Vitality Integrative Medicine

Personalized medicine for your optimal health

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 ☐ _____

Mother's Name Occupation

Father's Name Occupation

Person completing this questionnaire

Primary Address *Number, Street* *Apt. No.*

City *State* *Zip*

Home Phone _____ Parent's Work Phone _____

Parent's Cell Phone _____ Fax _____

Email _____

Emergency Contact *Name* *Phone Number*

Address *Apt. No.*

City *State* *Zip*

Referred by ○ Website ○ Friend or Family Member _____ ○ Phonebook ○ Other _____

PHARMACY INFORMATION

Primary Pharmacy *Name* *Phone Number*

Address

City *State* *Zip*

E-mail **Fax***

**** 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	Success: Excellent	Success: Good	Success: Fair
Example: Difficulty Maintaining Attention		*X*		*Elimination Diet*	*X*		

MEDICAL HISTORY

DISEASES/DIAGNOSIS/CONDITIONS *Check appropriate box and provide date of onset*

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 blood pressure) _____
- ☐ ☐ Rheumatic Fever _____
- ☐ ☐ Mitral Valve Prolapse _____
- ☐ ☐ Other _____

METABOLIC/ENDOCRINE

- ☐ ☐ Type 1 Diabetes _____
- ☐ ☐ Type 2 Diabetes _____
- ☐ ☐ Hypoglycemia _____
- ☐ ☐ Metabolic Syndrome _____
  (Insulin Resistance or Pre-Diabetes)
- ☐ ☐ Hypothyroidism (low thyroid) _____
- ☐ ☐ Hyperthyroidism (overactive thyroid) _____
- ☐ ☐ Endocrine Problems _____
- ☐ ☐ Polycystic Ovarian Syndrome (PCOS) _____
- ☐ ☐ Weight Gain _____
- ☐ ☐ Weight Loss _____
- ☐ ☐ Frequent Weight Fluctuations _____
- ☐ ☐ Bulimia _____
- ☐ ☐ Anorexia _____
- ☐ ☐ Binge Eating Disorder _____
- ☐ ☐ Night Eating Syndrome _____
- ☐ ☐ Eating Disorder (non-specific) _____
- ☐ ☐ Other _____

CANCER

- ☐ ☐ _____

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 Infectious Disease _____
- ☐ ☐ Poor Immune Function _____
  (frequent infections)
- ☐ ☐ 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 _____

SKIN DISEASES

- ☐ ☐ Eczema _____
- ☐ ☐ Psoriasis _____
- ☐ ☐ Acne _____
- ☐ ☐ Other _____

MEDICAL HISTORY (CONTINUED)

PAST	CURRENT	NEUROLOGIC/MOOD
☐	☐	Depression _____
☐	☐	Anxiety _____
☐	☐	Bipolar Disorder _____
☐	☐	Schizophrenia _____
☐	☐	Headaches _____
☐	☐	Migraines _____
☐	☐	ADD/ADHD _____
☐	☐	Sensory Integrative Disorder _____
☐	☐	Autism _____
☐	☐	Mild Cognitive Impairment _____
☐	☐	Multiple Sclerosis _____
☐	☐	ALS _____
☐	☐	Seizures _____
☐	☐	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 _____
- ☐ Physical Therapy _____
- ☐ 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
O Rh+ O 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 or see addendum.

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 counseling for your child? ☐ Yes ☐ No

Is your child or family currently in therapy? ☐ Yes ☐ No Describe:_____

Does your child have a favorite toy or object? ☐ Yes ☐ No

Does your child practice stress release methods? ☐ Yes ☐ No If yes, then 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? ☐ Yes ☐ No

SLEEP/REST

Average number of hours your child sleeps per night: ☐ >12 ☐ 10-12 ☐ 8-10 ☐ < 8

Does your child have trouble falling asleep? ☐ Yes ☐ No

Does your child feel rested upon awakening? ☐ Yes ☐ No

Does your child snore? ☐ Yes ☐ No

ROLES/RELATIONSHIP

List Family Members:

Family Member and Relationship	Age	Gender

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 females only)*

MENSTRUAL HISTORY

Age at first period:_____Menses Frequency:_____Length:_____Pain: ☐Yes ☐No Clotting: ☐Yes ☐No

Has your period ever skipped?_____For how long?_____

Last Menstrual Period:_____

Does your child use contraception? ☐Yes ☐No ☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner Vasectomy

Use of hormonal contraception such as: ☐ Birth Control Pills ☐ Patch ☐ Nuva Ring How long?_____

GI HISTORY

Has your child traveled to foreign countries? O Yes O No Where? _____

Wilderness Camping? O Yes O No Where? _____

Have you 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 description if applicable

☐ Difficulty getting pregnant (more than 6 months) _____
☐ Infertility drugs used Specify: _____
☐ In vitro fertilization _____
☐ 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? If so which months? _____
☐ Have birth problems _____

☐ Group B strep infection _____
☐ Have c-section because of _____
☐ Use induction for labor (such as Pitocin) _____
☐ Have anesthesia, if so list type _____
☐ 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:_____lb Total weight loss during pregnancy:_____lb

Please describe diet during pregnancy: _____

_____

_____

Please describe labor: _____

_____

PATIENT BIRTH HISTORY (CONTINUED)

PERINATAL

Pregnancy duration: *(Please indicate at what week was your baby born)*

☐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 month? ☐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 score at 1 minute: _____ Apgar score at 5 minutes: _____

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?

☐ 0-1months ☐ 2-6 months ☐ 7-15 months ☐16-24 months ☐ After 24 months

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? ☐Yes ☐No
Or is the impression strong? ☐Yes ☐No

DEVELOPMENTAL HISTORY

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

Sitting up _____months ☐Never
Crawl _____months ☐Never
Pulled to stand _____months ☐Never
Potty trained _____months ☐Never
Walked alone _____months ☐Never

Dry at night _____months ☐Never
First words (“mamma”, “dada”, etc.)_____months ☐Never
Spoke clearly _____months ☐Never
Lost language _____months ☐Never
Lost eye contact_____months ☐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 and 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 Grandmothe	Maternal Grandfather	Paternal Grandmothe	Paternal Grandfather	Aunts	Uncles	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? 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 (Peanuts, Eggs, etc.): _____

Height (feet/inches)_____ Current Weight _____

Longest 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? ☐0-1 ☐1-3 ☐3-5 ☐>5 meals per week

Check all the factors that apply to your child's current lifestyle and eating habits:

☐ Fast eater
☐ Erratic eating pattern
☐ Eat too much
☐ Dislike healthy food
☐ Time constraints
☐ Eat more than 50% 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
☐ Cow's Milk 1 2 3+
☐ Caffeine intake
☐ TV or videos with meals
☐ Challenges with food served outside the home (Ex. childcare, friend's home)

BREASTFED HISTORY

Breastfed? ☐ Yes ☐ No How long? _____ Problems latching on? ☐ Yes ☐ No

Sucking quality? ☐ Very Good ☐ Good ☐ Poor Exclusively breastfed for_____months

BOTTLE FED HISTORY

Bottle fed? ☐ Yes ☐ No Type of formula: ☐ Soy ☐ Cow's Milk ☐ 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? ☐ Yes ☐ No Refused to chew solids? ☐ Yes ☐ No

List mother's known food allergies or sensitivities: _____

Please describe any other eating concerns that you have regarding your child: _____

ACTIVITY

List type and amount of activity daily.

Type	Amount Daily

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

PAST	CURRENT	EXPOSURES
☐	☐	Mold in bathroom
☐	☐	Damp cellar
☐	☐	Pest extermination - Inside
☐	☐	Pest extermination - Outside
☐	☐	Forced hot air heat
☐	☐	Had water in basement
☐	☐	Mold visible on exterior of house
☐	☐	Heavily wooded or damp surroundings
☐	☐	Mold in cellar, crawl space, or basement
☐	☐	Moldy, musty school/daycare
☐	☐	Tobacco smoke
☐	☐	Well water
☐	☐	Carpet in bedroom
☐	☐	Carpet in most parts of house
☐	☐	Feather or down bedding

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
- ☐ 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 peoples feelings
- ☐ OK if parents leave
- ☐ Answers parent
- ☐ Follows instructions
- ☐ Pronounces words well
- ☐ Unusual memory
- ☐ Perfect musical pitch
- ☐ Good with math
- ☐ Good with computer
- ☐ 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 unusually large
- ☐ Unusually long eye lashes
- ☐ Pupils unusually small
- ☐ Dark circles under eyes
- ☐ Red lips
- ☐ Red fingers
- ☐ Red toes
- ☐ Webbed toes
- ☐ Red ears
- ☐ Double jointed
- ☐ High arched palate
- ☐ Lymph nodes enlarged neck
- ☐ Head warm
- ☐ Head sweats
- ☐ Night sweats
- ☐ Abnormal fatigue
- ☐ Failure to thrive
- ☐ Cold all over
- ☐ 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
- ☐ 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 circle 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 or lines in nails
- ☐ Dry skin in general
- ☐ Feet cracking
- ☐ Feet peeling
- ☐ Hands cracking
- ☐ Hands 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 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 (map-like)
- ☐ Sore tongue
- ☐ Tongue coated

- ☐ Canker 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
- ☐ Crampy pain with pooping
- ☐ Constipation
- ☐ 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

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 intol.
- ☐ 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 television 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
- ☐ Melt downs
- ☐ 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/asked
- ☐ Teases others
- ☐ Silly
- ☐ Shrieks
- ☐ Holds hands in strange pose
- ☐ Spends time w/ 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 finger side of face
- ☐ Bites or chews fingers
- ☐ Bites wrist or back of hands
- ☐ Chews on things

MOOD

- ☐ Apathy
- ☐ Blank look
- ☐ Depression
- ☐ Detached
- ☐ Disinterested
- ☐ Eye contact poor
- ☐ Isolates
- ☐ Negative
- ☐ Fright without cause
- ☐ Always frightened
- ☐ Anguish
- ☐ Discontented
- ☐ Does not want to be touched
- ☐ Inconsolable crying
- ☐ Irritable
- ☐ Looks like in pain
- ☐ Moaning, groaning
- ☐ Phobias
- ☐ Restless
- ☐ Severe mood swings
- ☐ Unhappy
- ☐ Agitated
- ☐ Anxious

SENSORY

- ☐ Bothered by certain sounds
- ☐ Covers ears with sounds
- ☐ 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
- ☐ Bothered 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 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 of 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 held 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
- ☐ Muscle twitches
- ☐ Fist clenching
- ☐ Jaw clenching
- ☐ Poor muscle tone/limp
- ☐ Tics
- ☐ Muscle tone low trunk
- ☐ Muscle weakness, atrophy
- ☐ Muscle tone low all over
- ☐ Tremors
- ☐ Cognitive delays
- ☐ Memory poor
- ☐ Poor attention, focus
- ☐ Slow and sluggish
- ☐ Expressive language delay

SPEECH

- ☐ Never spoke
- ☐ Occas. 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 @ 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
- ☐ Tidy

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
- ☐ Dry at night
- ☐ Seizures - focal
- ☐ Seizures - generalized
- ☐ Seizures - grand mal
- ☐ Seizures - petit mal
- ☐ Unusually fast heart beat
- ☐ Heart murmur
- ☐ Headaches
- ☐ Joint pains
- ☐ Leg pains
- ☐ Muscle pains

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 modify diet O5 O4 O3 O2 O1

Take several nutritional supplements each day O5 O4 O3 O2 O1

Keeping a record of everything eaten each day O5 O4 O3 O2 O1

Modify lifestyle (e.g., school/work demands, sleep habits) O5 O4 O3 O2 O1

Practicing a relaxation technique O5 O4 O3 O2 O1

Engaging in regular exercise O5 O4 O3 O2 O1

Having periodic lab tests to assess progress O5 O4 O3 O2 O1

Comments _____

_____

_____

Rate on a scale of 5 (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? - O5 O4 O3 O2 O1

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? - O5 O4 O3 O2 O1

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 personal health program? - O5 O4 O3 O2 O1

Comments _____

_____

_____

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.

- 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

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel Movements (#, form, color) _____

Stress/Mood/Emotions _____

Other Comments _____

DAY 2

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel Movements (#, form, color) _____

Stress/Mood/Emotions _____

Other Comments _____

DAY 3

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel Movements (#, form, color) _____

Stress/Mood/Emotions _____

Other Comments _____

MSQ - MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

NAME: _____ **DATE:** _____

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 the last 48 hours ONLY.

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

DIGESTIVE TRACT

___Nausea or vomiting
___Diarrhea
___Constipation
___Bloated feeling
___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 _____

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