THE SPRING CENTER

Kelly K. McCann, MD

Pediatric Medical Questionnaire

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

Medication/Supplement/Food	Reaction

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
Example: Difficulty Maintaining Attention		X		*Elimination Diet*	X		

Synopsis/Health History

Please use this page or your own to write a chronological history of your health journey up to this point. Please include important details and dates, if possible, of symptoms, occurrences, exposures etc. This will greatly help our Practitioners understand your background before you come in for your first appointment.

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_____

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

Hospitalizations ☐ None

Date	Reason

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

Smoking:

Currently Smoking? ☐ Yes ☐ No
If Yes: ☐ Cigarettes ☐ Cigars ☐ Vaping ☐ Marijuana
How many years?_____How many/much per day: _____Attempts to quit: _____
Previous Smoking: Howmany years?_____Quantity per day? _____
Second Hand Smoke Exposure? _____

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

- ☐ Difficulty getting pregnant (more than 6 months)
- ☐ Infertility drugs used Specify: _____
- ☐ Invitrofertilization _____
- ☐ 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 (which months?) _____
- ☐ Have birth problems _____
- ☐ Group B strep infection _____
- ☐ Have c-section because of _____
- ☐ Use induction for labor (such as Pitocin) _____
- ☐ Have anesthesia- what was used? _____
- ☐ 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 _____

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 scoe 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

Check Family members that apply	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:

☐ Fast eater
☐ Erratic eating pattern
☐ Eat too much
☐ Dislike healthy food
☐ Time constraints
☐ Eat more than 50% of 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
☐ Drinks cow's milk
☐ Caffeine intake
☐ TV or videos with meals
☐ Challenges with food served outside the home (Ex. childcare, friend's home)

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 using a screen (this incudes watching TV, on a computer/laptop/ipad/tablet, using a smart phone, playing video games etc.)_____

Environmental History

- ☐ Mold in bathroom
- ☐ Damp/moldy basement/crawl space
- ☐ Sprinkler hits outside of house
- ☐ Well water
- ☐ Had water in basement
- ☐ Mold visible on exterior of house
- ☐ Heavily wooded or damp surroundings
- ☐ Pest extermination- inside
- ☐ Pest extermination- outside
- ☐ Tobacco smoke
- ☐ Carpet in bedroom
- ☐ Carpet in most parts of house
- ☐ Feather or down bedding
- ☐ 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
- ☐ 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
- ☐ Perfect musical pitch
- ☐ Good with math
- ☐ Good with computers
- ☐ Good throwing and catching
- ☐ Good at climbing
- ☐ 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
- ☐ Overweight
- ☐ Underweight
- ☐ Pupils unusually large
- ☐ Unusual long eye lashes
- ☐ Pupils unusually small
- ☐ Dark circles under eyes
- ☐ Red fingers
- ☐ Red toes
- ☐ Webbed toes
- ☐ Red ears
- ☐ Double jointed
- ☐ High arched palate
- ☐ Lymph nodes enlarged neck
- ☐ Night sweats
- ☐ Abnormal fatigue
- ☐ Failure to thrive
- ☐ 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
- ☐ Oily skin
- ☐ Thick calluses
- ☐ Athletes foot
- ☐ Feet - stinky
- ☐ Diaper rash
- ☐ Odd body odor
- ☐ Strong body odor
- ☐ Acne
- ☐ Dark circle under eyes
- ☐ Eczema
- ☐ Flushing
- ☐ Sensitive to insect bites
- ☐ Stretch marks
- ☐ Cradle cap
- ☐ Dry Hair
- ☐ Dry Scalp
- ☐ Bites nails
- ☐ Nails brittle
- ☐ Nails frayed
- ☐ Nails pitted
- ☐ Nails soft
- ☐ Skin pale
- ☐ Dark birth mark(s)
- ☐ Easy bruising
- ☐ Light birth mark(s)
- ☐ Ragged cuticles
- ☐ Vitiligo
- ☐ White spots or lines in nails
- ☐ Dry skin in general
- ☐ Feet cracking
- ☐ Hands cracking
- ☐ Lower legs dry
- ☐ 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
- ☐ Sore tongue
- ☐ Tongue Coated
- ☐ Canker sores in mouth
- ☐ Gums bleed
- ☐ Teeth grinding
- ☐ Tooth cavities
- ☐ Tooth with amalgam fillings
- ☐ Mouth thrush (yeast infection)
- ☐ Sore throat
- ☐ 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
- ☐ Anal fissures
- ☐ Red ring around anus
- ☐ Stools light color
- ☐ Stools very stinky
- ☐ Stools with blood
- ☐ Stools with mucous
- ☐ Stools with undigested food
- ☐ Stool odor foul
- ☐ Stool odor yeasty

EATING

- ☐ Poor appetite
- ☐ Thirst
- ☐ Extreme water drinking
- ☐ Bingeing
- ☐ Craving for carbohydrates
- ☐ Craving for juice
- ☐ Craving for salt
- ☐ Diet soda craving
- ☐ Pica (eating non-edibles)
- ☐ Abnormal food cravings
- ☐ Carbohydrate 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

- ☐ Unusual play
- ☐ Aloof, indifferent, remote
- ☐ Doesn't do for self
- ☐ Extremely cautious
- ☐ 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
- ☐ Poor sharing
- ☐ Rejects help
- ☐ Curious/gets into things
- ☐ Erratic
- ☐ Unable to predict actions
- ☐ Destructive
- ☐ Hyperactive
- ☐ Constant movement
- ☐ Melt downs
- ☐ Tantrums
- ☐ Self-mutilation
- ☐ Runs away
- ☐ Whirls self like a top
- ☐ Climbs to high places
- ☐ Insists on what wanted
- ☐ Tries to control others
- ☐ Head banging
- ☐ Does opposite/asked
- ☐ Teases others
- ☐ Silly
- ☐ Shrieks
- ☐ Holds hands in strange pose
- ☐ Spends time w/ pointless task
- ☐ Toe walking
- ☐ Arched back with bright lights
- ☐ Imitates others
- ☐ Flaps hands
- ☐ Licking
- ☐ Visual stims
- ☐ Chews on things

MOOD

- ☐ Apathy
- ☐ Depression
- ☐ Disinterested
- ☐ Eye contact poor
- ☐ Always frightened
- ☐ Discontented
- ☐ Does not want to be touched
- ☐ Inconsolable crying
- ☐ Irritable
- ☐ Phobias
- ☐ Restless
- ☐ Severe mood swings
- ☐ Unhappy
- ☐ Anxious

SENSORY

- ☐ Bothered by certain sounds
- ☐ Covers ears with sounds
- ☐ Ear pain
- ☐ Ear ringing
- ☐ Hearing loss
- ☐ Likes certain sounds
- ☐ Sensitive to loud noise
- ☐ Tinnitus
- ☐ Acute sense of smell
- ☐ Blinking
- ☐ Bothered by bright lights
- ☐ Distorted vision
- ☐ Conjunctivitis
- ☐ Eye crusting
- ☐ Eye problem
- ☐ Lid margin redness
- ☐ Examines by sight
- ☐ Likes fans
- ☐ Likes flickering lights
- ☐ Poor vision
- ☐ Strabismus (crossed eye)
- ☐ Fearful of harmless object
- ☐ Fearful of unusual events
- ☐ Unaware of danger
- ☐ Unaware of people's feelings
- ☐ Upset if things change
- ☐ Adopts complicated rituals
- ☐ Car, truck, train obsession
- ☐ Collects particular things
- ☐ Fixated on one topic
- ☐ Repeats phrases
- ☐ Repetitive play
- ☐ Hates wearing shoes
- ☐ Insensitive to pain
- ☐ Likes head burrowed
- ☐ 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
- ☐ 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 weakness, atrophy
- ☐ Tremors
- ☐ Cognitive delays
- ☐ Memory poor
- ☐ Poor attention, focus
- ☐ Seizures - focal
- ☐ Seizures - generalized
- ☐ Seizures - grand mal
- ☐ Seizures - petit mal
- ☐ Unusual fast heart beat
- ☐ Joint pains
- ☐ Leg pains
- ☐ Muscle pains

SPEECH

- ☐ Expressive language poor
- ☐ Babbling
- ☐ Answers by repeating question
- ☐ Receptive language poor
- ☐ Lost language @ 12-24 months
- ☐ Lost language after 24 months
- ☐ Stuttering
- ☐ Talks to self
- ☐ Poor auditory processing
- ☐ Unusual sound of cry
- ☐ Timid

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

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 I, effect is not severe
4= Frequently have it, effect is severe

Digestive Tract
___Nausea or Vomititing
___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

DIET DIARY DAY 3 *Continued*

TIME	FOOD / BEVERAGE / AMOUNT	COMMENTS

OTHER COMMENTS / QUESTIONS / CONCERNS: