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Global Naturopath & GN Health Foods

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Directions for completing Children's Intake form

Welcome to Global Naturopath……

"A place where Parents and Professionals work together"

Carefully look over the History form and plan to fill out each page per day if felt necessary. Both parents should fill the form, as this might include the views and observations of both parents which are very crucial. Make a point to fill the form in as much detail as possible. The more detail the history form, the more the healthcare professional can know about your child.

Feel free to write in the margins or at the back of the questionnaire and to add detailed observations where appropriate for your child.

Don't be overwhelmed with the form; it is a dedication, which will help you also understand in detail a lot better about your child's problems and concerns. We together i.e parents and professionals can make a difference in your child.

Note: Please fill the Questionnaire and either email, fax or mail the form a week before you Initial evaluation. Please either attach or bring additional evaluation or medical reports for your child.

Children's Medical Questionnaire

Appointment Date _____
Appointment Time _____

Patient Profile

Child's Name _____
Date of birth _____ (MM/DD/YY) **Social Security #** _____**Sex M F**
Address: _____
Telephone (_____) _____
Child's Height _____ **Child's Weight** _____

What Diagnosis or explanation have you been given in the past about your child?

_____

_____

How did you hear about this Clinic? _____

Parent's Profile

Father's Name_____
Place of Birth_____
Current Address_____
Home Phone_____ **Work Phone**_____ **Cell Phone**_____
E-mail Address: _____

Mother's Name_____
Place of Birth_____
Current Address_____
Home Phone_____ **Work Phone**_____ **Cell Phone**_____
E-mail Address: _____

May we leave messages relating to your visits? ☐ No ☐ Yes

A note to our patients: **Please complete this questionnaire as thoroughly as possible. This is a confidential record and will not be released, except when you have provided us with written authorization to do so. Thank you.**

Who else lives at your house?

Name	Age	Relationship	Occupation
1.			

2. _____
3. _____

Who are the main people who look after the child?

1. _____
2. _____
3. _____

What Pets live with you (indoors and outdoors)?

_____
_____

When and where have you lived or travelled outside the US, since birth?

_____
_____
_____

Prenatal History

Check what all are applicable during the pregnancy

☐Planned pregnancy	☐Spotting	☐Nausea
☐Candida	☐Infections	☐Diabetes
☐Heartburn	☐Smoking	
☐Thyroid problems	☐Flu or cold	

Did the mother have any of the following during pregnancy?

☐ Emotional problems	☐ Infections	☐ Premature Labor
☐ Gained more than 35 pounds	☐ Bed-rest	☐ Toxemia
☐ Difficulty in conception	☐ Anemia	☐ Rashes
☐ Excessive swelling	☐ Vaginal bleeding	☐ Measles/German measles
☐ Excessive nausea/vomiting	☐ Flu	☐ High blood pressure
☐ Kidney disease	☐ Strep Throat	☐ Threatened miscarriage
☐ Rh incompatibility	☐ Headaches	☐ Severe cold
☐ Urinary problems	☐ Other virus	

☐ Special diet, describe: _____

☐ On any Medications:_____

☐ Other:_____

Mother's age at conception: _____

Did the mother have previous pregnancies? ☐ No ☐ Yes--**how many, including miscarriages?** _____

Did mother receive prenatal care during this pregnancy? ☐ No ☐ Yes--**beginning at month**_____

During the pregnancy, was the baby: ☐ Very active ☐ Average ☐ Rather quiet

Were there any unusual changes in the baby's activity level during pregnancy?
☐ No ☐ Yes

Did the mother receive a flu shot during your pregnancy? ☐ No ☐ Yes

Did the mother receive flu shots while you were breastfeeding? ☐ No ☐ Yes

Delivery History and Details

Was infant born full-term? ☐ Yes ☐ No
If premature- how early? If overdue- how late? _____
Birth weight:_____ **Birth Height** _____
Type of anesthetic used: ☐ None ☐ Spinal ☐ Local ☐ General

Length of active labor: Describe any complications during delivery
_____
_____
_____

Check all of the following that applied to the delivery
☐ Spontaneous ☐ Breech ☐ Forceps
☐ Head first ☐ Multiple births ☐ Cord around neck
☐ Induced; Reason: _____
☐ Cesarean; Reason: _____

Which of the following applied to the infant? (Check all that apply)
☐ Breathing problems ☐ Required oxygen ☐ Required incubator
☐ Jaundice at birth--Were Bilirubin lights used? ☐ No ☐ Yes – How long? _____
☐ Feeding problems ☐ Sleeping problems ☐ Infection
☐ Rash ☐ Excessive crying ☐ Seizures/convulsions
☐ Unusual appearance, describe: _____
☐ Bleeding into the brain _____

Did the infant require: ☐ X-Rays ☐ CT scans ☐ Blood transfusions
☐ Placement in the NICU, If so, for how long? _____

Length of stay in hospital: Mother _____Infant _____

Early Childhood History

During child's first three years, were any special problems noted in the following areas?

