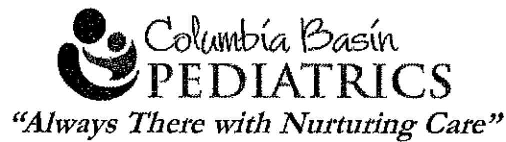

"Always There with Nurturing Care"

Ekta Khurana, MD,
Michelle Crawford, ARNP
Haley Scellick, ARNP
9521 Sandifur Parkway, Suite 2
Pasco, WA 99301
www.columbiapeds.com

Tel: (509) 946-7332 Fax: (509) 946-1995

Dear parent or guardian,

Thank you for your interest in Functional Medicine. I have found that Traditional Medicine has answers to most acute diseases but when it comes to chronic diseases or mental health it has its own limitations. This void is filled by Functional Medicine, which looks at the root cause of the symptoms and treats it from the inside out. Functional Medicine is a method that begins with the idea that diseases do not exist but instead are imbalances that need to be corrected for optimal health.

Thank you for your time in filling out our extensive questionnaire. It may seem very comprehensive, but medical history is an essential role in Functional Medicine. Please be as detailed as possible when filling out this questionnaire, we encourage that you provide as much detail as possible for the best results.

We do also ask that you provide a 5 day diet, symptom and behavior log. Please be as detailed as possible when providing nutrition information; providing names of brands and portions will assist in evaluating and understanding of what has been consumed. For the behavior and symptom portion, please document dates, times, durations and if anything that assists in relief of the symptom and/ or behavior.

In our efforts maximize your time, we do ask that you fill out and return this questionnaire prior to scheduling your appointment. Functional Medicine is too comprehensive to be completed during one office visit; it may take multiple visits to find what suits your child best.

Thank you again for your time,

Ekta Khurana, MD

GENERAL INFORMATION

Name: *First* *Middle* *Last*

Preferred Name:

Date of Birth: **Age:**

Gender: O Male O Female

Genetic Background: O African O European O Native American O Mediterranean O Asian O Ashkenazi O 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:

O Book O Website O Media O Family Member or Friend

O Google (which words)____________________ O 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.

Compounding/Supplement 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 feel your child was well? ______________________________

____

Did something trigger your child's change in health? ______________________________

____

Is there anything that makes your child feel worse? ______________________________

____

Is there anything that makes your child feel better? ______________________________

____

Please list current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe	Prior Treatment/Approach	Excellent	Good	Fair
Example: Difficulty Maintaining Attention		*X*		*Elimination Diet*	*X*		

MEDICAL HISTORY

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

Past	Current	GASTROINTESTINAL
☐	☐	Irritable Bowel Syndrome ________
☐	☐	Inflammatory Bowel Disease ________
☐	☐	Crohn's ________
☐	☐	Ulcerative Colitis ________
☐	☐	Gastritis or Peptic Ulcer Disease ________
☐	☐	GERD (reflux) ________
☐	☐	Celiac Disease ________
☐	☐	Other ________

Past	Current	CARDIOVASCULAR
☐	☐	Heart Disease ________
☐	☐	Elevated Cholesterol ________
☐	☐	Hypertension (high blood pressure) ________
☐	☐	Rheumatic Fever ________
☐	☐	Mitral Valve Prolapse ________
☐	☐	Other ________

Past	Current	METABOLIC/ ENDOCRINE
☐	☐	Type 1 Diabetes ________
☐	☐	Type 2 Diabetes ________
☐	☐	Hypoglycemia ________
☐	☐	Metabolic Syndrome (Pre-Diabetes) ________
☐	☐	Hypothyroidism (low thyroid) ________
☐	☐	Hyperthyroidism (overactive thyroid) ________
☐	☐	Endocrine Problems ________
☐	☐	Polycystic Ovarian Syndrom (PCOS) ________
☐	☐	Weight Gain ________
☐	☐	Weight Loss ________
☐	☐	Frequent Weight Fluctuations ________
☐	☐	Bulimia ________
☐	☐	Anorexia ________
☐	☐	Binge Eating Disorder ________
☐	☐	Night Eating Syndrome ________
☐	☐	Eating Disorder (non-specific) ________
☐	☐	Other ________

Past	Current	CANCER
☐	☐	________

Past	Current	GENITAL AND URINARY
☐	☐	Kidney Stones ________
☐	☐	Urinary Tract Infection ________
☐	☐	Yeast Infections ________
☐	☐	Other ________

Past	Current	MUSCULOSKELETAL/ PAIN
☐	☐	Arthritis ________
☐	☐	Fibromyalgia ________
☐	☐	Chronic Pain ________
☐	☐	Other ________

Past	Current	INFLAMMATION/
☐	☐	Chronic Fatigue Syndrome ________
☐	☐	Autoimmune Disease ________
☐	☐	Rheumatoid Arthritis ________
☐	☐	Lupus SLE ________
☐	☐	Immune Deficiency Disease ________
☐	☐	Severe Infectious Disease ________
☐	☐	Poor Immune Function ________
☐	☐	(frequent infection)
☐	☐	Food Allergies ________
☐	☐	Environmental Allergies ________
☐	☐	Multiple Chemical Sensitivities ________
☐	☐	Latex Allergy ________
☐	☐	Other ________

Past	Current	RESPIRATORY DISEASES
☐	☐	Frequent Ear Infections ________
☐	☐	Frequent Upper Respiratory Infections ________
☐	☐	Asthma ________
☐	☐	Chronic Sinusitis ________
☐	☐	Bronchitis ________
☐	☐	Sleep Apnea ________
☐	☐	Other ________

Past	Current	SKIN DISEASES
☐	☐	Eczema ________
☐	☐	Psoriasis ________
☐	☐	Acne ________
☐	☐	Other ________

MEDICAL HISTORY (CONTINUED)

NEUROLOGIC/ MOOD

Past	Current	Condition	Past	Current	Condition
☐	☐	Depression ______	☐	☐	Sensory Integrative Disorder ______
☐	☐	Anxiety ______	☐	☐	Autism ______
☐	☐	Bipolar Disorder ______	☐	☐	Mild Cognitive Impairment ______
☐	☐	Schizophrenia ______	☐	☐	ALS ______
☐	☐	Headaches ______	☐	☐	Seizures ______
☐	☐	Migranes ______	☐	☐	Arthritis ______
☐	☐	ADD/ ADHD ______	☐	☐	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 ______
- ☐ 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? 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:

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 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:

____

____

____

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

Crawl __________months O Never

Pulled to stand __________months O Never

Potty trained __________months O Never

Walked alone __________months O Never

Dry at night __________months O Never

First words("mama, dada" etc)_____months O Never

Spoke clearly __________months O Never

Lost language __________months O Never

Lost eye contact __________months O Never

MEDICATIONS

CURRENT MEDICATIONS

Medications	Dose	Frequency	Start Date (month/year)	Reason For Use

PREVIOUS MEDICATIONS: *Last 10 years*

Medications	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 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

FAMILY HISTORY

Check family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age(if still alive)												
Age at death (if diseased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis(Rheumatoid, Psoriatic, Ankylosing Sondylitis)												
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 (*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
- ☐ 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
- ☐ Gestational Diabetes____________________
- ☐ High blood pressure(pre-eclampsia)______________
- ☐ High blood pressure/toxemia_________________
- ☐ Have chemical exposure ____________________

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. Introductin of wheat or other grain at _________ months.

Choke/ Gas/ Vomit on milk? O Yes O Now 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.

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

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 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
- ☐ Like 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 warms
- ☐ 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

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 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

DIGESTIVE

- ☐ 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

- ☐ 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 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

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
- ☐ Unhappy
- ☐ Agitated
- ☐ Anxious

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
- ☐ Conjuctivitis
- ☐ 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
- □ Muscle twitches
- □ Fist clenching
- □ Jaw clenching
- □ Poor muscle tone/ limp
- □ Tics
- □ Muscle tone low trunk
- □ Muscle weakness, atophy
- □ Muscle tone low all over
- □ Tremors
- □ Cognitive delays
- □ Memory poor
- □ Poor attention, focus
- □ Slow and sluggish
- □ Expressive language delay

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
- □ 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
- □ Usual 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 heath, how willing is the patient in:

Significantly modifying diet: O 5 O 4 O 3 O 2 O1

Taking several nutritional supplements each day: O 5 O 4 O 3 O 2 O1

Keeping a record of everything eaten each day: O 5 O 4 O 3 O 2 O1

Modifying lifestyle (e.g., work demands, sleep habits): O 5 O 4 O 3 O 2 O1

Practicing a relaxation techniques: O 5 O 4 O 3 O 2 O1

Engaging in regular exercise: O 5 O 4 O 3 O 2 O1

Have periodic lab tests to assess progress: O 5 O 4 O 3 O 2 O1

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 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? O 5 O 4 O 3 O 2 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 child's health program? O 5 O 4 O 3 O 2 O1

Comments: ____

____

____

5-DAY DIET DIARY INSTRUCTIONS

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 5 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: ______________________
OtherComments:______________________

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:____

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 *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

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: _______

SPACE FOR ADDITIONAL NOTES