Child's Health History:

Patient Name:_____ **DOB:** _____

Assessment Date: _____

Height_____ **Weight** _____ (to be filled out by nurse on day of appointment.)

Temperature _____ (to be filled out by nurse on day of appointment.)

Parent/Guardian: Please explain briefly why you are bringing your child to the NSC:

_____

_____

_____

DEVELOPMENTAL DIAGNOSES:

Developmental Diagnosis Information:

Diagnosis Name (s):

_____

_____

_____

Professional Making Diagnosis: _____

Diagnosis Date: _____

Developmental Disorder Onset: (select one)

____ **Normal Development followed by Regression**

Normal development to at least 12 months followed by loss of skills together with onset of autistic like behaviors.

____ **Normal Development followed by Plateau**

Normal development to at least 12 months followed by a plateau of communications, social cognitive and/or developmental skills together with onset of autistic like behaviors. No loss of previously gained skills.

____ Developmental difficulties prior to 12 months

____ No developmental difficulties

Other :

_____

_____

_____

_____

Medications: List all medications your child is currently taking.

_____
_____
_____
_____
_____

Supplements: List all supplements your child is currently taking.

_____
_____
_____
_____
_____

ALLERGIES:

Drug Allergy Information: List all drug allergies, symptoms, and if they are known or suspected.

_____
_____
_____

Food Allergy Information: List all food allergies, symptoms, and if they are known or suspected.

_____
_____
_____

CONCERNS ASSESSMENT:

Concerning Issues or Behaviors: (Please list in descending order – greatest concern #1, etc.)

Concern #1: _____

Concern #2: _____

Concern #3: _____

Concern #4: _____

Concern #5: _____

ASSESSMENTS:

NEUROLOGICAL ASSESSMENT: Parent Description:

_____

_____

_____

Symptoms	**Rating**			
	None	Mild	Moderate	Severe
Expressive Language Deficit				
Receptive Language Deficit				
Social Integration Issues				
Physical Self Stimulatory Behavior				
Verbal Self Stimulatory Behavior				
Attention Deficits (focusing, concentration)				
Anxiety				
Obsessive Compulsive Behaviors				
Rigid Need for Routine				
Eye Contact Deficits				
Visual-Motor Skills Difficulties				
Hyperacusis				
Sleep Pattern Disruptions				
Toe Walking				
Headaches				
Short Memory				
Aggression				
Imbalance/Clumsiness				
Seizures				
Recurrent Falls				
Spinning objects or self				
Fear of Danger				
Inappropriate Emotions				

Comments:

_____

_____

_____

Symptoms:	Ever Present (Y/N)	Date Last Episode
Infant Colic		
Formula Intolerance		
Cow's Milk Intolerance		
Infant Stool Problems		
Stool Foul Odor		
Stool Contains Undigested Food		
Constipation (failure to pass stool for two or more days)		
Diarrhea (more than three stools per day)		
Pain (Is your child in pain?)		
Pain Prior to Bowel Movement		
Irritability Prior to Bowel Movement		
Withholds Stool or is Afraid to Pass a Movement		

Fingernails: Check those that Apply.

Pink		Grey/blue		White spots on nails	
Cracked/peeling/split		Soft		Hang nails	
Fungus		Hard			

Hair: Check those that apply.

Stiff		Dry		Brittle	
Thick		Soft			
Thin		Limp			

Face: Check those that apply.

Rosy cheeks		Red dots/bumps		White splotches	
Raised white dots		Red splotches		Tongue smooth/bumpy	
Eczema		Tongue coated white or grey		Dark circles under eyes	
Tongue red/glossy					

Trunk and Skin: Check those that apply.

Hard white dots		Rashes of any kind		Bloating	
Itchy		Eczema			

Stool Consistency: _____

Frequency of bowel movements (average per day): _____

Has your child undergone any investigations for GI symptoms? Y N If Yes, please explain: _____

_____

DIETARY INTERVENTION INFORMATION:

Diet: _____Start Date:_____

Helped Behaviors? Y/N Explain: _____

_____

_____

Helped GI? Y/N Explain:

_____

Child consumes fish ? Y / N. If yes, how many servings/week? _____

Self limited diet: ____ None ____ Mild ____ Moderate ____ Severe

Describe your child's favorite foods:

_____

_____

_____

Describe normal day's food intake, including serving sizes, all snacks and drinks.

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

Describe special feeding measures, including feeding tubes, swallowing difficulties, reflux, etc.

_____

_____

Comments: _____

_____

_____

_____

MEDICAL HISTORIES:

Check all that apply. Describe any checked items in comments section

	Mother was exposed to measles virus		Mother received flu shot during pregnancy
	Mother has/had dental amalgams		Maternal infections
	Mother had dental work done during pregnancy		Maternal medications during pregnancy
	Mother consumed fish during pregnancy		Mother received vaccines during pregnancy
	Mother Rh-		Prenatal care began after the first trimester
	Baby was premature		Complications at delivery

Comments:

_____

_____

_____

Baby's birth weight: _____

Was baby breast or bottle fed? _____

If breast fed, for how long? _____

If bottle fed, type of formula: _____

What was the primary source of water? _____

How old was your child when cow's milk was started? _____

Did baby have good suck/swallow coordination? Y / N

Childhood Milestones: Please give approximate age of occurrence.

	Social Smile		Responds to Emotion
	Verbalized Sounds Only		Verbal Imitation
	Single Words		Two or More Words
	Sentences		Rolled Over
	Sat Alone		Walked
	Slept Through the Night		

Hospitalizations: List year, hospital, and reason for Hospitalization:

_____

_____

_____

Childhood Exposures: Please answer "Yes" or "No" to the following:

Was Hepatitis B vaccine given to the baby prior to hospital discharge? _____

Professional carpet cleaning in home _____

Scotch guard furniture in home _____

Pesticides in the home _____

Maternal medications during breast feeding _____

Child consumed fish _____

Lead based paint in home _____

Any known toys with metals such as lead or mercury _____

Any Dental Amalgams _____

Other known exposures _____

Patient's Previous Illnesses: Please check all that apply.

Colic		Tonsillitis		Recurrent Sinusitis	
Reflux		RSV		Adverse Vaccine Reaction	
Croup		Seizures		Asthma	
OCD		Seasonal Allergies		Encephalitis	
Herpes/Cold Sores		Meningitis		Frequent Viral Infections	
Chicken Pox		Tics		Pneumonia	
Trouble Falling Asleep		Trouble Staying Awake		Strep Throat	
Allergic Rhinitis		Ear Infections		Mononucleosis	
Ear Tubes		Other			

Comments:_____

_____

_____

Vaccine Information:

Please provide us with a copy of all immunizations your child has received and dates they were received. Below, describe any adverse reactions your child may have had to any of the immunizations. Also, describe any loss of skill afterwards.

_____

_____

_____

_____

Family History: Check and indicate relationship to patient.

Autism/ PDD		Asperger's		Scleroderma	
Chromosomal Abnormalities		Chronic Fatigue Syndrome		Multiple Sclerosis (MS)	
Anxiety Disorder		Depression		ADD/ADHD	
Diabetes – Insulin Dependent		Inflammatory Bowel Disease		Alzheimer's Disease	
Schizophrenia		Parkinson's		OCD	
Seizures		Speech Disorder		Bipolar	
Fragile X Syndrome		Irritable Bowel Syndrome		Other genetic abnormalities	
Cancer		Thyroid Disease		Allergies (airborne)	
Lupus		Allergies (food)		Rheumatoid Arthritis	
Heart Disease, Stroke, High Blood Pressure		Fibromyalgia		Pituitary adenoma	
Other autoimmune disorder		Headaches/Migraines		Asthma	
Dizziness/Vertigo					

Please indicate with a check mark (✓) the extent to which your child exhibited the following behaviors over the past two weeks:

	Not at all	**Just a little**	**Quite a bit**
Seemed worried, guilty or anxious			
Seemed tense, uptight or nervous			
Was impulsive, acted without thinking			
Seemed in a low mood, sad, or depressed			
Had difficulty concentrating or focusing			
Seemed "stressed out"; "broke down"			
Seemed forgetful, had memory problems			
Got angry, lost temper			

THERAPY INTERVENTION INFORMATION: Please list any therapy interventions (behavioral, speech, occupational, physical, vision, etc.) that your child has undertaken or is currently receiving, how long they have been in the therapy, and results. (Improved behaviors, improved school performance, etc.)

_____
_____
_____
_____

HEAVY METAL TESTING:

Has your child had previous Heavy Metal Testing? Y / N.

If "Yes", was it by _____ stool ____ urine ____ hair ____ blood

Has your child ever done chelation? Y / N.

If "Yes", please list chelating agents: _____

Primary Care Physician: _____

Date of last exam: _____

Other Physicians currently treating your child: _____
_____
_____
_____

Optometrist/Ophthalmologist: _____

Date of Last Eye Exam: _____

Findings: _____

Additional Comments:

_____
_____
_____
_____