**PATIENT INFORMATION**

Patient Name:

Mother's Name:

Father's Name:

Are parents: Married/Together/Divorced/Other:

If not married, what is the custody arrangement? Please describe:

Patient Date of Birth:

Gender:  Male  Female

Street Address:

City, State Zip:

Country (If other than the USA):

Home Phone (Area code first):

Mother's Cell Phone (Area code first):

Father's Cell Phone (Area code first):

Mother's Work Phone (Area code first):

Father's Work Phone (Area code first):

Preferred Fax:

Preferred Email:

Patient's Primary Care Physician:

Primary Care Physician's Address/Phone/Fax:

Preferred Local Pharmacy Name/Phone/Fax:

Do you have a preferred local compounding pharmacy? If so provide Name/Phone/Fax:

Emergency Contact Name:

Relationship to Patient:

Address:

Phone:

**PRIVACY CONSTRAINTS *(Choose One)*:**

No Constraints-OK to leave messages, send mail and e-mail

Restrictions-person to person communication with patient/guardian only

Other

**INSURANCE INFORMATION *(while we do not participate in any insurance "networks" and fees are due in full at the time of your visit, our electronic medical record is able to create a universal claim form for you to file if you wish)***

Policy Holder's Name:

Policy Holder's Date of Birth:

Policy Holder's Relationship to Patient:

Insurance Company's Name:

Claims Address (on back of card):

ID Number:

Group Number:

Employer Name as Listed on Policy:

*In the sections that follow, we are trying to familiarize ourselves with your child. Please be as descriptive as possible.*

**PREGNANCY AND DELIVERY**

1. Maternal age at delivery:
2. Anything unusual about the pregnancy? (Illnesses, medications, antibiotics, difficulty):
3. Mother had vaccinations during pregnancy: Yes/No
4. Mother had amalgam (silver) fillings in place during pregnancy: Yes/No
5. Mother had dental work during pregnancy: Yes/No
6. Mother had a possible known or suspected environmental toxin exposure during pregnancy: Yes/No. If yes, please describe:
7. Mother's Blood Type:
8. Child's Blood Type, if known:
9. Miscarriages?
10. Labor and Delivery Duration:
11. Delivery Method *(Choose One)*:  Vaginal Induced C-Section
12. Baby was delivered at (#) weeks gestation:
13. Group B Strep:
14. Antibiotics at Delivery?
15. Anything unusual about the delivery?
16. APGAR Score if remembered:
17. Anything unusual about the baby's hospital stay or initial newborn period?

**INFANCY**

1. Breastfeeding (describe the length and character of feeding effort):
2. Colic or milk intolerance (describe symptoms if present):
3. Formula used:
4. When was food introduced?

**MEDICAL HISTORY**

1. Frequency of and age at first ear infections:
2. Asthma or allergies? If yes please describe:
3. Accidents or trauma? If yes please describe:
4. Hospitalizations/Surgeries? If yes list dates as well as illness/procedures:
5. Diagnostic tests that have been performed on your child:
6. Specialist your child has seen and their impressions:
7. Right or left-handed?

**IMMUNIZATIONS**

1. Child received the routine immunization schedule: Yes/No
2. Child showed reactions to shots: Yes/No. If yes, please describe:
3. Child has had flu shots: Yes/No

**DEVELOPMENT**

1. Age at which you suspected something was unusual? Please describe what you felt was different:
2. Age at which your child rolled over:
3. Age at which your child sat up:
4. Age at which your child walked:
5. Words your child said at the time of their first birthday:
6. Did your child ever lose spoken words? If so please describe the speech regression:
7. Did your child lose social and/or motor skills? If so please describe:
8. Did you associate any regression with a vaccine? If so please describe:

**CURRENT STATUS: GI**

1. Major food cravings:
2. List all foods your child consumes:
3. Does your child eat or mouth nonfood items? If so please describe:
4. Potty trained? If yes, at what age?
5. Describe your child’s stools-color, smell, consistency (liquid, mashed potatoes, rocks, etc.) shape, (balls, snakes, etc.) frequency, blood, mucus or whole food present, sink/float:
6. Does your child have bloating/pass excessive gas/unusual belching/stomach ache/unusual behaviors associated with bowel movements?

**CURRENT STATUS: SENSORY/BEHAVIORS:**

1. Does your child cover their ears or show auditory defensive behavior?
2. Does your child have processing problems (auditory, visual, motor, etc.)?
3. How does your child handle crowded places?
4. Does your child have difficulty with the transition from one activity or setting to another? Please describe:
5. Does your child like certain kinds of touch and/or dislike others? Describe:
6. Does your child have a sensitivity to food textures or difficulty swallowing?
7. Does your child have a sensitivity to the texture of certain clothing or tags?
8. Is cutting hair, nail cutting or brushing teeth difficult?
9. Does your child have any OCD (obsessive/compulsive) type behaviors (lining things up, rigid rituals, "stuck" on an object)?
10. Does your child have any stimming/repetitive behaviors (toe walking, hand flapping, spinning themselves or objects, etc.)?
11. Does your child headbang/nail bite/self-mutilate/bite their arms or hands/skin pick? If so, describe:
12. Is your child moody/irritable/ difficulty focusing/ impulsive/ overactive/ anxious/fearful/ aggressive? Please describe:
13. Does your child have fine motor difficulties, difficulty with buttons/zippers, clumsiness, and/or gross motor skill troubles, etc.?
14. Child has history of pain insensitivity: Yes/No

**CURRENT STATUS: SOCIAL/LANGUAGE**

1. How does your child interact with children who are the same age as they are?
2. How does your child interact with children who are older or younger than they are?
3. How does your child interact with adults?
4. Does your child have language and/or signs? Describe:
5. What type of school/educational program is your child enrolled in currently?
6. What therapies is your child involved with currently?
7. What therapies have you tried in the past?

**CURRENT STATUS: CONSTITUTIONAL/MEDICATIONS/SUPPLEMENTS:**

1. Describe sleep from birth to present- briefly:
2. Currently, how long to fall asleep, do they stay asleep, awakening time, naps:
3. Current seizures or tics? Yes/No. If yes, please describe:
4. Does your child have low muscle tone or lax joints? Yes/No
5. Any funny odors or unusual sweating during sleep: Yes/No
6. With what daily activities do you have to help your child? (Dressing, bathing, brushing teeth, eating):
7. What medications and nutritional supplements is your child taking currently? (list name, dose, and frequency):

**CURRENT STATUS: WHAT HELPS, WHAT DOESN’T:**

1. What medications and nutritional supplements have helped the most?
2. What medications and supplements have a negative effect?
3. What aspects of your child’s current status concern you most?
4. Things (environment/infection/other) that make your child’s behavior worse:
5. Things that make your child’s behavior better:
6. What are your goals for your child’s medical care? List them in order of importance:
7. Is there anything else we should know about your child or your family?

**REVIEW OF SYSTEMS *(if present, please indicate if not described above)***

1. Breath holding, seizures, headache:
2. Fatigue/flushing/ dark circles under eyes/weakness/stiffness:
3. Cold hands/feet, cold/heat intolerance/ tingling of hands or feet/ cracking or peeling of hands or feet:
4. Recurrent/chronic fever, recurrent illness/infection:
5. Blinking/ tics/ ringing in ears:
6. Bad breath/ nose bleeds/swollen gums/ dry lips or mouth:
7. An acute sense of smell/ hearing:
8. Night blindness in child/family:
9. Geographic tongue:
10. Dermatographism (you can “write” on their skin with your fingernail and leave a transient red mark):
11. Hoarseness/ sore throats:
12. Grinding teeth:
13. Anal itching or itchy skin or itchy scalp:
14. Eczema/ psoriasis/hives/acne/seborrhea (cradle cap)/ sensitivity to bug bites/ other rashes:
15. Easy bruising/ dry skin/ pale skin/ oily skin:
16. Thickening of nails, ridging or splitting of nails, brittle or soft nails:
17. Strategies to put pressure on the abdomen, reflux, colic:
18. Does your child lean on people or objects, do they lay down to play?:

**FAMILY HISTORY *In this section, we are looking for genetic tendencies. If your child is adopted, please complete to the best of your knowledge, information about the biologic parents. Please consider, for each person, the following: asthma, allergies, diabetes, blood pressure problems, strokes or heart attacks when young (40’s and 50’s), blood clotting troubles (deep venous thromboses, pulmonary emboli, abnormal menstrual cycles), kidney disease, seizures, migraines, and other neurologic disorders, mental disorders (diagnosed, and “Uncle Louie was a little nutty”, especially schizophrenia, bipolar disease, depression, anxiety), substance use/abuse, hormone problems (most commonly thyroid troubles), autoimmune diseases (Lupus, rheumatoid arthritis, chronic fatigue, multiple sclerosis, etc.), night vision disturbance, gut troubles (Celiac, Crohn’s, constipation, irritable bowel, etc.), learning disabilities, ADHD, etc.:***

1. Mother’s date of birth and medical history:
2. Father’s date of birth and medical history:
3. Siblings- names and dates of birth and medical history:
4. Maternal grandmother year of birth and medical history:
5. Maternal grandfather year of birth and medical history:
6. Paternal grandmother year of birth and medical history:
7. Paternal grandfather year of birth and medical history:
8. Any maternal siblings and significant medical history:
9. Any paternal siblings and significant medical history:
10. Any of your child’s cousins with significant medical history:

**SOCIAL HISTORY**

1. Mother’s education:
2. Mother’s occupation:
3. Father’s education:
4. Father’s occupation:
5. Who lives in the house?
6. Who would your child call their family?
7. Who are your child’s caregivers?
8. Do you have family nearby?
9. What is your support system for the treatment and care of your child?
10. Do you have pets? If so, what kind, and how does your child do with them?
11. Does anyone smoke at home?

**ENVIRONMENTAL HISTORY**

1. Location of home (city/suburban/wooded/farm/etc.):
2. The water source for home (well/city/filtration system and type if present):
3. Heating/Cooling system type (electric/gas/oil/other):
4. Do you live near power lines/woods/industrial area/water?
5. If you live near water, please describe (swamp, river, ocean, retention pond, etc.):
6. Does your home, and especially your child’s room, have a lot of dust/mold/feathers/stuffed animals? Please describe: