

The Spring Center

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Internal Medicine

Integrative Medicine

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Pediatrics

General Information

Name *First* _____ *Middle* _____ *Last* _____

Preferred Name _____

Date of Birth _____ Age _____ Gender _____

Genetic Background (circle all that apply):

African European Native American Mediterranean

Asian Ashkenazi Middle Eastern Other: _____

Highest Education level: _____

Job Title: _____

Nature of Business: _____

Primary Address: _____

Billing Address: _____

Preferred Phone: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

E-mail: _____

Emergency Contact

Name _____ *Relationship* _____

Address _____ *Phone:* _____

City _____ *State* _____ *Zip* _____

Primary Care Physician

Name _____ *Phone:* _____

Address _____ *Fax :* _____

City _____ *State* _____ *Zip* _____

Pharmacy Information

Primary Pharmacy

Name _____ *Phone* _____

Address _____ *Fax** _____

City _____ *State* _____ *Zip* _____

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

Compounding/Supplement Pharmacy

Name _____ *Phone* _____

Address _____ *Fax** _____

City _____ *State* _____ *Zip* _____

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

Pediatric Medical Questionnaire

Allergies

<u>Medication/Supplement/Food</u>	<u>Reaction</u>

Complaints & Concerns

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

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

1. _____
2. _____
3. _____

When was the last time you 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
<i>Example: Difficulty Maintaining Attention</i>		X		<i>Elimination Diet</i>	X		

Medical History

Check box if yes and provide date and details if applicable

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 BP) _____
- Rheumatic Fever _____
- Mitral Valve Prolapse _____
- Other _____

Metabolic/Endocrine

- Type 1 Diabetes _____
- Type 2 Diabetes _____
- Hypoglycemia _____
- Metabolic Syndrome (Insulin resistant or pre-diabetic) _____
- Hypothyroidism (low) _____
- Hyperthyroidism (overactive) _____
- Endocrine Problems _____
- PCOS _____
- Weight Gain _____
- Weight Loss _____
- Frequent Weight Fluctuations _____
- Bulimia _____
- Anorexia _____
- Binge Eating Disorder _____
- Night Eating Syndrome _____
- Eating Disorder (non-specific) _____
- Other _____

Genital and 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 Infections Disease _____
- Poor Immune Function (Frequent infection) _____
- 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 _____

Cancer

- Other _____

Skin Diseases

- Eczema _____
- Psoriasis _____
- Acne _____
- Other _____

Neurologic/Mood

- Depression _____
- Anxiety _____
- Bipolar Disorder _____
- Schizophrenia _____
- Headaches _____
- ADD/ADHD _____
- Sensory Integrative Disorder _____
- Autism _____
- Mild Cognitive Impairment _____
- Multiple Sclerosis _____
- ALS _____
- Seizures _____
- Other _____

Medical History Continued

Previous Evaluations

Check box if yes and provide date and details if applicable

- Full Physical Exam _____
- Psychological Evaluations _____
- Wechsler Preschool & Primary Scale of Intelligence _____

- Speech and Language Evaluations _____
- Genetic Evaluation _____
- Neurological Evaluation _____
- Vision Evaluation _____
- Osteopathic _____
- Acupuncture _____
- Physical Therapy _____
- Occupational Therapy _____
- Sensory Integration Therapy _____
- Language Class _____
- Sign Language _____
- Homeopathic _____
- Naturopathic _____
- Craniosacral _____
- Chiropractic _____
- MRI _____
- CT Scan _____
- Upper Endoscopy _____
- Upper GI Series _____
- Ultrasound _____
- Other _____

Hospitalizations None

Date	Reason
_____	_____
_____	_____
_____	_____
_____	_____

Injuries

Check box if yes and provide date and details if applicable

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

Surgeries

Check box if yes and provide date and details if applicable

- Appendectomy _____
- Circumcision _____
- Hernia Repair _____
- Tonsillectomy _____
- Adenoidectomy _____
- Dental Surgery _____
- Tubes in Ears _____
- Other _____

Blood Type: A B AB O 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.

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 counselling for your child? Yes No

Is your child or family currently in therapy? Yes No

If so, please describe: _____

Does your child have a favorite toy or object? Yes No

Does your child practice any relaxation techniques? Yes No

Circle 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? _____

Does your child have trouble falling asleep? Yes No

Does your child feel rested upon awakening? Yes No

Does your child snore? Yes No

Roles/Relationships

List family members:

Family Member and Relationship	Age	Gender

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

What are their occupations? _____

Who does your child get emotional support from?

Check all that apply: Family Friends Religious/Spiritual Pets Other: _____

Gynecologic History

Menstrual History

Age at first period: _____ Menses Frequency: : _____ Length: : _____ Pain: Yes No Clotting: Yes No

Has your period ever skipped? Yes No If so, for how long? _____

Last Menstrual Period? _____

Does your child use Contraception? Yes No If so, what type? _____

GI History

Has your child traveled to foreign countries? Yes No Where? _____

Wilderness camping? Yes No Where? _____

Ever had severe Gastroenteritis? _____

Ever had severe Diarrhea? _____

Dental History

Silver Mercury Fillings? Yes No If so, how many?

Circle all that apply: 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: _____ Age at birth: _____

Mother's Pregnancy

Check box if yes and provide description if applicable

- | | |
|---|--|
| <input type="checkbox"/> Difficulty getting pregnant (more than 6 months) | <input type="checkbox"/> Group B strep infection _____ |
| <input type="checkbox"/> Infertility drugs used Specify: _____ | <input type="checkbox"/> Have c-section because of _____ |
| <input type="checkbox"/> In vitro fertilization _____ | <input type="checkbox"/> Use induction for labor (such as Pitocin) _____ |
| <input type="checkbox"/> Drink alcohol _____ | <input type="checkbox"/> Have anesthesia- what was used? _____ |
| <input type="checkbox"/> Drink coffee _____ | <input type="checkbox"/> Use oxygen during labor _____ |
| <input type="checkbox"/> Smoke tobacco _____ | <input type="checkbox"/> Have an x-ray _____ |
| <input type="checkbox"/> Take Progesterone _____ | <input type="checkbox"/> Have Rhogam, if so how many shots _____ |
| <input type="checkbox"/> Take prenatal vitamins _____ | How many when pregnant? _____ |
| <input type="checkbox"/> Take antibiotics during Labor? _____ | <input type="checkbox"/> Gestational Diabetes _____ |
| <input type="checkbox"/> Take other drugs Specify: _____ | <input type="checkbox"/> High blood pressure (pre-eclampsia) _____ |
| <input type="checkbox"/> Excessive vomiting, nausea (more than 3 weeks) _____ | <input type="checkbox"/> High blood pressure/toxemia _____ |
| <input type="checkbox"/> Have viral infection _____ | <input type="checkbox"/> Have chemical exposure _____ |
| <input type="checkbox"/> Have a yeast infection _____ | <input type="checkbox"/> Father have chemical exposure _____ |
| <input type="checkbox"/> Have amalgam fillings put in teeth _____ | <input type="checkbox"/> Move to a newly built house _____ |
| <input type="checkbox"/> Have amalgam fillings removed from teeth _____ | <input type="checkbox"/> House painted indoors _____ |
| <input type="checkbox"/> Number of fillings in teeth when pregnant? _____ | <input type="checkbox"/> House painted outdoors _____ |
| <input type="checkbox"/> Have bleeding (which months?) _____ | <input type="checkbox"/> House exterminated for insects _____ |
| <input type="checkbox"/> Have birth problems _____ | |

Pregnancy

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

Please describe diet during pregnancy: _____

Please describe labor: _____

Perinatal

Pregnancy Duration:

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 few months? Yes No

Antibiotics first month? Yes No

Experienced no complications first month of life? Yes No

Birth Weight and APGAR

Weight at birth: _____ lbs APGAR score at one minute: _____ APGAR score at 5 minutes: _____

Early Childhood Illnesses

Number of ear aches in the first two years: _____

Number of other infections in the first two years: _____

Number of times antibiotics were taken in first two years of life: _____

Number of courses of prophylactic antibiotics in first two years of life: _____

First antibiotic at _____ month(s)