☐ Irritability	☐ Breathing problems	☐ Colic
☐ Difficulty sleeping	☐ Eating problems	☐ Temper tantrums
☐ Failure to thrive	☐ Excessive crying	☐ Withdrawn behavior
☐ Poor eye contact	☐ Early learning problems	☐ Destructive behavior
☐ Convulsions/Seizures	☐ Twitching	☐ Separation anxiety

☐ Other_____

_____

_____

_____

Indicate at what age in (months and years) when child reached his or her milestones

_____ sat unaided	_____ crawled	_____ walked
_____ Smiling	_____ Laughing	_____ Rolling Over
_____ Standing	_____ started solid foods	_____ fed self with spoon
_____ gave up bottle	_____ Bladder trained-day	_____ bladder trained-night
_____ bowel trained	_____ rides tricycle	_____ rides bike

Did your child ever have a regression? Describe it in detail, according to you what caused it, and what skills lost.

_____

_____

_____

_____

_____

Did your child had sleep Issues, when was an infant. Describe, how long would sleep without waking up straight.

_____

_____

_____

_____

Was it difficult to calm your child when infant? Did you see constant crying and hard to satisfy?

_____

_____

Present General Health

Current Weight: _____
Current Height: _____
Has the child gained or lost any weight in the past 6-12 months? Y N
If yes how much? _____

How would you describe the general state of health of your child (please circle one)?
Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates of your child, since birth.

_____
_____
_____
_____
_____
_____
_____

Any known allergies to medicines, environmental, dietary etc.?

_____
_____
_____
_____

Please list all current medications your child is taking (prescription or over-the-counter)

_____
_____
_____
_____

Please list past prescription medications and approximate age when child has taken them

No.	Medication Name	Dose (if known)	Approx. Start Date	Reason for Taking It	Approx. End Date

Approximately how many times have you been treated with antibiotics, and for what reasons? What antibiotics were used?

_____
_____
_____
_____
_____

Please indicate what immunizations you have had

☐ **DPT (diphtheria, pertussis, tetanus)** ☐ **HIB** ☐ **Hepatitis A**
☐ **Tetanus booster; date? _____** ☐ **"Flu"** ☐ **Hepatitis B**
☐ **MMR (measles, mumps, rubella)** ☐ **Polio** ☐ **Smallpox**

Other _____
_____

Please indicate any adverse reactions in response to any of these vaccines. Did you see any regressions after Vaccination?

_____
_____
_____
_____
_____

Diagnosis, Testing and Evaluations History

Type of doctor's seen, approximate dates, diagnosis, tests and treatments suggested/ given

No.	Dr's Name	Doctor Specialty	Approx. Date Seen	Diagnosis given	Tests performed	Test results

Laboratory tests done previously, also include results summary

No.	Name of Test	Doctor who ordered the test	Approx. Date Done (month/year)	Results	Reason for Taking It

Current Concerns about your child

Please check all that apply

- ☐ aggression
- ☐ over activity
- ☐ preoccupations
- ☐ hitting
- ☐ sleeps in parents' bed
- ☐ argumentative
- ☐ won't take baths
- ☐ wets the bed
- ☐ school adjustment
- ☐ motor skills
- ☐ has few friends
- ☐ language difficulties
- ☐ temper tantrums
- ☐ self-injury
- ☐ has nightmares
- ☐ easily distracted
- ☐ appetite/food selections
- ☐ pulls out own hair
- ☐ cruel to animal
- ☐ depressed or anxious
- ☐ has no friends
- ☐ toilet training
- ☐ biting
- ☐ sleep problems
- ☐ nervousness
- ☐ self-help skills
- ☐ Chewing objects
- ☐ inattentive
- ☐ low muscle tone
- ☐ inappropriate sexual behavior
- ☐ self-stimulatory behaviors: rocking, spinning, flapping hands, visual scrutiny

Others_____

_____

What is the biggest problem with your child? How long is this problem for and what you think caused it?

1._____
2. _____
3. _____
4. _____
5. _____
6. _____

What seems to upset your child?

_____

_____

What seems to calm your child?

_____

_____

Please list other health care providers you are seeing, in reference to your child. Include the Primary Care Physician Information.

1. _____

_____

(_____)_____

2.

_____

_____

(_____)_____

3.

_____

Present Development History

Language development
Indicate age when child begin babbling, such as repeating syllables, in attempts to communicate

_____
Using single words? _____
Using phrases/short sentences? _____
Have there been any hearing concerns? ☐No ☐Yes Hearing testing – date?

Adaptive Skills

Feeds self	☐No	☐Yes, beginning at age _____
Dresses self	☐No	☐Yes, beginning at age _____
Bathes self	☐No	☐Yes, beginning at age _____
Helps with household chores	☐No	☐Yes, beginning at age _____
Knows first and last name	☐No	☐Yes, beginning at age _____
Says "please" and "thank you"	☐No	☐Yes, beginning at age _____
Able to walk up/down stairs	☐No	☐Yes, beginning at age _____

Has the child ever lost skills, which at one time he/she was able to perform?
☐No ☐Yes
If yes, please explain_____

When your child is disruptive or misbehaves, what steps are you likely to take to deal with the problem?
☐Time out ☐Loss of allowance/privileges
☐Physical punishment ☐Yelling
☐Ignoring ☐ Grounding
☐Other, describe
_____

Who is mainly in charge of discipline?
_____
_____

What do you find most difficult about raising your child?
_____
_____
_____

Past and Present Behavior Checklist

CHECKLIST: Please mark in each area that describe your child currently or in the past. Please also include if these symptoms are seen in any family members from mother or father side, mark the relationship to the patient.

General

Past	Current	Past	Current
☐	☐ Cold hand and feet	☐	☐ Cold Intolerance
☐	☐ High Fever	☐	☐ Heat Intolerance
☐	☐ Fatigue	☐	☐ Difficulty falling asleep
☐	☐ Night walking	☐	☐ Daytime Sleeplessness, Lethargy
☐	☐ Headaches	☐	☐ Hand Banging
☐	☐ Sense of Taste Distorted	☐	☐ Rocking

Muscular Responses

Past	Current	Past	Current
☐	☐ Calf Cramps	☐	☐ Foot Cramps
☐	☐ Constant Movement	☐	☐ Muscle Twitches around eyes
☐	☐ Muscle twitches in legs	☐	☐ Muscle Twitches Arms
☐	☐ Chest Tightness	☐	☐ Tics
☐	☐ Tension Headaches	☐	☐ Muscle Spasm in Neck,
☐	☐ Muscle Spasm in shoulder/Back	☐	☐ Muscle weakness
☐	☐ Muscle pain	☐	☐ Muscle Stiffness
☐	☐ Muscle Tremor	☐	☐ Touch aversion
☐	☐ Limb Apraxia		

Mood and nerves

Past	Current	Past	Current
☐	☐ Anxiety	☐	☐ Irritability
☐	☐ Depression	☐	☐ Panic Attacks
☐	☐ Hyperactivity	☐	☐ Phobias
☐	☐ Fearfulness	☐	☐ Sighing
☐	☐ Suicidal Thoughts	☐	☐ Light-headiness
☐	☐ Dizzy (Spin)	☐	☐ Fainting
☐	☐ Seizures	☐	☐ Difficulty concentrating
☐	☐ Difficulty maintaining balance	☐	☐ Difficulty with thinking
☐	☐ Difficulty with Judgment	☐	☐ Difficulty with short term memory
☐	☐ Difficulty with long term memory	☐	☐ Learning Problems
☐	☐ Tingling	☐	☐ Constant eye blinking
☐	☐ Toe walking		
☐	☐ Stereotype movements: circle, arm flapping, jumping, spinning, rocking etc.		

Eyes health

Past	Current		Past	Current	
☐	☐	Conjunctivitis	☐	☐	Eye Pain
☐	☐	Distorted Vision	☐	☐	Eye Crushing
☐	☐	Lid Margins red	☐	☐	Itchiness
☐	☐	Sensitivity to Sunlight	☐	☐	Frequent blinking
☐	☐	Poor eye-hand coordination	☐	☐	Blurred Vision
☐	☐	Watering	☐	☐	Granulated lids
☐	☐	Burning sensation	☐	☐	Puffiness under eyes
☐	☐	Mucous in eyes	☐	☐	Rubbing eyes
☐	☐	Cross eyedness	☐	☐	Dilated pupils
☐	☐	Turns eyes to read/ draw	☐	☐	Poor acuity
☐	☐	Deep set eyes	☐	☐	Loss of lateral eye movement
☐	☐	Rocks back and forth	☐	☐	Wrinkles under eyes
☐	☐	Blood spots in eyes	☐	☐	Dark circle under eyes
☐	☐	Swollen eyes	☐	☐	Dryness in eyes
☐	☐	Development Optometry	☐	☐	Diptopia (double vision)
☐	☐	Spots/flashes before eyes	☐	☐	Rocks side to side
☐	☐	Swelling between eyebrows	☐	☐	Very long eyelashes
☐	☐	Pupils react sluggishly to light	☐	☐	Squints eyes frequently
☐	☐	Brownish stain on outer iris	☐	☐	Turns head and squints one eye to see
☐	☐	Looks from corner of eyes	☐	☐	Eyes worst from Season Allergies

Ear Health

Past	Current		Past	Current	
☐	☐	Ear Pain	☐	☐	Ear Infections
☐	☐	Ear ringing	☐	☐	Ear Noises
☐	☐	Hearing Loss	☐	☐	Auditory Processing Difficulties
☐	☐	Sensitivity to loud sound	☐	☐	Ear Fullness
☐	☐	Frequent ear infections	☐	☐	Nerve deafness
☐	☐	Sense of imbalance	☐	☐	Pain in ears
☐	☐	Fluid accumulation	☐	☐	Tubes in ears
☐	☐	Eustachian block	☐	☐	Crusting
☐	☐	Uneven skin around ears	☐	☐	Prominent ears
☐	☐	Red ear lobes	☐	☐	Dizziness
☐	☐	Wears hearing aid	☐	☐	Itching inside ears
☐	☐	Drainage	☐	☐	Hearing on/off
☐	☐	Pressure inside ears	☐	☐	Ruptured ear drums
☐	☐	Excessive wax problems	☐	☐	Eczema behind ears
☐	☐	Soft cartilage around ears	☐	☐	Ear problems with seasonal allergies

Speech and Language (Receptive and Expressive)

Past	Current	
☐	☐	slow speech development
☐	☐	Slurs speech
☐	☐	Uses baby talk
☐	☐	unusual tone or pitch
☐	☐	repeats words/ phrases
☐	☐	difficult to understand speech
☐	☐	seldom speaks unless prompted
☐	☐	Echolalia
☐	☐	has language of his or her own (may sound like foreign language/jargon)
☐	☐	repeats questions, instead of answering them
☐	☐	repeats dialogue from movies or songs verbatim
☐	☐	does not understand without gestures
☐	☐	Speech comprehension deficits
☐	☐	Few words in vocabulary
☐	☐	Articulation problems
☐	☐	Receptive language delays
☐	☐	Expressive language delays
☐	☐	Word processing or retrieval problems
☐	☐	Incorrect use of words
☐	☐	Poor Verbal Comprehension
☐	☐	Language improved with auditory training
☐	☐	Drooling interferes with speech
☐	☐	Improper vowel sounds
☐	☐	Stuttering
☐	☐	High Pitch to speech
☐	☐	Child screams or shrieks
☐	☐	Follows one step directions
☐	☐	Follows two step directions
☐	☐	Follows multiple steps directions

Answer all that applies

Describe child's receptive language

_____

_____

Decribe child's expressive speech

_____

Relating with other people

Past	Current	Past	Current
☐	☐ Lack of eye contact	☐	☐ prefers to be by self
☐	☐ "in a world of his/her own"	☐	☐ aloof, distant
☐	☐ Social withdrawal	☐	☐ Social Skills deficits
☐	☐ Shyness	☐	☐ clings to people
☐	☐ fearful of strangers	☐	☐ not cuddly as baby
☐	☐ does not like to be held	☐	☐ doesn't recognize parent

☐ ☐ does not play with other children
☐ ☐ prefers playing with younger or older children
☐ ☐ Wants others to behave in his or her own way
☐ ☐ Is not able to understand when people pick on him or her
☐ ☐ Learns from peer role models
☐ ☐ Prefers to be around only siblings

Imitation

Past	Current
☐	☐ doesn't imitate waving "bye-bye" or "patty cake" etc. (physical imitation)
☐	☐ doesn't repeat words or things said to him
☐	☐ doesn't repeat words generally**,** but usually did what he was asked to do
☐	☐ Imitation skills are good, learns from imitations
☐	☐ Learns from peer role models

Response to Sounds, Speech

Past	Current
☐	☐ often ignores sounds
☐	☐ often ignores what is said to him/her
☐	☐ afraid of certain sounds
☐	☐ really likes certain sounds (music, motors, etc.)
☐	☐ seems to hear distant or soft sounds that most other people don't hear or notice
☐	☐ unpredictable response to sounds (sometimes reacts, sometimes doesn't)
☐	☐ responds to speech and sounds like other children of the same age

Visual Response

Past	Current
☐	☐ stares vacantly around room
☐	☐ plays with turning lights on and off
☐	☐ often doesn't look at things
☐	☐ distracted by lights – stares at certain lights
☐	☐ likes to look at self in mirror
☐	☐ very interested in small parts of an object
☐	☐ likes to look at shiny objects
☐	☐ looks at things out of the corners of eyes
☐	☐ stares at parts of his/her body (e.g. hands)
☐	☐ often avoids looking at people when they are talking to him

Eating Issues

Past	Current		Past	Current	
☐	☐	Can't loose weight	☐	☐	Can't gain weight
☐	☐	Poor appetite	☐	☐	Food craving issues
☐	☐	Food Intolerance	☐	☐	Salt craving
☐	☐	Bread cravings	☐	☐	Chocolate cravings
☐	☐	Diet soda cravings	☐	☐	Juice cravings
☐	☐	Milk cravings	☐	☐	Likes one type or texture of foods
☐	☐	Craves sugar	☐	☐	Craves pizza or other cheese product
☐	☐	Oral motor issues	☐	☐	Does not chew on food
☐	☐	Throwing up after meal	☐	☐	Difficulty swallowing foods
☐	☐	Hates to touch foods that are of different textures			

Digestion Issues

Past	Current		Past	Current	
☐	☐	Thrush	☐	☐	Teeth grinding
☐	☐	Bloody gums	☐	☐	Periodontal disorder
☐	☐	Dry mouth	☐	☐	Geographic tongue
☐	☐	Sore tongue	☐	☐	Canker sores
☐	☐	Cold sores	☐	☐	Sore throat
☐	☐	Swollen lymph nodes	☐	☐	Nausea
☐	☐	Vomiting	☐	☐	Upper abdomen pain
☐	☐	Lower abdomen pain	☐	☐	Bloating of upper abdomen
☐	☐	Bloating: lower abdomen	☐	☐	Burping
☐	☐	Farting	☐	☐	Diarrhea
☐	☐	Constipation	☐	☐	Undigested foods in stool
☐	☐	Mucous in stool	☐	☐	Blood in stool
☐	☐	Hemorrhoids	☐	☐	Anal Spasms
☐	☐	Colic	☐	☐	Heartburn
☐	☐	Indigestion	☐	☐	Ulcers
☐	☐	Craves Sweet	☐	☐	Holds back bowel movement
☐	☐	Smears feces	☐	☐	Stool strong bad smell
☐	☐	Stool is large bulky	☐	☐	Stool is soft and mushy
☐	☐	Stool floats in water toilet	☐	☐	Bowel more than 3 times per day

Skin Issues and Problems

Past	Current		Past	Current	
☐	☐	Psoriasis	☐	☐	Eczema
☐	☐	Hives	☐	☐	Rashes
☐	☐	Cradle cap	☐	☐	Bumps on upper arms
☐	☐	Acne on back	☐	☐	Acne on face
☐	☐	Acne on chest	☐	☐	Acne on shoulders
☐	☐	Easy bruising	☐	☐	Dark circles under eyes
☐	☐	Patchy dullness	☐	☐	Thick callousness
☐	☐	Oily skin	☐	☐	Read face hair
☐	☐	Pale skin	☐	☐	Ears got red
☐	☐	Sensitive to bug bites	☐	☐	Itching of scalp

Skin in general_____

Nails Analysis

Past	Current		Past	Current	
☐	☐	Habit of nail biting	☐	☐	Nails are soft
☐	☐	Nails brittle	☐	☐	thickening of finger nails
☐	☐	Thickening of toe nails	☐	☐	fungus foot
☐	☐	Fungus fingers	☐	☐	ridges in nails
☐	☐	Ragged cuticles			

Sensory Issues- Hearing and Visual

Light Sleep	☐never	☐occasionally	☐frequently	☐consistently
Poor balance	☐never	☐occasionally	☐frequently	☐consistently
Makes loud noises	☐never	☐occasionally	☐frequently	☐consistently
Over sensitivity to sound	☐never	☐occasionally	☐frequently	☐consistently
High pitch sound	☐never	☐occasionally	☐frequently	☐consistently
Low pitch sound	☐never	☐occasionally	☐frequently	☐consistently
Whistles sound	☐never	☐occasionally	☐frequently	☐consistently
Shrieks	☐never	☐occasionally	☐frequently	☐consistently
Vocalizes	☐never	☐occasionally	☐frequently	☐consistently
Moves towards sound	☐never	☐occasionally	☐frequently	☐consistently
Inappropriate Laughing	☐never	☐occasionally	☐frequently	☐consistently
Receptive Speech is problem	☐never	☐occasionally	☐frequently	☐consistently
Tearing and mouthing paper	☐never	☐occasionally	☐frequently	☐consistently
Slamming doors	☐never	☐occasionally	☐frequently	☐consistently
Flushing toilet	☐never	☐occasionally	☐frequently	☐consistently
Q-tip in ears is problem	☐never	☐occasionally	☐frequently	☐consistently
Waves fingers in front of eyes	☐never	☐occasionally	☐frequently	☐consistently
Poor depth perception	☐never	☐occasionally	☐frequently	☐consistently
Frequent tearing	☐never	☐occasionally	☐frequently	☐consistently
Distracted with visual input	☐never	☐occasionally	☐frequently	☐consistently
Tracks moving objects	☐never	☐occasionally	☐frequently	☐consistently
Confuses left and right	☐never	☐occasionally	☐frequently	☐consistently
Tilts head a lot during work	☐never	☐occasionally	☐frequently	☐consistently
Squints, covers one eye	☐never	☐occasionally	☐frequently	☐consistently
Dislikes light	☐never	☐occasionally	☐frequently	☐consistently
Double vision	☐never	☐occasionally	☐frequently	☐consistently
Clumsy	☐never	☐occasionally	☐frequently	☐consistently
Stares at bright light/sun	☐never	☐occasionally	☐frequently	☐consistently

Sensory Issues- Touch

Hair cut is a problem	☐never ☐occasionally ☐frequently ☐consistently
Fingernails being cut, is problem	☐never ☐occasionally ☐frequently ☐consistently
Hand Biting	☐never ☐occasionally ☐frequently ☐consistently
Feeling textures	☐never ☐occasionally ☐frequently ☐consistently
Head Banging	☐never ☐occasionally ☐frequently ☐consistently
Toe walking	☐never ☐occasionally ☐frequently ☐consistently
Grasps things too tight	☐never ☐occasionally ☐frequently ☐consistently
Scratches constantly	☐never ☐occasionally ☐frequently ☐consistently
Pinches self	☐never ☐occasionally ☐frequently ☐consistently
Relaxes in odd positions	☐never ☐occasionally ☐frequently ☐consistently
Resists wearing certain texture clothes	☐never ☐occasionally ☐frequently ☐consistently
Pulls off clothes	☐never ☐occasionally ☐frequently ☐consistently
Leg shaking	☐never ☐occasionally ☐frequently ☐consistently
Withdraws from touch	☐never ☐occasionally ☐frequently ☐consistently
Withdraws from touch	☐never ☐occasionally ☐frequently ☐consistently
Bumps into objects	☐never ☐occasionally ☐frequently ☐consistently
Rubs head against objects	☐never ☐occasionally ☐frequently ☐consistently
Hands in pants	☐never ☐occasionally ☐frequently ☐consistently
Stands too close to others	☐never ☐occasionally ☐frequently ☐consistently
Refuses to undress	☐never ☐occasionally ☐frequently ☐consistently
Rubs spots after being touched	☐never ☐occasionally ☐frequently ☐consistently
Tactile defensiveness	☐never ☐occasionally ☐frequently ☐consistently
Rocks back and forth	☐never ☐occasionally ☐frequently ☐consistently
Drops objects easily	☐never ☐occasionally ☐frequently ☐consistently
Grinds teethes at night	☐never ☐occasionally ☐frequently ☐consistently
Slaps self	☐never ☐occasionally ☐frequently ☐consistently
Pinches others	☐never ☐occasionally ☐frequently ☐consistently
Shivers when not even cold	☐never ☐occasionally ☐frequently ☐consistently
Likes to hand onto furniture	☐never ☐occasionally ☐frequently ☐consistently
Twirling in circle	☐never ☐occasionally ☐frequently ☐consistently
Arm flapping	☐never ☐occasionally ☐frequently ☐consistently
Touch objects and others	☐never ☐occasionally ☐frequently ☐consistently
Falls or trips often	☐never ☐occasionally ☐frequently ☐consistently
Self abusive behaviors	☐never ☐occasionally ☐frequently ☐consistently
Masturbation	☐never ☐occasionally ☐frequently ☐consistently
Pushes on pants and sleeves	☐never ☐occasionally ☐frequently ☐consistently
Resists grooming	☐never ☐occasionally ☐frequently ☐consistently
Hides under table	☐never ☐occasionally ☐frequently ☐consistently
Pulls hair or self or others	☐never ☐occasionally ☐frequently ☐consistently
Hesitancy on stairs and ramps	☐never ☐occasionally ☐frequently ☐consistently
Scratches teethes on palm of hands	☐never ☐occasionally ☐frequently ☐consistently
Rubs hands together	☐never ☐occasionally ☐frequently ☐consistently
Aggressive towards others	☐never ☐occasionally ☐frequently ☐consistently
Heads for highest spot/climbs	☐never ☐occasionally ☐frequently ☐consistently
Hides head under blanket	☐never ☐occasionally ☐frequently ☐consistently
Feeling textures	☐never ☐occasionally ☐frequently ☐consistently
Likes being tightly tied up	☐never ☐occasionally ☐frequently ☐consistently

Likes being tickled by others	☐never ☐occasionally ☐frequently ☐consistently
Likes swinging	☐never ☐occasionally ☐frequently ☐consistently
Likes swimming and water activities	☐never ☐occasionally ☐frequently ☐consistently
Likes hair being washed	☐never ☐occasionally ☐frequently ☐consistently
Sensitive to exposure to heat	☐never ☐occasionally ☐frequently ☐consistently
Sensitive to exposure to cold	☐never ☐occasionally ☐frequently ☐consistently
Likes finger play	☐never ☐occasionally ☐frequently ☐consistently
Likes deep pressure	☐never ☐occasionally ☐frequently ☐consistently
Sensitive to being touched	☐never ☐occasionally ☐frequently ☐consistently
Wedges self in tight spaces	☐never ☐occasionally ☐frequently ☐consistently
Likes amusement rides	☐never ☐occasionally ☐frequently ☐consistently

Sensory Issues- Smell

Sniffs foods before eating	☐never ☐occasionally ☐frequently ☐consistently
Sniffs non-food items	☐never ☐occasionally ☐frequently ☐consistently
Keen sense of smell	☐never ☐occasionally ☐frequently ☐consistently
Doesn't responds to smell	☐never ☐occasionally ☐frequently ☐consistently
Hand blowing	☐never ☐occasionally ☐frequently ☐consistently
Breadth holding	☐never ☐occasionally ☐frequently ☐consistently
Stuffs objects in nose	☐never ☐occasionally ☐frequently ☐consistently
Rapid breathing thru nose	☐never ☐occasionally ☐frequently ☐consistently
Pinches nostrils	☐never ☐occasionally ☐frequently ☐consistently
Sniffs other people	☐never ☐occasionally ☐frequently ☐consistently
Sniffs feces	☐never ☐occasionally ☐frequently ☐consistently
Plays with urine	☐never ☐occasionally ☐frequently ☐consistently
Sensitive to cigars and cigarettes	☐never ☐occasionally ☐frequently ☐consistently
Sensitive to bleach and ammonia	☐never ☐occasionally ☐frequently ☐consistently
Sensitive to gasoline	☐never ☐occasionally ☐frequently ☐consistently
Sensitive to sulfur and vinegar	☐never ☐occasionally ☐frequently ☐consistently

Sensory Issues- Smell

Strong food preference	☐never ☐occasionally ☐frequently ☐consistently
Drooling problems	☐never ☐occasionally ☐frequently ☐consistently
Stuffs food in mouth	☐never ☐occasionally ☐frequently ☐consistently
Mouths objects	☐never ☐occasionally ☐frequently ☐consistently
Bothered by food texture	☐never ☐occasionally ☐frequently ☐consistently
Bothered by food temperature	☐never ☐occasionally ☐frequently ☐consistently
Thumbsucking	☐never ☐occasionally ☐frequently ☐consistently
Licks Objects	☐never ☐occasionally ☐frequently ☐consistently
Spits	☐never ☐occasionally ☐frequently ☐consistently
Will eat feces	☐never ☐occasionally ☐frequently ☐consistently

Family Medical and Psychiatric History

Have any members of the biological mother's or biological father's families had any of the following problems or disorders (check all that apply and state who had them)

Check all applies	Relation to Patient who has these symptoms
☐ Birth Defect	
☐ Chromosomal/genetic disorder	
☐ Obsessive Compulsive Disorder	
☐ Cerebral Palsy	
☐ Severe head injury	
☐ High blood pressure	
☐ Kidney disease	
☐ Migraine headaches	
☐ Multiple Sclerosis	
☐ Physical handicap	
☐ Nervousness/Anxiety	
☐ Stroke	
☐ Tuberous Sclerosis	
☐ Alzheimer's disease	
☐ Hemophilia	
☐ Huntington's chorea	
☐ Muscular dystrophy	
☐ Parkinson's disease	
☐ Sickle-cell anemia	
☐ Cancer	
☐ Seizures/epilepsy	
☐ Diabetes	
☐ Heart disease	
☐ Food allergies	
☐ Alcohol/drug abuse	
☐ Depression	
☐ Physical/Sexual abuse	
☐ Schizophrenia	
☐ Mental Retardation	
☐ Speech/language delay	
☐ Autism/PDD	
☐ Reading problem	
☐ Other learning disability	
☐ Emotional disturbance/mental illness	
☐ Bipolar/manic-depressive disorder	
☐ Tics/Tourette's syndrome	
☐ Antisocial Behavior (assaults, thefts, arrests)	
☐Childhood behavior disorder (aggressive/defiant/ADHD)	
☐Other:	

Early Childhood Intervention (ECI)

If child under the age 3 years, Please bring copies of your most recent ECI Individual Family Service Plan (IFSP), and relevant reports to your appointment.

Is your child currently a client of ECI? ☐ Yes ☐ No (skip to Private Services)

Which ECI Center: _____

Define the Eligibility category:_____

Child's age when ECI services began: _____

Which services is your child currently receiving through which regional center

☐ Speech therapy
☐ Occupational therapy
☐ Physical therapy
☐ Adaptive Physical Education
☐ Discrete Trial Training (DTT/ABA)
☐ Social Skills
☐ Others Define_____

Please describe in detail about your child's academic Performance, any concerns you have. Please bring a recent copy of child's IEP or 504 or any additional documents pertaining to your child's academics at school and at home.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Vitamins, Minerals or Other Nutritional Supplements

List all the supplements child is currently taking or taken in past. List all the Supplements in as much detail as possible (including mg, IU, form….)

No.	Supplements	Date Started	Date Stopped	Dosage	Response Seen

****Attach additional Sheet if applicable.**

Diet and Nutrition Profile

List special diets Currently Implemented and Effects seen after the diet.

_____
_____
_____
_____
_____
_____
_____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

_____
_____
_____

Do you live in area, where water is Soft_____ Hard_____ don't know_____
(Note: Hard water makes no suds easily)

Does the child eat lot of sugar on daily basis (include all the treats)? This includes soda, candy, ice creams, white bread, cookies …….

_____
_____
_____

Does the child diet includes (answer if child is very young, else N/A)
☐ **Breast Milk** ☐ **Formulas** ☐ **Cereals** ☐ **Fruits & Vegetables**

Does your child drinks more than once per day? If yes, then what milk he is on? Describe

_____

What foods you had to avoid in the past, as they gave symptoms like gas/ diarrhea etc.

_____
_____

Is there something special about your child's eating or drinking habit that is a challenge?

_____
_____

Is there any particular food or food type that your child craves? And if any reactions noted after consuming the food.

_____
_____
_____
_____

Describe a typical day's Diet of your child

Days/Meal	Breakfast	Lunch	Snack	Dinner
Day 1				
Day 2				
Day 3				
Day 4				
Day 5				
Day 6				
Day 7				

- **Please attach a separate sheet if applicable.**
- **In above table, include the beverages consumed.**
- **In above table, also add, the lunch taken to school (including snacks, drinks etc.)**

Personal and Family History (check "yes" if you have had the condition/Is the condition past or current/If a family member had the condition- please list who i.e. Mother, aunt, grandfather.

Conditions	Relationship to Person	Present state of Person
Allergies		
Asthma		
Heart Disease		
Drug/ Alcoholism		
Colitis Kidney Disease		
Depression		
High Blood Pressure		
Thyroid		
Diabetes		
Obesity		
Arthritis		
Allergies/Hay		
Liver Disease		
Mental Illness		
Cancer		
Colon Cancer		
Breast Cancer		
Stroke		
Scarlet Fever		
Lyme Disease		
Tuberculosis		
Eczema		
Hepatitis		
Anemia		

Is there anything that you feel is important that has not been covered?

_____

_____

_____