
10. Y__ N__ Kidney infections
11. Y__ N__ Frequently grabs penis or vaginal area
12. _____ How many rounds of antibiotics has your child had in their entire life?
13. Y__ N__ Has used Diflucan, Nystatin or other antifungals. How many times? _____
14. Y__ N__ Spaced out, foggy, in a different world
15. Y__ N__ Cravings for desserts and sugary foods
16. Y__ N__ Depression or irritability

Name:

Tics and Obsessive Tendencies:

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

Mitochondrial screening section:

Y__ N__ Poor muscle tone
Y__ N__ Curved back, "C" shape when sitting
Y__ N__ Difficulty knowing self in space
Y__ N__ Tires easily
Y__ N__ Eye-hand coordination is poor
Y__ N__ Joints are hyper-flexible
Y__ N__ Expressive and Receptive speech is poor
Y__ N__ "Crashes" when they get sick→gets dehydrated or even hospitalized?

Sleep Patterns: (check all that apply) Usual Bedtime: _____
Wake-up Time: _____

__ Falls asleep easily
__ Difficulty falling asleep Circle one: Always Frequently Occasionally Never
__ Once asleep, stays asleep all night and body is peaceful and calm
__ Once asleep, stays asleep all night but body is restless, tosses and turns (covers all torn up)
__ Awakens once a night, and goes right back to sleep
__ Frequent night awakenings
__ Does not go back to sleep easily
__ Not unusual to "be up for the day" at extremely early hour, e.g. 2 or 3 a.m.
__ Other, describe: _____
__ Sleeps in own bed
__ Sleeps with parents
__ Sleeps more than normal
__ Sleeps less than normal

1. Y__ N__ Moans or cries in sleep
2. Y__ N__ Sweat at night
3. Y__ N__ Nightmares
4. Y__ N__ Night terrors
5. Y__ N__ Sleep walks
6. Y__ N__ Takes melatonin How much? _____
7. Y__ N__ Takes Clonidine or other prescription medication for sleep
8. Y__ N__ Uses Essential Oils for sleep Circle one: Diffused into air Rubbed into skin
9. How many caffeinated drinks are consumed each day? _____

Miscellaneous:

1. What is your child's exercise level?
    Y__ N__ Completely sedentary
    Y__ N__ Not much exercise
    Y__ N__ Moderate level of exercise
    Y__ N__ High level of exercise
    Y__ N __ Plays on a sports team Which sport? _____

Name:

2. Y__ N__ History of being sexually, physically or verbally abused (Circleall that apply)
3. Y__ N__ Headaches Describe: _____
4. Y__ N__ Visual Hallucinations
5. Y__ N__ Auditory Hallucinations

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

Vegetables: _____ Fruits: _____
_____ _____
_____ _____
_____ _____

Dairy: _____ Meats: _____
_____ _____
_____ _____
_____ _____

Snacks: _____ Seeds _____
_____ Nuts _____
_____ Beans _____
_____ Legumes _____

Breads, pastas, pizzas, rice, etc: _____
_____
_____

1. Y__ N__ Difficulty swallowing
2. Y__ N __ Difficulty chewing
3. Y__ N__ Picky eater
4. Y__ N__ Artificial sweeteners
5. Y__ N__ Attitude or mood changes after meals

6. Foods that are demanded or wanted every day:_____

7. If your child were on a desert island, which 3 foods would he take with him?

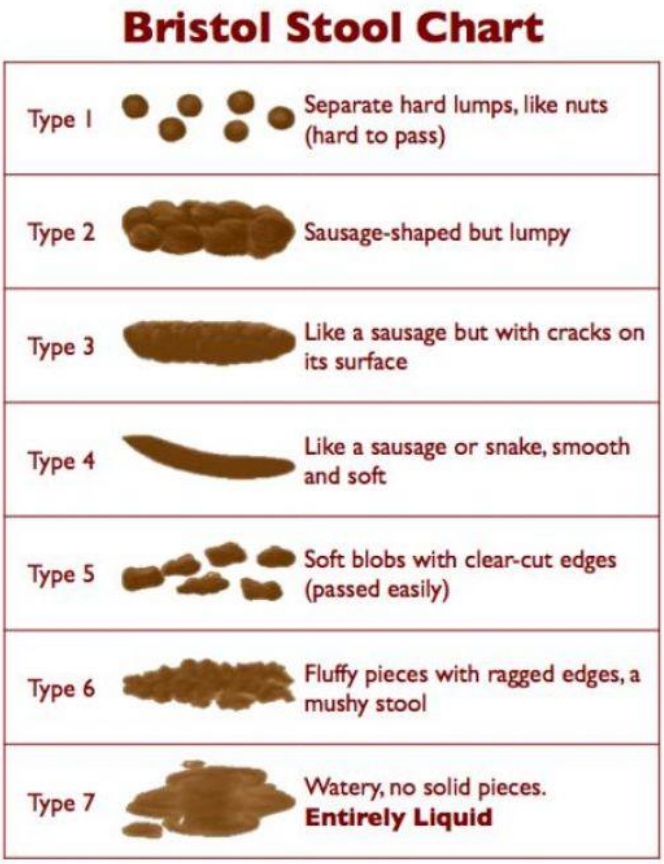
8. Y__ N__ Drinks a lot of milk. (white/chocolate/strawberry) # of glasses per day: _____
How much would he/she drink if you let him have all he wanted?_____

9. Y__ N__ Ever been on the Gluten-free/Casein-free Diet For how long?_____
Was it done strictly? _____ What happened? _____

10.Y__ N__ Any other diets? (Specific Carbohydrate, Feingold Diet, Low Oxalate Diet, Candida)

Bowel Habits:

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



Check all that apply:

__ Enormous bowel movements
__ Diarrhea **and** constipation
__ Don't know, don't go in with him/her anymore
__ Undigested food present in stools
__ Mucus in the stools
__ Sandy or gritty-looking stools
__ Sticky stools, or child has trouble cleaning self after BM, uses too much toilet paper

12. Y__ N__ Do you give any enemas, suppositories, laxatives, etc?
13. Y__ N__ Does your child have to crouch/perch on the toilet seat to have a bowel movement?
14. How often does he or she have a bowel movement? _____
15. Y__ N__ Foul-smelling bowel movements (more than "normal")
16. Y__ N__ Gassiness
17. Y__ N__ Foul-smelling gas

18. What does his/her breath smell like?

__ Not bad
__ Like freshly baked bread
__ Stinky, bad
__ Just like poop

Name:

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

Reflux screening section:

Y__ N__ Has known reflux
Y__ N__ Swallows or clears throat frequently
Y__ N__ Has the tooth enamel been eroded by gastric acid?
Y__ N__ Facial grimacing
Y__ N__ Gritting teeth
Y__ N__ Wincing
Y__ N__ Sighing, groaning
Y__ N__ Burping
Y__ N__ Pacing around the house, hyperactive, jumping up and down
Y__ N__ Puts off going to sleep
Y__ N__ Frequent waking at night
Y__ N__ Falls asleep propped up in bed, propped up on couch, or bent over a pillow

Seizures:

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

Signs of zinc deficiency:

Y__ N__ Has white dots or lines on fingernails
Y__ N__ Acne/sparse hair/psoriasis
Y__ N__ Canker sores
Y__ N__ Chews on toys, objects, clothing

Signs of a magnesium deficiency:

Y__ N__ Muscle twitches/tingling
Y__ N__ Sighing
Y__ N__ Salt craving
Y__ N__ Chews on toys, objects, clothing

Signs of an essential fatty acid deficiency:

Y__ N__ Keratosis pilaris
Y__ N__ Dry, coarse hair

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

___ Speech
___ Physical Therapy
___ Occupational
___ ABA
___ Counseling
___ Anger Management
___Floor Time
___ Other
___ Son Rise
___ Vision Therapy
___ Social Skills
___ Sensory Integration
___ Light Therapy
___ Music Therapy
___ Listening therapy
___ Relationship Development Intervention

Which therapies have helped the most? _____

Dental:

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

Focus, Attention and Impulsivity:

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

Name:

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

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

Peer Relationships and Behavioral Difficulties:

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

Unusual Behaviors:

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

Intellectual Status: (Your best estimate)

__ Has a diagnosis of "ID" (Intellectual Disability) (Formerly known as Mental Retardation)
__ Below average intelligence
__ Average intelligence
__ Above average intelligence
__ Superior intelligence
__ Genius

Name:

Female Health:(if applicable)

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

Emotional Difficulties:

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

2. Y__ N__ Ever had full psychological testing and evaluation (Axis 1-V)?
   Please include a copy of the report.

3. Y__ N__ Does he/she ever run away?

4. Y__ N__ Ever been in a residential treatment center?
   Name of facility: _____
   Reason: _____

5. Y__ N__ Ever been arrested?
   How many times? _____
   Reason: _____

Maturity:

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

Life Skills:

Y__ N__ Can bathe self
Y__ N__ Can dress self
Y__ N__ Can brush own teeth
Y__ N__ Can help with light housekeeping chores (dishes, vacuuming, dusting)
Y__ N__ Can do own laundry
Y__ N__ Can do some cooking
Y__ N__ Can cross the street safely and unassisted
Y__ N__ Is aware of “Stranger Danger”
Y__ N__ Has a driver’s license
Y__ N__ Is a college student
Y__ N__ Attends a technical school
Y__ N__ Is employed full-time
Y__ N__ Is employed part-time
Y__ N__ Has a sheltered job

Home Situation:

1. How many homes does the child live in, or divide time between? _____

2. If more than one home, will both homes be cooperative with treatment plans? _____

3. Please describe any difficult family situations which may hinder treatment:

4. Who lives in the primary home?
   - __ Mother__ Grandmother
   - __ Father__ Grandfather
   - __ Stepmother__ Others List: _____
   - __ Stepfather _____
   - __ Girlfriend_____
   - __ Boyfriend_____
   - __ Brothers Ages: _____
   - __ SistersAges: _____

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

6. What county is the school in? _____

Family history:(Please check all that apply)

__ Allergies
__ Alzheimer's
__ Asthma
__ Autism
__ Celiac disease
__ Chronic Fatigue syndrome
__ Crohn's disease
__ Eczema Yeast problems
__ Fibromyalgia
__ Genetic disorders
__ Irritable Bowel Syndrome
__ Lupus
__ Multiple Sclerosis
__ Obsessive Compulsive disorder
__ Parkinson's
__ Seizures
__ Tic disorders
__ Thyroid disorders
__ Tourette disorder
__ Ulcerative colitis
__ Wheat (gluten) sensitivity

Medication/Supplement Log
List all prescription and over-the-counter supplements
Date:_____

Prescriptions:

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

Over-The-Counter Supplements:

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

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

_____

_____

Revised March 2018

Name: