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Please take the time to go through the paperwork enclosed and complete it to the best of your ability. Your responses will help us to help you.

We want you to know that we truly care about your family and are committed to treating you as if you were members of our own family. Our ability to assess and intervene on your behalf is very much dependent on us developing a relationship based on communication. Please give us feedback on how we are doing. We believe that your input is an essential part of your child's treatment.

PERSONAL INFORMATION				
Child's Name: First:		**Last:**		**Middle Initial:**
Parent(s) Name(s):				
Address: Street:			**City:**	
State:	**Zip:** -		**Phone: ( ) —**	
Work Phone: ( )			**Cell : ( )**	
Email :			**Fax: ( )**	
Child's birth date: Month:	**Day:**	**Year:**	**Child's Sex (Circle One):**	**Male/Female**
Child's Pediatrician's Name:				
City:	**State:**	**Zip:**	**Phone #: ( )**	
How did you find this practice?				
Child's Siblings:	**Sex: (Circle One)**		**Birth Date:**	
Name:	**Male/Female**			
Name:	**Male/Female**			
Name:	**Male/Female**			
Parent's occupation(s):				
Note: Please bring a fairly recent picture of your child that we may keep <u>plus</u> a baby picture that we may look at and return.				
<u>Diagnoses or explanation given to you about your child (Date of diagnosis:) :</u>				

Please List Your Top 3 Concerns:

1.

2.

3.

PRENATAL HISTORY

Maternal age at delivery: _____ years

Illnesses during pregnancy:

Medication during pregnancy:

Other complications during pregnancy:

Complications during labor and delivery:

Mode of delivery: C-section/vaginal? If C-section, explain why:

If vaginal delivery, did you have forceps/vacuum?

Medication(s) during labor and delivery?

Full term/premature? (Circle one) **How many weeks? _____ Weeks**

Complications after delivery? (Was the child in any distress)

Medications given to child during hospital stay?

Any maternal family history of autoimmune diseases?

EARLY DEVELOPMENT

Did baby come home on time?

Fussy/colicky?

Breast fed/Formula Fed?

How long?

Reflux/Spitting up?

Prone to ear/throat infections in first 2 years?

How many rounds of antibiotics in first 2 yrs:

How was child's eye contact?

Developmental Milestones

When did your child:

Sit Up? _____

Roll Over? _____

Crawl? _____

Babble? _____

Walk? _____

Say 1st Word? _____

Did he/she crawl/move appropriately early on?

Did your child receive immunizations?

Any Reactions? (Please bring immunization schedule)

When did you first notice your child's problem?

What did you notice?

What it gradual or sudden onset?

Please make notation of any other event, action, etc. that you think may have some bearing/ relationship to your child's condition. Again, be as detailed as possible and do not hesitate to mention anything, no matter how small or insignificant, that you believe is related to your child's problem(s):

Did you get Early Intervention? If so, what services and for how long?

Has the child ever been hospitalized?

Have you ever seen a DAN Doctor/Other Specialists? (please list names and dates)

List current therapy/educational programs?

What are your child's preferred activities?

How does your child sleep?

PRESENT TIME

Are both parents present at home?

Quality of home life?

How much language does your child have?

Can they stick their tongue out all the way?

Are they Sensitive To: (describe)

Light?

Sound?

Touch?

How is their hearing/vision?

Do they tilt their head when watching TV?

Any peculiar eye movements?

Any history of seizures?

Medications?

Any particular diet?

Does he/she startle easily? Gag easily?

Scripting/Repetitive Behaviors?

How is their posture?

Are they fascinated by spinning?

Do they have self stimulatory behaviors? (describe)

Do they Eczema/Asthma/Allergies?

Is their face symmetrical (even) on both sides? (IE. One eye smaller than the other)

How is their fine motor control?

How is their gross motor control?

Run/Bike Ride?

How is their balance/motor planning?

Do they POOP every day? Formed? Color? Mucus?

DIETARY/NUTRITIONAL HISTORY

Foods my child eats: (Place a check in appropriate column)					
Food					
	Daily	**3 - 5 times/ week**	**1 - 3 times/ week**	**Never or almost never**	**Used to eat a lot but no longer does**
Candy:					
Cookies:					
Caffeine (soda, tea, etc.):					
Chocolate:					
Milk: Whole:					
2 % :					
1 % :					
Skim:					
Cheese:					
Ice Cream:					
Salty Foods:					
Meat:					
Pasta:					
Bread: White:					
Wheat:					
Other:					

DIETARY/NUTRITIONAL HISTORY (Continued)

DAY 1
Breakfast:
Morning snack(s):
Lunch:
Afternoon snack(s):
Dinner:
DAY 2
Breakfast:
Morning snack(s):
Lunch:
Afternoon snack(s):
Dinner:
DAY 3
Breakfast:
Morning snack(s):
Lunch:
Afternoon snack(s):
Dinner:

SIGNS AND SYMPTOMS

Please check any signs/symptoms your child may demonstrate and note duration and details if appropriate:

No.	Description	Mild	Moderate	Severe	Duration	Unique details
1	Mood swings					
2	Irritability/tantrums					
3	Fears/anxieties					
4	Difficulty falling to sleep					
5	Nail/hand/arm biting					
6	Hand/arm biting					
7	Recurrent/chronic fever					
8	Aggressiveness (hitting, kicking, biting others)					
9	Head banging					
10	Nightmares					
11	Bed wetting/soiling					
12	Hyperactivity					
13	Inability to concentrate/focus					
14	Always fidgety in his/her seat					
15	Impulsive					
16	Breath holding					
17	Dizziness					
18	Acute sense of smell					
19	Poor coordination					
20	Problems with buttons, ties, snaps or zippers					
21	Processing problems - visual, motor, language, etc.					
22	Problems with social interactions					
23	Sensitive to crowds					
24	Trouble remembering					
25	Low self-esteem					
26	Fatigue					
27	Cold hands/feet					
28	Cold intolerance					
29	Heat intolerance					

SIGNS AND SYMPTOMS (Continued)

Please check any signs/symptoms your child may demonstrate and note duration and details if appropriate:

No.	Description	Mild	Moderate	Severe	Duration	Unique details
30	Stomach ache					
31	Skin flushing					
32	Difficulty waking					
33	Night waking					
34	Mucous/blood in stools					
35	Anal itching					
36	Toe walking					
37	Day time wetting/soiling					
38	Numbness/tingling in hands/feet					
39	Headache					
40	Blinking					
41	Tics					
41	Eye discharge					
43	Dark circles/puffiness under eyes					
44	Earaches					
45	Congestion					
46	Dripping nose					
47	Ridges/pitting of nails					
48	White spots/lines on nails					
49	Puts pressure on abdomen					
50	Any OCD (obsessive compulsive) behaviors					
51	Bad breath					
52	Nose bleeds					
53	Sore throats					
54	Hoarseness					
55	Cough					
56	Wheezing					

Please consider this question carefully.

If you could have ONE health wish for your child, what would it be?

Please Read and Sign Below

I understand that my child's symptoms may relate to other underlying biochemical and neurological issues and that evaluation and treatment of these issues may positively impact behavior and cognition. I am not seeking a treatment or cure for a disease such as Autism, but rather an approach focusing on my child as an individual and his/her potential physiological problems.

I understand that no environmental cause has proven to be linked to Autistic Spectrum Disorder (ASD) or Attention Deficit Hyperactivity Disorder (ADHD) or related problems in children or adults. However, due to the possible causative links, I desire to have the biochemical, immunological and toxicological aspects of my child's problems investigated and treated.

I am familiar with writings or the contents of writings that describe the factors associated with the rise in incidence of ASD and related problems. These include the Newsletters of the Autism Research Institute, information from TACA and Generation Rescue as well as numerous articles and parent books.

I desire that my child be evaluated with diagnostic steps aimed at some or all of the following factors that are referred to in the current medical literature. These factors include but are not limited to:

- Necessary dietary changes
- Vitamin, mineral, amino acid/fatty acid supplementation
- Detoxification, immune, antimicrobial and enzyme therapy
- Spinal adjustments/sensory therapies
- Other adjunctive interventions

I understand that many elements of this approach may be described as unproven or experimental.

My signature below confirms my consent to the diagnostic approach embodied in this document and acknowledges that I have had ample opportunity to voice concerns or ask questions. Any specific measures taken have been or will be carried out by me or under my supervision as a parent.

To the extent that some of the approaches embodied in this document have already been undertaken in my child's care I acknowledge that my understanding of the approaches at the time of first considering each of these steps was essentially no different than at the time of signing this document. At no time in the course of my child's care did any of the doctors in the NY Health Solutions Practice lack my completely informed consent.

Parent/Guardian Signature: _____

For
Patient:_____ Date:_____