FUNCTIONAL MEDICINE
PEDIATRIC NEW PATIENT
INTAKE FORMS
For ages 0-13 years

THESE FORMS & YOUR MEDICAL RECORDS MUST BE SUBMITTED TO OUR OFFICE AT LEAST 7 DAYS PRIOR TO YOUR FIRST APPOINTMENT
DID YOU REMEMBER TO?

- Read all of the practice documents
- Obtain your medical records and/or test results from previously seen physicians and have them sent at least 7 days prior to your appointment date to:
  
  Austin UltraHealth  
  Westlake Medical Center  
  5656 Bee Cave Road Suite D-203  
  Austin, TX 78746  
  Fax #: 512-721-0348

- Provide us with your pharmacy name, address, phone and FAX number.
- Check with your insurance company about Out of Network lab coverage.

FILL OUT AND/OR SIGN THE FOLLOWING FORMS

- Important Patient Information
- Informed Consent Regarding Email or the Internet Use Of Protected Personal Information
- Notice of Medicare Denial
- General Information
- Medical Questionnaire
- 3-Day Diet Diary
- MSQ - Medical Symptom/Toxicity Questionnaire

Thank you,

We are looking forward to working with you to achieve UltraHealth

*PLEASE KEEP PAGES 1 - 8 FOR YOUR RECORDS*
Dear Patient,

Welcome! We look forward to meeting you and working with you to achieve UltraHealth.

**WHAT TO EXPECT DURING YOUR CONSULTATION AT AUSTIN ULTRAHEALTH**

**YOU ARRIVE TO THE OFFICE**
- Update personal forms and sign consent forms if not done previously
- Vital signs taken

**PLEASE COME FASTING – WE WILL DRAW BLOOD AT YOUR VISIT.** Bring a snack if you’d like.
**If you take THYROID MEDICATION please DO NOT take it the morning of your appointment**

**FUNCTIONAL MEDICINE INITIAL CONSULTATION:**
- Vitals are taken, picture is taken, HIPPA forms and policies are signed
- Consult with Dr. Myers (70 min)
- Blood draw with on-site phlebotomist (please come fasting)
- Consult with Brianne Herman, RD, LD the nutritionist (50 min)
- Pay for consult, labs, and any supplements purchased.

Please plan 3 hours for your initial consultation.  
Bring a snack if you’d like.

**Functional Medicine Initial Follow Up Consults:**
- Consult with Dr. Myers to review labs and progress (50 min)
- Consult with our nutritionist, Brianne Herman, RD, LD (50 min)
- Please plan to spend 3 hours for your initial follow up consultation

**WRAP UP AND CHECK OUT** (with Assistant Practice Manager 10-20 minutes)
- Pay for consult, and labs.
- Schedule follow-up appointments
- Obtain an invoice to send to your insurance company for reimbursement

Any supplements purchased that day will be paid for separately at the front desk.
PRACTICE POLICIES FOR PATIENTS

Our goal is to provide you with the highest level of personalized care possible. We are committed to helping you achieve UltraHealth.

It is important to read all of the enclosed information carefully and return it to our office least 7 days prior to your appointment. You can return it to our office by mail, email or fax. Our system is not interactive, so you will need to print out the documents and then rescan them if you choose to email them to us.

Having these forms 7 days in advance will allow Dr. Myers and Brianne to help solve your problems more efficiently and enhance the quality of your care. If your Intake Form and Medical Records have not been received at least 7 days prior to your initial appointment, it may take Dr. Myers and the nutritionist up to 30 minutes of your appointment time to review your chart.

WEBSITE
Information about Austin UltraHealth and all relevant patient forms are available through the website: www.austinultrahealth.com and may be found on the new patient page.

MEDICAL RECORDS FROM OTHER DOCTORS/CLINICS/HOSPITALS
Medical records can only be released with your authorization. It is your responsibility to obtain previous medical records from other physicians, or health care providers that you wish Dr. Myers or Brianne to review. Please contact your physician or other health care provider to obtain these records and make sure that we have received them at least 7 days prior to your initial appointment.

Your medical records should be mailed or faxed to:
Austin UltraHealth, 5656 Bee Cave Rd Ste. D-203 Austin, TX 78746 Fax #: 512-721-0348

COPIES OF MEDICAL RECORDS & LABS FROM OUR OFFICE
You will be given a copy of your labs at each visit to keep for your records. [Should you need additional copies of your medical records; a $25 fee will be charged for copies and postage.]

FUNCTIONAL MEDICINE CONSULTATION FEES
Initial Consultation is $500: This includes visits with Dr. Myers and the nutritionist, Brianne.
Initial follow up appointment is $500: This includes visits with Dr. Myers and the nutritionist, Brianne.
All other consultations with Dr. Myers are $325.00 (50 min).
All other consults with Brianne are $85 (50 min), $45 (25 min), $25 (15 min).

FUNCTIONAL NUTRITION CONSULTATION FEES
Initial Nutrition Consultation is $125
Initial follow up appointment is $85
All other consults with Brianne are $85 (50 min), $45 (25 min), $25 (15 min)

LAB TESTS
We have phlebotomist from CPL at our office to draw your blood just after your appointment. PLEASE ARRIVE FASTING. You may drink water, but avoid all other foods/drink. PLEASE CALL YOUR INSURANCE CARRIER PRIOR TO YOUR APPOINTMENT TO KNOW WHAT YOUR COVERAGE IS. Some labs that involve stool, urine or saliva samples are done by you in your home. You will be given all lab kits and step-by-step instructions for at home test at the time of your consult. Once all of the final lab results are received, we will go over them at your follow-up visits.
CPL is at our office Monday – Friday 7:30-12:30. You DO NOT need an appointment to get labs drawn.
SUPPLEMENTS
All of the supplements that are recommended at Austin UltraHealth are available for purchase in our office. You are not obligated to purchase supplements from our office.

Supplements may be purchased in our office or mailed directly to you. Please send orders to supplements@austinultrahealth.com and allow 24 hours for processing.

RETURNS/REFUNDS
Supplements (except for probiotics and protein powders) and Functional Lab kits may be returned for a refund or exchange if in original condition and unopened or unused within 14 days of purchase. Functional Lab kits must be done within 1 year of purchase. CPL Prepaid Labs will be refunded if labs not drawn and notice is given within 7 days of payment.

CREDIT CARDS
We require a credit card number at the time of scheduling your first appointment. This credit card will be used to hold your appointment and will be kept on file to use for all appointments, labs and supplements unless otherwise specified by you at the time of check out. We do not take American Express.

CANCELLATION AND RESCHEDULING OF APPOINTMENTS
There is a 48 hour (2 business days) cancellation and rescheduling policy. Your appointment must be cancelled or rescheduled at least 48 hours (2 business days) prior to your consultation time or you will be charged a cancellation fee, unless we are able to fill your appointment time. The cancellation fee for a new patient appointment is half the cost of the appointment, the cancellation fee for all other appointments is the full cost of the appointment. You may cancel your appointment by calling the office 512-383-5343 or emailing office@austinultrahealth.com.

LATE ARRIVAL APPOINTMENTS
We are committed to being on time with patients’ appointments in order to prevent clients from waiting. If you arrive late to the office for your consult your appointment will end at the scheduled time and you will be charged for the length of the originally scheduled visit.

FOLLOW UP APPOINTMENTS
At the time of check out you will be scheduled for a follow up appointment. We will assume you will honor this appointment time unless you notify us otherwise at least 48 hours/ 2 business days prior to your scheduled appointment.

PAYMENT OPTIONS
Cash, checks or credit cards (MasterCard, Visa, Discover) are all accepted methods of payment for services. When you schedule the initial visit, we request a credit card on file to hold the appointment for you. No charges will be applied to your credit card unless you miss or cancel an appointment without proper notice. On the day of your scheduled appointment, all charges for consultations, laboratory testing and nutritional supplements will be itemized and payment is due on the day of service.

Follow-up phone, or in person consultations will be billed to your credit card on file unless you provide other payment information and instructions prior to your appointment. If additional lab tests are required and our office sends test kits, the appropriate fees will be charged to your account. Credit card on file will also be used for supplements mailed unless otherwise specified.
INSURANCE INFORMATION
Medical insurance is not accepted and our office cannot assist you with claim resolution. In addition, Dr. Myers and Brianne are not Medicare providers. You will be provided with a billing summary that you can submit to your insurance carrier. Neither Dr. Myers nor Brianne submit their medical notes to insurance companies.

DISABILITY FORMS
Neither Dr. Myers nor Brianne fills out medical disability forms for patients. On very rare occasions Dr. Myers will write a letter to detail the medical necessity of testing. Under such circumstances, Dr. Myers bills at her hourly rate to write such letters. Dr. Myers does not submit her medical notes to support disability claims.

OFFICE HOURS
Our office hours are Monday – Friday, 9 am to 5 pm CST.

If you are going to stop by the office to pick up supplements we ask that you kindly email your order to us at supplements@austinultrahealth.com prior to your visit. If you need lab kits or anything of that nature please call us at (512) 383-5343 or email office@austinultrahealth.com.

PHONE CALLS AND MESSAGES
- Phone messages left will be responded to within 24 hours (during business hours).
  - To reach the office, please call (512) 383-5343
  - If you call after hours, the office staff will return your call on the next business day.
  - **If you have a medical emergency, call 911 or go directly to the nearest ER.**
  - When leaving a message, please be brief and include the following information:
    - ✓ Full name, spell your last name, and date of birth
    - ✓ Reason for call
    - ✓ Phone number(s)
    - ✓ E-mail address (if desired)

PRESCRIPTION REFILL REQUESTS
For prescription refills, we ask that you contact your pharmacy and have them fax over the medication refill request. Our fax number is (512) 721-0348. **It may take up to 72 business hours to process a prescription refill.** Please note that Dr. Myers is generally not in the office on Fridays to authorize refills. Please plan ahead to avoid any interruptions in your medications.

EMAIL
If you would like to schedule an appointment or cancel an appointment, have lab kit questions or administrative questions, please email office@austinultrahealth.com.

If you have a nutrition, Elimination Diet or supplement question please email our nutritionist, Brianne Herman, RD, LD, at nutritionist@austinultrahealth.com.

If you would like to order supplements from us, or would like us to have a supplement order ready for you to pick up at the office, please send an email to: supplements@austinultrahealth.com.

If you need immediate assistance please call the office. If you have a medical emergency please call 911.
MISCELLANEOUS
Please refrain from wearing any perfumes, colognes or heavily scented lotions to the office, as Dr. Myers is very sensitive to these products.

