

WELCOME

We are looking forward to seeing you and finding effective ways to help you and your child. Thank you for taking the time to fill out the information below in as much detail as possible. We anticipate it may take approximately 15-30 minutes to complete depending on the complexity of the problems. It will help us gather the information we need and make the best use of our time together. **Please return this form before your appointment.** Please also include any medical reports or other evaluations that you feel are relevant which would also be very useful to help us in our assessment.

Because we perform an in-depth evaluation the entire initial assessment usually takes place over 2 one-hour sessions about 1-3 weeks apart. There may be laboratory tests done in the interval. Often, sensitive issues are best discussed without the child in the room. If you feel this may be an important part of your visit and your child needs more supervision than a safe waiting room, please plan to have an additional caretaker come to the appointment. Please let us know if you are unable to do this. We have toys, books and a DVD player available. If your child has favorite items that will be helpful please feel free to bring them.

PATIENT INFORMATION

Child's Name: _____ Form Completed by: _____
Child's Date of Birth: _____ Date Completed: _____
Child's Age: _____ Child's Sex: M F

Primary Care Physician: _____	Referred by: _____
City, State: _____	City, State: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____

FAMILY INFORMATION

Families come in many forms. Please use the two columns below for the child's parent(s) and/or main caregivers. This could be the biological parents, step parent(s), same sex parents, grandparent(s), etc.

	Mother	Father
Name	_____	_____
Address	_____	_____
Home Phone	_____	_____
Work Phone	_____	_____
Cell Phone	_____	_____
Email	_____	_____
Ethnicity/Primary Language	_____	_____

Education Level _____
& Occupation _____

SPECIALISTS WORKING WITH YOUR CHILD

Please list the names and contact information for all medical specialists and therapists who are or have worked with your child

- 1.
- 2.
- 3.
- 4.
- 5.

Please check those additional therapies your child currently receives. Provide contact information if available

- Speech Therapy
- Occupational Therapy
- Physical Therapy
- Homeopathy
- Acupuncture
- Osteopathic manipulation
- Other

MAJOR DIAGNOSES OR PROBLEMS THAT YOU WOULD LIKE ADDRESSED: (i.e. ADHD, pain problem, Autism, behavior concerns, headaches, etc.)

QUESTIONS YOU WOULD LIKE ANSWERED:

USE THE FOLLOWING SPACE TO DESCRIBE YOUR CHILD IN AS MUCH DETAIL AS YOU WOULD LIKE.

Please include any factors that you think are relevant. This is a chance to tell his or her story to help us get a sense of who your child is. You can have your child participate as well.

CURRENT HEALTH PROBLEMS

Check any that apply

- | | | | |
|------------------|--------------------------|------------------------|--------------------------|
| Abdominal pain | <input type="checkbox"/> | Behavior problems | <input type="checkbox"/> |
| Diarrhea | <input type="checkbox"/> | Developmental delay | <input type="checkbox"/> |
| Constipation | <input type="checkbox"/> | Attention difficulties | <input type="checkbox"/> |
| Urinary problems | <input type="checkbox"/> | Anxiety | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | Sleep problems | <input type="checkbox"/> |
| Allergies | <input type="checkbox"/> | Headaches | <input type="checkbox"/> |
| Eczema | <input type="checkbox"/> | Learning differences | <input type="checkbox"/> |

Seizures

Other

PAST MEDICAL HISTORY

Check any that apply

- Abdominal pain
- Diarrhea
- Constipation
- Urinary problems
- Asthma
- Allergies
- Eczema
- Seizures

- Behavior problems
- Developmental delay
- Attention difficulties
- Anxiety
- Sleep problems
- Headaches
- Learning differences
- Other

ALLERGIES

List any medications your child is allergic to and type of reaction.

List any foods you believe or suspect your child is allergic to and type of reaction.

List any environmental that your child is allergic to and type of reaction (i.e. trees, grass, perfume, cleansers).

FAMILY MEDICAL HISTORY

Please check all medical conditions that have occurred in the child's immediate relatives (parents, grandparents, siblings and half-siblings, aunts, uncles and cousins). Name relationship to child in the space provided.

	No	Yes	Mother's Family	Father's Family
Gastrointestinal problems (IBS, Reflux...)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Attention Deficit Disorder (ADHD)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Congenital Syndromes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Autism or Autistic Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Chronic Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Obsessive compulsive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Alcohol or chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Other _____

PATIENT'S MEDICATIONS (CURRENT AND PAST)

Name of medication	What is (was) it used for?	Dosage & Frequency	How long has it been used? Or, reason it was stopped

VITAMINS, HERBAL REMEDIES, OR HOMEOPATHIC MEDICINE (CURRENT AND PAST)

Name of remedy/vitamin	What is (was) it used for?	Dosage & Frequency	How long has patient used?

Describe any hospitalizations of the child:

Describe any surgeries your child has had:

BIRTH HISTORY

Please describe any problems during pregnancy or with delivery. Were there any problems right after birth?
 Did you breastfeed and if so for how long?

SLEEP

Does your child experience any of the following difficulties with **sleep**?

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Waking in the night | <input type="checkbox"/> Night terrors | <input type="checkbox"/> Sleeps too much |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Early morning waking | <input type="checkbox"/> Falls asleep during day | <input type="checkbox"/> Restless Leg Syndrome |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Not well rested upon awakening | | |

_____ Average hours of sleep at night

_____ Hours of sleep during the day

_____ Time child goes to bed

_____ Time child wakes up

_____ Time child goes to sleep

EATING/NUTRITION

Do you have any of the following concerns about your child's **eating/nutrition**?

- | | |
|--|--|
| <input type="checkbox"/> Poor food choices | <input type="checkbox"/> Avoids foods due to texture |
| <input type="checkbox"/> Overeats | <input type="checkbox"/> Skips meals |

Is your child on a special diet?

Please describe your child's typical diet:

Breakfast

Lunch

Snacks

Dinner

_____ Number of caffeine drinks per day (Pepsi, coffee, etc.)

_____ Number of sugar drinks per day (Pop, Juice, etc.)

_____ Number of chocolate servings per day (candy bar, etc.)

_____ Number of sugar servings per day (cookie, etc.)

_____ How many times week does your child eat in a restaurant?

_____ How many times/week does your child eat "fast food"?

EXERCISE/ACTIVITY

Do you have any of the following concerns about your child's exercise/activity?

- Excessive physical activity Limited physical activity Lack of interest in physical activity

How many hours per week does your child exercise?

How much time does your child spend outdoors each day?

How many hours/day does your child spend in front of any type of screen (TV, video games, computer, other)?

SCHOOL INFORMATION

School Name: _____ Grade: _____

Address: _____ Has your child ever repeated or skipped a grade:
 No Yes Grade: _____

Teacher(s): _____ School/Guidance Counselor: _____

Phone: _____ Fax: _____

How many days of school has your child missed **this academic year**? _____

How many days of school has your child missed **last academic year**? _____

Has your child had a school evaluation due to special learning needs? No Yes

Does your child have an Individualized Education Plan (IEP)? No Yes

Does your child have a 504 Plan? No Yes

Describe specific concerns about your child's school, grades, or classmates:

OTHER SOCIAL AND FAMILY HISTORY

Who lives in the house with your child?

Have there been any recent significant stressful events in your child's life:

