

Center for Well Being

3601 Minnesota Drive, #160
Edina, MN 55435
Tel: 952-885-0822

Please Complete In Full

Today's 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 _____

Mother's Name: _____ Occupation: _____

Father's Name: _____ Occupation: _____

Primary Address (person completing this questionnaire)

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: _____ Email: _____

Emergency Contact:

Name Phone Number

Address

Apt. No.

City

State

Zip

Medical Physician:

Name

Phone Number

Fax

Chiropractic Physician:

Name

Phone Number

Referred by Book Website
 Media Friend or Family Member: _____
 Other _____

CREDIT CARD INFORMATION

Patient _____ Date _____

DOB _____

Preferred Method of Payment (please circle one): Cash / Check / Credit Card

Credit Card Type (please circle one): VISA MASTERCARD DISCOVER

PRIMARY CARD

Name on Card _____

Card Type Visa MasterCard Discover

Account Number _____

Expiration Date (mm/yy) _____

CVV# _____

SECONDARY CARD

Name on Card _____

Card Type Visa MasterCard Discover

Account Number _____

Expiration Date (mm/yy) _____

CVV# _____

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:

Success

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

Medical History

Diseases/Diagnosis/Conditions (Check appropriate box and provide date of onset)

GASTROINTESTINAL

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel Syndrome _____
<input type="checkbox"/>	<input type="checkbox"/>	Inflammatory Bowel Disease _____
<input type="checkbox"/>	<input type="checkbox"/>	Crohn's _____
<input type="checkbox"/>	<input type="checkbox"/>	Ulcerative Colitis _____
<input type="checkbox"/>	<input type="checkbox"/>	Gastritis or Peptic Ulcer Disease _____
<input type="checkbox"/>	<input type="checkbox"/>	GERD (reflux) _____
<input type="checkbox"/>	<input type="checkbox"/>	Celiac Disease _____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

CARDIOVASCULAR

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease _____
<input type="checkbox"/>	<input type="checkbox"/>	Elevated Cholesterol _____
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (high blood pressure) _____
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever _____
<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse _____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

METABOLIC/ENDOCRINE

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Type 1 Diabetes _____
<input type="checkbox"/>	<input type="checkbox"/>	Type 2 Diabetes _____
<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia _____
<input type="checkbox"/>	<input type="checkbox"/>	Metabolic Syndrome (Insulin Resistance or Pre-Diabetes) _____
<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroidism (low thyroid) _____
<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroidism (overactive thyroid) _____
<input type="checkbox"/>	<input type="checkbox"/>	Endocrine Problems _____
<input type="checkbox"/>	<input type="checkbox"/>	Polycystic Ovarian Syndrome (PCOS) _____
<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain _____
<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss _____
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Weight Fluctuations _____
<input type="checkbox"/>	<input type="checkbox"/>	Bulimia _____
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia _____
<input type="checkbox"/>	<input type="checkbox"/>	Binge Eating Disorder _____
<input type="checkbox"/>	<input type="checkbox"/>	Night Eating Syndrome _____
<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder (non-specific) _____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

CANCER

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	_____

GENITAL AND URINARY SYSTEMS

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones _____
<input type="checkbox"/>	<input type="checkbox"/>	Urinary Tract Infections _____
<input type="checkbox"/>	<input type="checkbox"/>	Yeast Infections _____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

MUSCULOSKELETAL/PAIN

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis _____
<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia _____
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Pain _____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

INFLAMMATORY/AUTOIMMUNE

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue Syndrome _____
<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune Disease _____
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis _____
<input type="checkbox"/>	<input type="checkbox"/>	Lupus SLE _____
<input type="checkbox"/>	<input type="checkbox"/>	Immune Deficiency Disease _____
<input type="checkbox"/>	<input type="checkbox"/>	Severe Infectious Disease _____
<input type="checkbox"/>	<input type="checkbox"/>	Poor Immune Function (frequent infections) _____
<input type="checkbox"/>	<input type="checkbox"/>	Food Allergies _____
<input type="checkbox"/>	<input type="checkbox"/>	Environmental Allergies _____
<input type="checkbox"/>	<input type="checkbox"/>	Multiple Chemical Sensitivities _____
<input type="checkbox"/>	<input type="checkbox"/>	Latex Allergy _____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

RESPIRATORY DISEASES

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Ear Infections _____
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Upper Respiratory Infections _____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma _____
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis _____
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis _____
<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea _____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

SKIN DISEASES

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Eczema_____
<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis_____
<input type="checkbox"/>	<input type="checkbox"/>	Acne_____
<input type="checkbox"/>	<input type="checkbox"/>	Other_____

NEUROLOGIC/MOOD

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Depression_____
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety_____
<input type="checkbox"/>	<input type="checkbox"/>	Bipolar Disorder_____
<input type="checkbox"/>	<input type="checkbox"/>	Schizophrenia_____
<input type="checkbox"/>	<input type="checkbox"/>	Headaches_____
<input type="checkbox"/>	<input type="checkbox"/>	Migraines_____
<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD_____
<input type="checkbox"/>	<input type="checkbox"/>	Sensory Integrative Disorder _____
<input type="checkbox"/>	<input type="checkbox"/>	Autism_____
<input type="checkbox"/>	<input type="checkbox"/>	Mild Cognitive Impairment_____
<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis_____
<input type="checkbox"/>	<input type="checkbox"/>	ALS_____
<input type="checkbox"/>	<input type="checkbox"/>	Seizures_____
<input type="checkbox"/>	<input type="checkbox"/>	Other Neurological Problems_____

PREVIOUS EVALUATIONS

Check box if yes and provide date

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Full Physical Exam_____
<input type="checkbox"/>	<input type="checkbox"/>	Psychological Evaluations _____
<input type="checkbox"/>	<input type="checkbox"/>	Wechsler Preschool & Primary Scale of Intelligence _____
<input type="checkbox"/>	<input type="checkbox"/>	Speech and Language Evaluations _____
<input type="checkbox"/>	<input type="checkbox"/>	Genetic Evaluation _____
<input type="checkbox"/>	<input type="checkbox"/>	Neurological Evaluations _____
<input type="checkbox"/>	<input type="checkbox"/>	Gastroenterology Evaluations _____
<input type="checkbox"/>	<input type="checkbox"/>	Celiac/Gluten testing _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergy Evaluation _____
<input type="checkbox"/>	<input type="checkbox"/>	Nutritional Evaluation _____
<input type="checkbox"/>	<input type="checkbox"/>	Auditory Evaluation _____
<input type="checkbox"/>	<input type="checkbox"/>	Vision Evaluation _____
<input type="checkbox"/>	<input type="checkbox"/>	Osteopathic _____
<input type="checkbox"/>	<input type="checkbox"/>	Acupuncture_____
<input type="checkbox"/>	<input type="checkbox"/>	Physical Therapy _____
<input type="checkbox"/>	<input type="checkbox"/>	Occupational Therapy _____

<input type="checkbox"/>	<input type="checkbox"/>	Sensory Integration Therapy _____
<input type="checkbox"/>	<input type="checkbox"/>	Language Classes _____
<input type="checkbox"/>	<input type="checkbox"/>	Sign Language _____
<input type="checkbox"/>	<input type="checkbox"/>	Homeopathic _____
<input type="checkbox"/>	<input type="checkbox"/>	Naturopathic_____
<input type="checkbox"/>	<input type="checkbox"/>	Craniosacral _____
<input type="checkbox"/>	<input type="checkbox"/>	Chiropractic _____
<input type="checkbox"/>	<input type="checkbox"/>	MRI _____
<input type="checkbox"/>	<input type="checkbox"/>	CT Scan _____
<input type="checkbox"/>	<input type="checkbox"/>	Upper Endoscopy _____
<input type="checkbox"/>	<input type="checkbox"/>	Upper GI Series _____
<input type="checkbox"/>	<input type="checkbox"/>	Ultrasound_____

INJURIES

Check box if yes and provide date

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Back injury _____
<input type="checkbox"/>	<input type="checkbox"/>	Neck Injury _____
<input type="checkbox"/>	<input type="checkbox"/>	Head Injury _____
<input type="checkbox"/>	<input type="checkbox"/>	Broken Bones_____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

SURGERIES

Check box if yes and provide date

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Appendectomy _____
<input type="checkbox"/>	<input type="checkbox"/>	Circumcision _____
<input type="checkbox"/>	<input type="checkbox"/>	Hernia _____
<input type="checkbox"/>	<input type="checkbox"/>	Tonsils _____
<input type="checkbox"/>	<input type="checkbox"/>	Adenoids _____
<input type="checkbox"/>	<input type="checkbox"/>	Dental Surgery_____
<input type="checkbox"/>	<input type="checkbox"/>	Tubes in Ears_____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

BLOOD TYPE: ○A ○B ○AB ○0
○Rh+ ○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

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/RELATIONSHIPS

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: Yes No Clotting: Yes 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? Yes No Condom Diaphragm IUD Partner vasectomy

GI HISTORY

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

Wilderness Camping? Yes No Where? _____

Ever had severe: Gastroenteritis 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? Yes 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 (which months?) _____
- Have birth problems _____
- Group B strep infection _____
- Have c-section because of _____
- Use induction for labor (such as Pitocin) _____
- Have anesthesia -what was used? _____
- 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: _____

PERINATAL

Pregnancy duration: *X* following the week of gestation.

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 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?

0-1months 2-6 months 6-15 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

Have your medications or supplements ever caused you unusual side effects or problems? Yes No
Describe: _____

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

Have you had prolonged or regular use of Tylenol? Yes No

Have you 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

NUTRITIONAL HISTORY

Has your child ever had a nutrition consultation? Yes No

Have you made any changes in your child's diet because of health problems? Yes No

Describe _____

Does your child follow a special diet or nutritional program? Yes 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 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 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

BOTTLEFED 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

EXPOSURES

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

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
- Unusual 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 finger nails
- 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
- Unusual 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 modifying diet - 5 4 3 2 1

Taking several nutritional supplements each day - 5 4 3 2 1

Keeping a record of everything eaten each day - 5 4 3 2 1

Modifying lifestyle (e.g., work demands, sleep habits) - 5 4 3 2 1

Engaging in regular exercise - 5 4 3 2 1

Have periodic lab tests to assess progress - 5 4 3 2 1

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? - 5 4 3 2 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? - 5 4 3 2 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? –

5 4 3 2 1

Comments _____

DAY 2

TIME	FOOD/BEV/AMOUNT	COMMENTS

Bowel Movements (#, form, color) _____
Stress/Mood/Emotions _____
Other Comments _____
Other _____

DAY 3

TIME	FOOD/BEV/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 track your child's progress over time. Rate each of the following symptoms based upon your child's health profile for the past 30 days. If you are taking after the first time, record your child's symptoms for the last 48 hours ONLY.

POINTS 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
- Bloating feeling
- Belching, or passing gas
- Heartburn
- Intestinal/Stomach pain

Total _____

EARS

- Itchy ears Total
- 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 _____