Dr. Myers brings Bella, her very sweet 12 year old yellow lab mix to the office. Bella sleeps all day under Dr. Myers’ desk and generally goes unnoticed by patients. If you are allergic to dogs or wish not to have Bella at the office – please let us know prior to your appointment so that Dr. Myers may leave Bella at home.

Wishing you UltraHealth,

The Austin UltraHealth Team

FREQUENTLY ASKED QUESTIONS

What is your website address?
Information about the practice can be found at www.austinultrahealth.com

How may I purchase supplements?
Dr. Myers has extensively researched supplements and recommends only the highest quality of nutritional supplements. All of the supplements that are recommended at Austin UltraHealth are available for purchase in our office. You may purchase supplements after each visit or if you need something in the interim you are welcome to come by the office. We do ask that you please email us your order (supplements@austinultrahealth.com) prior to coming to pick up supplements.

If you live out of town, you may email supplements@austinultrahealth.com and we will fill your order and mail it to you within 48 hours.

Do you think you can help me with my health problem?
Dr. Myers and her team use an innovative systems approach to assessing and treating your health care concerns. Perhaps you have experienced being examined by your doctor, having blood tests done, x-rays or other diagnostic tests taken, only for your doctor to report back that “all your tests are normal”. Yet, both you and your doctor know that you are sick. Unfortunately, this experience is all too common.

Most physicians are trained to look only in specific places for the answers, using the same familiar labs or diagnostic tests. Yet, many causes of illness cannot be found in these places. The usual tests do not look for food allergies, hidden infections, environmental toxins, mold exposures, nutritional deficiencies and metabolic imbalances. New gene testing can uncover underlying genetic predispositions that can be modified through diet, lifestyle, supplements or medications.

At Austin UltraHealth, on the other hand, we use innovative testing to help patients prevent illness and recover from many chronic and difficult-to-treat conditions. Dr. Myers is skilled in evaluating, assessing and treating chronic problems such as fibromyalgia, fatigue syndromes, autoimmune diseases, inflammatory disorders, mood and behavior disorders, Irritable Bowel Syndrome (IBS), seasonal allergies, and other chronic, complex conditions. Dr. Myers also focuses on the prevention and treatment of heart disease, diabetes, dementia, hormonal imbalances and digestive disorders.

How will lab tests be performed at Austin UltraHealth?
Some testing can be done through conventional laboratories and others are only available through
During your medical consultation, Dr. Myers and Brianne will determine which tests are needed and review with you testing recommendations, instructions (ex. fasting or non-fasting, etc.) and costs. Some testing requires collecting urine, saliva or stool at home. Others may require you to go to a local laboratory to have blood drawn. In all cases, we will assist you in coordinating initial and follow-up testing.

**Do you take insurance?**
Austin UltraHealth does not accept insurance or Medicare; we do not file insurance claims on your behalf; nor do we assist with claim resolution. However, we will provide a detailed receipt of services performed and you can submit this to your insurance carrier. For assistance with your reimbursement you may want to contact your insurance provider. We expect payment in full by check, cash or credit card due at the time services are provided.

**What credit cards do you accept?**
We accept the following credit cards: MasterCard, Visa and Discover. We do not accept American Express. It is important to maintain an active credit card on file with our office for billing of follow-up consultations, laboratory testing, and supplement orders.

**Is Dr. Amy Myers a primary care physician?**
Dr. Myers is trained as an emergency physician and can handle many of your primary care needs, however she requests that you maintain a primary care doctor for an annual physical exam, Pap smear, prostate exam, etc. Dr. Myers also does not provide acute care services. She is happy to work with you closely as a consultant and coach in preventive, nutritional and functional medicine to help you address the roots of chronic health problems. Dr. Myers is also happy to confer with your primary care doctor if desired.

**Do I have to see the physician in person for my medical consultation?**
Yes, Texas requires that Dr. Myers meet a patient in person in the state of Texas to provide an initial medical consultation. Follow-up appointments can be arranged by telephone or in person.

**Whom do I contact?**
The office phone number is: (512) 383-5343.

Assistant Practice Manager (appointment scheduling, lab questions): office@austinultrahealth.com

Practice Manager (all office, insurance, administrative, logistical questions): admin@austinultrahealth.com

Brianne Herman RD,LD, our nutritionist (nutritional, elimination diet and basic supplement questions): nutritionist@austinultrahealth.com

Supplement Orders: supplements@austinultrahealth.com
IMPORTANT PATIENT INFORMATION

APPOINTMENTS
- Initial consult and first follow up are $500 each. The first appointment consists of 70 minutes with Dr. Myers and 30 minutes with our nutritionist, Brianne Herman, RD, LD. The first follow up consists of 50 minutes with Dr. Myers and 50 minutes with Brianne.
- Please allow 2.5 to 3 hours for these appointments
- Each additional follow up is priced as follows
  Dr. Myers- $325/hr
  Brianne Herman, RD, LD - $85/50min

- There is a 48 hour/2 business day cancellation policy (please see cancellation policy in Practice Policies for Patients).
  We reserve the right to charge your credit card on file for the full amount of the missed visit for a follow up appointment and half the amount for a new patient appointment if it is not canceled or rescheduled 48 hours (2 business days) prior to your appointment. By signing below you agree to our cancellation policy and authorize Amy Myers MD, PA to charge your credit card on file for any missed visits.

LAB TESTS
- All lab results will be reviewed with you at the time of your follow up appointment. We do not email lab results to patients. The exception to this is if you have a follow up appointment by phone – we will email you your lab results prior to your appointment.

RETURNS/REFUNDS
- Supplements (except probiotics and protein powders) and Functional Lab kits may be returned for a refund or exchange if in original condition and unopened or unused within 14 days of purchase.
- Functional Lab kits must be completed within 1 year of purchase.
- CPL Prepaid Labs will be refunded if labs not drawn and notice is given within 7 days of payment.

RETURN CHECK FEE
- A $35 fee will be assessed for all checks returned for insufficient funds

BILLING/INSURANCE
- You will receive an invoice at the completion of your visit that you may submit to your insurance for reimbursement. We do not help with insurance claim resolution.
- Payment for the office visit, phone consultation, or lab tests is expected at time of service. All credit card payment will be processed the same day of the visit, or phone call.
- If test kits or supplements are sent to you, you will be charged the day they are mailed.
- Austin UltraHealth does not accept insurance; however, you can submit your patient statement to your insurance carrier.
- We will give you instructions for insurance filing, a copy of your bill and all codes necessary for insurance filing. We do not, however aid you in insurance claim resolution or respond to insurance carrier requests for more information.

PRIMARY CARE PHYSICIAN
- Please note that neither Dr. Amy Myers nor Brianne Herman, RD, LD is your primary care physician. We recommend that you have a primary care physician.

______________________________  ______________________________
Patient Signature                  Date
ALL MEDICARE PATIENTS MUST SIGN THIS FORM

NOTICE OF POSSIBLE MEDICARE DENIAL
Medicare will only pay for services determined to be reasonable and necessary under Section 1862 (a) (1) of Medicare Law. If a particular service is considered not acceptable and unnecessary under Medicare standards, Medicare will deny payment for those excluded services.

MEDICARE NOTICE
Neither Dr. Amy Myers nor Brianne Herman, RD, LD is a Medicare provider; therefore, your payment is due at the time services are provided. Any claims submitted will have to be sent by the patient; payment reimbursement is not guaranteed and is subject to Medicare eligibility/reimbursement rules and regulations.

PATIENT ACKNOWLEDGEMENT
My physician, and/or staff have informed me, that he or she believes services provided will likely be denied by Medicare for reasons stated above.

Signature

Print name

Date
INFORMED CONSENT REGARDING E-MAIL OR THE INTERNET USE OF PROTECTED PERSONAL INFORMATION

Austin UltraHealth provides patients the opportunity to communicate with them by e-mail. Transmitting confidential health information by e-mail, however, has a number of risks, both general and specific, that should be considered before using e-mail.

1. Risks:
   a. General e-mail risks are the following: e-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward e-mail to other recipients without the original sender(s) permission, or knowledge; users can easily misaddress an e-mail; e-mail is easier to falsify than handwritten, or signed documents; backup copies of e-mail may exist even after the sender, or recipient has deleted his/her history.
   b. Specific e-mail risks are the following: e-mail containing information pertaining to diagnosis and/or treatment must be included in the protected personal health information; all individuals who have access to the protected personal health information will have access to the e-mail messages; patients who send, or receive e-mail from their place of employment risk having their employer read their e-mail.

2. It is the policy of Austin UltraHealth that all e-mail messages sent or received, which concern the diagnosis, or treatment, of the patient will be a part of that patient’s protected personal health information and we will treat such e-mail messages, or internet communications, with the same degree of confidentiality as afforded other portions of the protected personal health information. Austin UltraHealth will use reasonable means to protect the security and confidentiality of e-mail, or internet communication. Because of the risks outlined above, we cannot, however, guarantee the security and confidentiality of e-mail, or internet communications.

3. Patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following conditions:
   a. All e-mail to, or from, patients concerning diagnosis and/or treatment will be made a part of the protected personal health information. As a part of the protected personal health information, other individuals, Dr. Amy Myers, Brianne Herman, RD, LD, physicians, nurses, other healthcare practitioners, insurance coordinators, and upon written authorization other healthcare providers and insurers will have access to e-mail messages contained in protected personal health information.
   b. Austin UltraHealth practitioners may forward e-mail messages within the practice as necessary for diagnosis and treatment. We will not, however, forward the e-mail outside the practice without the consent of the patient as required by law.
   c. We at Austin UltraHealth will endeavor to read e-mail promptly, but can provide no assurance that the recipient of the particular e-mail will read the e-mail message promptly. Therefore, e-mail must not be used in a medical emergency.
   d. It is the responsibility of the sender to determine whether the intended recipient received the e-mail and when the recipient will respond.
   e. Because some medical information is so sensitive that unauthorized disclosure can be very damaging, e-mail should not be used for communications concerning diagnosis, or treatment of AIDS/HIV infection; other sexually transmissible, or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; Behavioral health, Mental health, or developmental disability; or alcohol and drug abuse.
f. Austin UltraHealth cannot guarantee that electronic communications will be private. However, we will take reasonable steps to protect the confidentiality of the e-mail, or internet communication. However, Dr. Amy Myers and Brianne Herman RD, LD are not liable for improper disclosure of confidential information not caused by its employee’s gross negligence, or wanton misconduct.

g. If consent is given for the use of e-mail, it is the responsibility of the patient to inform Austin UltraHealth staff of any type of information you do not want to be sent by e-mail.

h. It is the responsibility of the patient to protect their password or other means of access to e-mail sent, or received, from Austin UltraHealth, to protect confidentiality. Austin UltraHealth is not liable for breaches of confidentiality caused by the patient.

Any further use of e-mail initiated by the patient that discusses diagnosis, or treatment, constitutes informed consent to the foregoing.

I understand that my consent to the use of e-mail may be withdrawn at any time by e-mail, or written communication, to Austin UltraHealth at admin@austinultrahealth.com

I have read this form carefully and understand the risks and responsibilities associated with the use of e-mail. I agree to assume all risks associated with the use of e-mail.

Name Printed: ________________________________________________________________

Signature: ___________________________________________________________________

Date: __________________________________________
**GENERAL INFORMATION**

Name: First  
Middle  
Last  

Preferred Name:  

Date of Birth:  
Age:  

Gender:  
- [ ] Male  
- [ ] Female  

Genetic Background:  
- [ ] African  
- [ ] European  
- [ ] Native American  
- [ ] Mediterranean  
- [ ] Asian  
- [ ] Ashkenazi  
- [ ] Middle Eastern  

*Person completing this questionnaire*

Mother's Name  
Occupation  

Father's Name  
Occupation  

Primary Address:  
Number, Street:  
Apt. No.  
City  
State  
Zip  

Alternate Address:  
Number, Street:  
Apt. No.  
City  
State  
Zip  

Home Phone 1:  

Home Phone 2:  

Parent's Work Phone:  

Parent's Cell Phone:  

Fax:  

E-mail:  

Emergency Contact:  
Name  
Phone Number:  
Address  
Apt. No.  
City  
State  
Zip  

Physician's Name:  

Phone Number  
Fax  

Referred by:  
- [ ] Book  
- [ ] Website  
- [ ] Media  
- [ ] Family Member or Friend  
- [ ] Google (which words)  
- [ ] Other  


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<td><strong>Primary Pharmacy:</strong></td>
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<td>Address</td>
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<td>City</td>
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<td><em>It is extremely important that you list the pharmacy's fax number.</em></td>
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<th><strong>Compounding/Supplement Pharmacy:</strong></th>
<th>Name</th>
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<td><em>It is extremely important that you list the pharmacy's fax number.</em></td>
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# PEDIATRIC MEDICAL QUESTIONNAIRE

## ALLERGIES

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<tr>
<th>Medication/ Supplement/ Food</th>
<th>Reaction</th>
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## 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:

<table>
<thead>
<tr>
<th>Describe Problem</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Prior Treatment/ Approach</th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
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<tbody>
<tr>
<td>Example: Difficulty Maintaining Attention</td>
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<td>Elimination Diet</td>
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<td>Medical History</td>
<td>Past</td>
<td>Current</td>
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<td>Gastritis or Peptic Ulcer Disease</td>
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### MEDICAL HISTORY (CONTINUED)

#### Past Current

**NEUROLOGIC/ MOOD**

- Depression
- Anxiety
- Bipolar Disorder
- Schizophrenia
- Headaches
- Migranes
- ADD/ ADHD

- Sensory Integrative Disorder
- Autism
- Mild Cognitive Impairment
- ALS
- Seizures
- Arthritis
- Other Neurological Problems

**PREVIOUS EVALUATIONS**

*Check box if yes and provide date*

- Full Physical Exam
- Psychological Evaluations
- Wechsler Preschool & Primary Scale of Intelligence
- Speech and Language Evaluations
- Genetic Evaluation
- Neurological Evaluations
- Gastroenterology Evaluations
- Celiac/Gluten testing
- Allergy Evaluation
- Nutritional Evaluation
- Auditory Evaluation
- Vision Evaluation
- Osteopathic
- Acupuncture
- Occupational Therapy
- Sensory Integration Therapy
- Language Classes
- Sign Language
- Homeopathic
- Naturopathic
- Craniosacral
- Chiropractic
- MRI
- CT Scan
- Upper Endoscopy
- Upper GI Series
- Ultrasound

**INJURIES**

*Check box if yes and provide date*

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

**SURGERIES**

*Check box if yes and provide date*

- Appendectomy
- Circumcision
- Hernia
- Tonsils
- Adenoids
- Dental Surgery
- Tubes in Ears
- Other

**BLOOD TYPE:** O A O B O AB O O Rh+ O Unknown

**HOSPITALIZATIONS**

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IMMUNIZATIONS
Is your child up to date with immunizations? O Yes  O No
Do you feel immunizations have had an impact on your child’s health? O Yes  O No
If relevant, attach a copy of your child’s immunization record or see addendum.

PSYCHOSOCIAL
Has your child experienced any major life changes that may have impacted his/her health? O Yes  O No
Has your child ever experienced any major losses? O Yes  O No

STRESS/COPING
Have you ever sought counseling for your child? O Yes  O No
Is your child or family currently in therapy? O Yes  O No  Describe: ________________________________
Does your child have a favorite toy or object? O Yes  O No
Check 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? O Yes  O No

SLEEP/REST
Average number of hours your child sleeps at night: O >12  O 10-12  O 8-10  O <8
Does your child have trouble falling asleep? O Yes  O No
Does your child feel rested upon awakening? O Yes  O No
Does your child snore? O Yes  O No

ROLES/RELATIONSHIP
List Family Members:

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<tr>
<th>Family Member and Relationship</th>
<th>Age</th>
<th>Gender</th>
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Who are the main people who care for your child? _________________________________
Their Employment/Occupation: ____________________________________________
Resources for emotional support?
Check all that apply: □ Spouse □ Family □ Friends □ Religious/Spiritual □ Pets □ Other: _______

GYNECOLOGIC HISTORY (for women only)

MENSTRUAL HISTORY
Age at first period: _____ Menses Frequency: _____ Length: _____ Pain: O Yes  O No  Clotting: O Yes  O No
Has your period ever skipped? ________ For how long? _________
Last Menstrual Period: ________________
Use of hormonal contraception such as: □ Birth Control Pills □ Patch □ Nuva Ring  How long? _________
Do you use contraception? O Yes  O No □ Condom □ Diaphragm □ IUD □ Partner Vasectomy
GI HISTORY
Has your child traveled to foreign countries? O Yes  O No   Where? __________________________________________
Wilderness Camping? O Yes  O No   Where? __________________________________________
Ever had severe:  O Gastroenteritis  O Diarrhea

DENTAL HISTORY
☐ Silver Mercury Fillings   How many? _________
☐ Gold Fillings ☐ Root Canals ☐ Implants ☐ Tooth Pain ☐ Bleeding Gums
☐ Gingivitis ☐ Problems with Chewing
Do you floss regularly? O Yes  O No

PATIENT BIRTH HISTORY
MOTHER’S PAST PREGNANCIES
Number of: Pregnancies _________ Live births: _________ Miscarriages: _________

MOTHER’S PREGNANCY
Check box if yes and provide date
☐ Difficulty getting pregnant(more than 6 months) _________
☐ Infertility drugs used Specify:__________________________
☐ In vitro fertilization ________________________________
☐ Drink alcohol _______________________________________
☐ 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 step infection ________________________________
☐ Have c-section because of____________________________
☐ Use induction for labor (such as Pitocin)________________
☐ Have anaesthesia – what was used?____________________
☐ Use oxygen during labor ______________________________
☐ 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 newly built house ____________________________
☐ House painted indoors ________________________________
☐ House painted outdoors _______________________________
☐ House exterminated for insects _________________________

PREGNANCY
Total weight gain during pregnancy: _______ lb  Total weight loss during pregnancy: _______ lb
Please describe diet during pregnancy:
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
Please describe labor:
____________________________________________________________________________________________
____________________________________________________________________________________________
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19
PATIENT BIRTH HISTORY (CONTINUED)

PERINATAL

Pregnancy duration: X following the week of gestation
O 24  O 25  O 26  O 27  O 28  O 29  O 30  O 31  O 32  O 33  O 34  O 35
O 36  O 37  O 38  O 39  O 40(full term)  O 41  O 42  O 43  O 44 Weeks
Very active before birth?  O  Yes  O  No
Hospital/Birthing Center?  O  Yes  O  No
 Needed Newborn Special Care?  O  Yes  O  No
Appeared healthy?  O  Yes  O  No
Easily consoled during first month?  O  Yes  O  No
Antibiotics first month?  O  Yes  O  No
Experienced no complications first month of life?  O  Yes  O  No

BIRTH WEIGHT AND APGAR

Weight at birth: ______lbs   Apgar score at one minute: _______   Apgar score at 5 mins: ______

EARLY CHILDHOOD ILLNESSES

Number of earaches in the first two years: _______
Number of other infections in the first two years: _______
Number of times you had antibiotics in the first two years of life: _______
Number of courses of prophylactic antibiotics in first 2 years of life: _______
First antibiotic at _______ months.
First illness at ________ months.

DESCRIPTION OF DEVELOPMENTAL PROBLEMS

If your child has developmental problems, at what age did they occur?
O 0-1 months  O 2-6 months  O 6-15 months  O 16-24 months  O After 24 months
Is this impression shared among parents and others caring for the child?  O  Yes  O  No
Does this impression, as the timing of onset, differ among parents and others caring for the child?  O  Yes  O  No
Is the impression, as to the timing of onset, weak?  O  Yes  O  No
Or is this impression strong?  O  Yes  O  No

DEVELOPMENTAL HISTORY

Please indicate the approximate age in months for the following milestones (example: walking 14 months):

Sitting up  ________months  O  Never   Dry at night  ________months  O  Never
Crawl  ________months  O  Never   First words (“mama, dada” etc)_____months  O  Never
Pulled to stand  ________months  O  Never   Spoke clearly  ________months  O  Never
Potty trained  ________months  O  Never   Lost language  ________months  O  Never
Walked alone  ________months  O  Never   Lost eye contact ________months  O  Never
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<th>Dose</th>
<th>Frequency</th>
<th>Start Date (month/year)</th>
<th>Reason For Use</th>
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**PREVIOUS MEDICATIONS: Last 10 years**

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**NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)**

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Have your medications or supplements ever caused you unusual side effects or problems?  O Yes  O No

Describe: ____________________________________________________________

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin?  O Yes  O No

Have you had prolonged or regular use of Tylenol?  O Yes  O No
Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc)  
O Yes  O No

Frequent antibiotics > 3 times/year O Yes  O No

Long term antibiotics O Yes  O No

Use of steroids (prednisone, nasal allergy inhalers) in the past O Yes  O No

Use of oral contraceptives O Yes  O No

<table>
<thead>
<tr>
<th>FAMILY HISTORY</th>
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<tbody>
<tr>
<td>Check family members that apply</td>
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<th>Mother</th>
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<th>Children</th>
<th>Maternal Grandmother</th>
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<td>Breast or Ovarian Cancer</td>
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<td>Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Spondylitis)</td>
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<td>Food Allergies, Sensitivities or Intolerances</td>
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</table>
Substance Abuse (such as alcoholism)
Psychiatric Disorders
Depression
Schizophrenia
ADHD
Autism
Bipolar Disease

NUTRITION HISTORY

Has your child ever had a nutrition consultation? O Yes  O No
Have you made any changes in your child’s diet because of health problems? O Yes  O No Describe _______
Does your child follow a special diet or nutritional program? O Yes  O No
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.):
___________________________________________________________

Height (feet/inches) ___________  Current Weight ________________

Longest Weight Fluctuations O Yes  O No

Does your child avoid any particular foods? O Yes  O 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? O 0-1  O 1-3  O 3-5  O > 5 meals per week
Check all the factors that apply to your child’s current lifestyle and eating habits:

☐ Fast eater  ☐ Most family meals together
☐ Erratic eating pattern  ☐ Use food as a bribe or reward
☐ Eat too much  ☐ Erratic mealtimes
☐ Dislike healthy food  ☐ Most meals eaten at the table
☐ Time constraints  ☐ High juice intake
☐ Eat more than 50% meals away from home  ☐ Low fruit/vegetable intake
☐ Poor snack choices  ☐ High sugar/sweet intake
☐ Sensory issues with food  ☐ Gestational Diabetes________________________
☐ Picky eater  ☐ High blood pressure(pre-eclampsia)_________________________
☐ Limited variety of foods < 5/day  ☐ High blood pressure/toxemia_________________
☐ Prefers cold food  ☐ Have chemical exposure _____________________________
☐ Prefers hot food  ☐  _____________________________________________
☐ Every meal is a struggle  ☐  _____________________________________________
BREASTFED HISTORY
Breastfed? O Yes O No  Type of formula: O Soy O Cow’s Milk O Low Allergy
Introduction of cow’s milk at ________ months. Introduction of solid foods at ________ months.
First foods introduced at ________ months. Introduction of wheat or other grain at ________ months.
Choke/ Gas/ Vomit on milk? O Yes O No  Refused to chew solids? O Yes O No
List mother’s known food allergies or sensitivities: ____________________________
Please describe any other eating concerns you have regarded with your child: ____________________________

ACTIVITY
List type and amount of activity daily.

<table>
<thead>
<tr>
<th>Type</th>
<th>Amount Daily</th>
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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
Please check appropriate box.

<table>
<thead>
<tr>
<th>Past</th>
<th>Current</th>
<th>EXPOSURES</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>□ □  Mold in bathroom</td>
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<td>□ □</td>
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<td>□ □  Damp cellar</td>
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<td>□ □</td>
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<td>□ □  Pest extermination – Inside</td>
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<td>□ □</td>
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<td>□ □  Pest extermination – Outside</td>
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<td>□ □</td>
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<td>□ □  Forced hot air heat</td>
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<td>□ □</td>
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<td>□ □  Had water in basement</td>
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<td>□ □  Mold visible on exterior of house</td>
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<td>□ □</td>
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<td>□ □  Heavily wooded or damp surroundings</td>
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<tr>
<td>□ □</td>
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<td>□ □  Mold in cellar, crawl space, or basement</td>
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<td>□ □</td>
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<td>□ □  Moldy, musty school/daycare</td>
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<td>□ □  Tobacco smoke</td>
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<td>□ □  Well water</td>
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<td>□ □  Carpet in bedroom</td>
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<td>□ □</td>
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<td>□ □  Carpet in most parts of the house</td>
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<tr>
<td>□ □</td>
<td></td>
<td>□ □  Feather or down bedding</td>
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</table>

SOME THINGS ABOUT YOUR PARENTS
When were your parents married? ____________________ If separated, when? ____________
If divorced, when? ____________________ If remarried, when? ____________
Custody arrangements: ___________________________________________________________

MOTHER – PERSONAL  FATHER – PERSONAL
Age at your birth ____________________  Age at your birth ____________________
Education ____________________  Education ____________________
Ethnicity ____________________  Ethnicity ____________________
Blood type ____________________  Blood type ____________________
SYMPTOM REVIEW

Please check all current symptoms occurring or present in the past 6 months.

STRENGTHS
- Especially attractive
- 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
- Okay if parents leave
- Answers parent
- Follows instructions
- Pronounces words well
- Good with math
- Good with computers
- Good with fine work
- Good throwing and catching
- Good 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)
- Awakens screaming/crying
- Awakes 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 usually large
- Unusually long eyelashes
- Pupils unusually small
- Dark circles under eyes
- Red lips
- Red fingers
- Red toes
- Webbed toes
- Red ears
- Double jointed
- Lymph nodes enlarged in neck
- Head heals
- Head sweats
- Night sweats
- Abnormal fatigue
- Failure to thrive
- Cold all over
- Cold hands and feet
- Cold intolerance
- Hands/feet–very sweaty
- Perspiration–odd odor
- 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 circles 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 fingernails
- Thickening toenails
- Vitiligo
- White spots of lines in nails
- Dry skin in general
- Feet cracking
- Hand peeling
- Lower legs dry
- Skin lackluster
- Itchy skin in general
- Itchy scalp
- Itchy ear canals
- Itchy eyes
- Itchy nose
- Itchy roof of mouth
- Itchy arms
- Itchy hands
- Itchy feet
- Itchy anus
- Itchy penis
- Itchy vagina
- Breath bad
- Increased salivation
- Drooling
- Cracking lip corners
- Cold sores on lips, face
- Geographic tongue (map-like)
- Sore tongue
- Tongue coated
- Cancer 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
- Cramping pain with pooping
- Constipation
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 TV for a 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
- Melts down
- 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 of asked
- Silly
- Shrieks
- Holds hands in strange pose
- Spends time with 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 finder side of face
- Bites or chews fingers
- Bites wrist or back of hands
- Chews on things
- 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

MOOD
- Apathy
- Blank look
- Depression
- Detached
- Disinterest
- Eye contact poor
- Isolates
- Negative fright without cause
- Always frightened
- Anguish
- Disconnected
- Does not want to be touched
- Inconsolable crying
- Irritable
- Looks like in pain
- Moaning, groaning
- Phobias
- Restless
- Severe mood swings

SENSORY
- Bothered by certain sounds
- Covers ears with sound
- 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
- Bother 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 the 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 peoples’ 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
- Finger tip squeezing
- Hates wearing shoes
- Insensitive to pain
- Likes head burrowed
- Likes head pressed hard
- Likes head rubbed
- Likes head under blanket
- Likes to be help 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
Fist clenching
Jaw clenching
Poor muscle tone/limp
Tics
Muscle tone low trunk
Muscle weakness, atrophy
Muscle tone low all over
Tremors
Calf cramps
Foot cramps
Muscle pain
Muscle tone tense
Fist clenching
Jaw clenching
Poor muscle tone/limp
Tics
Muscle tone low trunk
Muscle weakness, atrophy
Muscle tone low all over
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Foot cramps
Muscle pain
Muscle tone tense
Fist clenching
Jaw clenching
Poor muscle tone/limp
Tics
Muscle tone low trunk
Muscle weakness, atrophy
Muscle tone low all over
Tremors

SPEECH
Never spoke
Occasional 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
Says “I”
Says “no”
Says “yes”
Lost language at 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

RESPIRATORY
Pneumonia
Bad odor in nose
Breath holding
Bronchitis
Congestion change with season
Congestion in the fall
Congestion in the spring
Congestion in the summer
Congestion in the winter

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
Usual fast heart beat
Heart murmur
Headaches
Joint pains
Leg pains
Muscle pains

Cough
Post nasal drip
Runny nose
Sighing
Sinus fullness
Wheezeing
Yawning

RESPIRATORY

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READINESS ASSESSMENT

Rate on a scale of 5 (very willing) to 1 (not willing)

In order to improve your child's health, how willing is the patient in:

- Significantly modifying diet: O 5 O 4 O 3 O 2 O 1
- Taking several nutritional supplements each day: O 5 O 4 O 3 O 2 O 1
- Keeping a record of everything eaten each day: O 5 O 4 O 3 O 2 O 1
- Modifying lifestyle (e.g., work demands, sleep habits): O 5 O 4 O 3 O 2 O 1
- Practicing a relaxation techniques: O 5 O 4 O 3 O 2 O 1
- Engaging in regular exercise: O 5 O 4 O 3 O 2 O 1
- Have periodic lab tests to assess progress: O 5 O 4 O 3 O 2 O 1

Comments: ____________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Rate on a scale of 5 (very confident) to 1 (not confident)

Your ability to organize and follow through on the above health related activities: O 5 O 4 O 3 O 2 O 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 of 5 (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? O 5 O 4 O 3 O 2 O 1

Comments: ____________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact)

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

Comments: ____________________________
______________________________________________________________________________
______________________________________________________________________________
PLEASE SUBMIT WITH THE ENTIRE INTAKE FORM. DO NOT WAIT AND BRING WITH YOU TO THE APPOINTMENT. WE NEED TO REVIEW PRIOR TO YOUR APPOINTMENT.

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.

- Do not change your eating behavior at this time, as the purpose of this food record is to analyze your present eating habits.
- Record information as soon as possible after the food has been consumed.
- 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**

Name: ______________________________________ Date: ____________________

**DAY 1**

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Bowel Movements (#, form,color):______________________________________
Stress/Mood/Emotions:__________________________________________________
Other Comments:______________________________________________________
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Bowel Movements (#, form, color): ________________________________
Stress/Mood/Emotions: ________________________________
Other Comments: ________________________________
The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are completing this after your first time, then record your symptoms for ONLY the last 48 hours.

**POINT SCALE**

- 0 = Never or almost never have the symptom
- 1 = Occasionally have it, effect is not severe
- 2 = Occasionally have, effect is severe
- 3 = Frequently have it, effect is not severe
- 4 = Frequently have it, effect is severe

**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

### DISEASES 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**
- **Hair loss**
- **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 or urgent urination**
- **Genital itch or discharge**

**Total**

**GRAND TOTAL:**