First illness at _____ month(s)

Description of Developmental Problems

If your child has developmental problems, at what age did they occur? _____

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 or strong? _____

Developmental History

Please indicate the approximate age in months for the following milestones

Sitting up _____ month(s) Never

Crawling _____ month(s) Never

Pulled to stand _____ month(s) Never

Potty trained _____ month(s) Never

Walked alone _____ month(s) Never

Dry at night _____ month(s) Never

First words _____ month(s) Never

Spoke clearly _____ month(s) Never

Lost language _____ month(s) Never

Lost eye contact _____ month(s) Never

Medications

CURRENT MEDICATIONS

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

PREVIOUS MEDICATIONS *Last 10 years*

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

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Supplication & Brand	Dose	Frequency	Start Date (month/year)	Reason For Use

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

<i>Check Family members that apply</i>	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunt	Uncle	Other
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 Spondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Diseases (such as Lupus)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												

Nutrition History

Has your child ever had a nutrition consultation?

Have you made any changes in your child's diet because of health problems?

Does your child follow a special diet or nutritional program?

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 (Ex. Peanuts, Eggs, etc.): _____

Current Weight _____ Height (feet/inches) _____ Weight fluctuations? Yes No

Does your child avoid any particular foods? Yes No If yes, types and reason: _____

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

Who does the shopping in your household? _____

Who does the cooking in your household? _____

How many meals does your child eat out per week? _____

Check all the factors that apply to your current lifestyle and eating habits:

- | | |
|--|--|
| <input type="checkbox"/> Fast eater | <input type="checkbox"/> Most family meals together |
| <input type="checkbox"/> Erratic eating pattern | <input type="checkbox"/> Use food as a bribe or reward |
| <input type="checkbox"/> Eat too much | <input type="checkbox"/> Erratic mealtimes |
| <input type="checkbox"/> Dislike healthy food | <input type="checkbox"/> Most meals eaten at the table |
| <input type="checkbox"/> Time constraints | <input type="checkbox"/> High juice intake |
| <input type="checkbox"/> Eat more than 50% of meals away from home | <input type="checkbox"/> Low fruit/vegetable intake |
| <input type="checkbox"/> Poor snack choices | <input type="checkbox"/> High sugar/sweet intake |
| <input type="checkbox"/> Sensory issues with food | <input type="checkbox"/> Drinks soda or diet soda |
| <input type="checkbox"/> Picky eater | <input type="checkbox"/> Drinks cow's milk |
| <input type="checkbox"/> Limited variety of foods <5/day | <input type="checkbox"/> Caffeine intake |
| <input type="checkbox"/> Prefers cold food | <input type="checkbox"/> TV or videos with meals |
| <input type="checkbox"/> Prefers hot food | <input type="checkbox"/> Challenges with food served outside the home (Ex. childcare, friend's home) |
| <input type="checkbox"/> Every meal is a struggle | |

Breast fed history

Breastfed? Yes No If yes, how long? _____ Problems latching? Yes No

How long was your child exclusively breast fed? _____

Bottle fed History

Bottle Fed? Type of formula: Soy Cow's milk Low Allergy

Introduction of cow's milk at _____ month(s) Introduction of solid foods at _____ month(s)

First foods introduced _____ month(s) Choke/vomit/gas on milk? Yes No Refused to chew solids? Yes No

List mother's known food allergies or sensitivities: _____

Please describe any other eating concerns you have regarding your child: _____

Activity

List type and amount of activity daily.

Type	Amount Daily
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

How much time does your child spend watching tv? _____

How much time does your child spend on the computer or playing video games? _____

Environmental History

- | | |
|--|--|
| <input type="checkbox"/> Mold in bathroom | <input type="checkbox"/> Pest extermination- inside |
| <input type="checkbox"/> Damp/moldy basement/crawl space | <input type="checkbox"/> Pest extermination- inside |
| <input type="checkbox"/> Sprinkler hits outside of house | <input type="checkbox"/> Tobacco smoke |
| <input type="checkbox"/> Pest extermination - Outside | <input type="checkbox"/> Well water |
| <input type="checkbox"/> Had water in basement | <input type="checkbox"/> Carpet in bedroom |
| <input type="checkbox"/> Mold visible on exterior of house | <input type="checkbox"/> Carpet in most parts of house |
| <input type="checkbox"/> Heavily wooded or damp surroundings | <input type="checkbox"/> Feather or down bedding |
| | <input type="checkbox"/> Forced hot air heat |

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

- Accepts new clothes
- Cuddly
- Physically coordinated
- Happy
- Pleasant/easy to care for
- Sensitive/affectionate
- Wants to be liked
- Responsible
- Draws accurate pictures
- Sensitive to people's feelings
- OK if parents leave
- Answers parent
- Follows instructions
- Pronounces words well
- Unusual memory
- Perfect musical pitch
- Good with math
- Good with computers
- Good throwing and catching
- Good at 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)
- Wakes up screaming/crying
- Wakes up 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

- Unusual 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 finger nails
- 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 lack luster
- 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

- Colds sores on lips, face
- Geographic tongue
- 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 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 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

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 people's feelings
- Unaware of self as person
- Upset if things change
- Upset if things aren't right
- Adopts complicated rituals
- Car, truck, train obsession
- Collects particular things
- Draws only certain things
- Fixated on one topic
- Lines objects precisely
- Repeats old phrases
- Repetitive play/objects
- Fingertip 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
- 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
- Unusual fast heart beat
- Heart murmur
- Headaches
- Joint pains
- Leg pains
- Muscle pains

Readiness Assessment

Rate on a scale from 1-5. 5 being 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 (i.e. Work demands, sleep habits etc.) 5 4 3 2 1

Practicing a relaxation technique 5 4 3 2 1

Engaging in regular exercise 5 4 3 2 1

Have periodic lab tests to assess progress 5 4 3 2 1

Comments: _____

Rate on a scale from 1-5. 5 being 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 from 1-5. 5 being 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 from 1-5. 5 being very frequent contact to 1 very infrequent contact

How much on-going support and contact (i.e. telephone consults, questions etc.) from our professional staff would be helpful to you as you implement your child's health program? 5 4 3 2 1

Comments: _____

MSQ Medical Symptom/ Toxicity Questionnaire

The Toxicity and Symptom screening questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps track your child's progress overtime. Rate each of the following symptoms based up on your child's health profile for the past 30 days.

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
___ 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
___ 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/urgent urination
___ Genital itch or discharge
Total _____

Grand Total _____

Key to Questionnaire – Add individual scores and total each group. Add each group score and give a grand total

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

3-DAY DIET DIARY INSTRUCTIONS

It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan. Please complete this Diet Diary for 3 consecutive days including one weekend day.

- Describe the food or beverage as accurately as possible e.g., milk - what kind? (whole, 2%, nonfat); toast (whole wheat, white, buttered); chicken (fried, baked, breaded); coffee (decaffeinated with sugar and ½ & ½).
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, ½ cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
- Record all beverages, including water, coffee, tea, sports drinks, sodas/diet sodas, etc.
- Include any additional comments about your eating habits on this form (ex. craving sweet, skipped meal and why, when the meal was at a restaurant, etc).
- Please note all bowel movements and their consistency (regular, loose, firm, etc.)

DIET DIARY DAY 1

Name: _____ Date: _____

Daily Exercise (Type of Activity / Time of Day / Duration): _____

Daily Bowel Movements: _____

TIME	FOOD / BEVERAGE / AMOUNT	COMMENTS

DIET DIARY DAY 2

Name: _____ Date: _____

Daily Exercise (Type of Activity / Time of Day / Duration): _____

Daily Bowel Movements: _____

TIME	FOOD / BEVERAGE / AMOUNT	COMMENTS

DIET DIARY DAY 3

Name: _____ Date: _____

Daily Exercise (Type of Activity / Time of Day / Duration): _____

Daily Bowel Movements: _____

TIME	FOOD / BEVERAGE / AMOUNT	COMMENTS

