835 7th street Suite 5 Clermont FL 34711

352-404-8961 fax:352-404-8996

Name_____ Date _____
Age _____ M F Date of Birth (M/D/Y) _____/_____/_____
Home Address_____
City _____ State_____ Zip Code _____
Phone # (home)_____ Phone # (cell)_____
Email address: _____
How did you hear of our office? If referred, please indicate by whom _____
_____
Parent/ Guardian Information:
Mother's Name _____Work Phone: _____
Occupation: _____
Father's Name_____ Work Phone: _____
Occupation: _____
Names of Healthcare Providers:
Medical Doctor(s) _____
Other _____
Developmental History
Sat at_____(months) Crawled at _____ Walked at_____ Talked at_____
Regression of speech? ___No ___Yes, at what age?_____
Was child breastfed? ___No ___Yes, if so how long? _____
Formula used? ___No ___Yes, if so introduced at what age?_____
Colic/irritability as baby? ___No ___Yes
Other Health Issues:
Does your child suffer with health problems: ___ Allergies ___ Asthma ___ Eczema
___ Kidney Problems ___ Lung Disease ___ Diabetes ___ Thyroid Disease ___ Seizures
___ Heart Disease ___ Repeated Infections ___Other, please explain_____
Did your child's condition change following an illness or seizure? ___No ___Yes, explain_____
_____
Behavior Good Variable Disruptive
Biting Hitting Head banging Toe- walking
Aggression Teeth grinding Hyperactivity Sideways glancing
Cries easily Mood swings Irritability Pushes on eyes
Excessive spinning Hand movements Odd fascinations: describe _____
Sensitivity to: Sound Touch Smells Lights
Play skills: appropriate Inappropriate/repetitive Variable
Interaction with other children: Frequent Occasional None
Motor Skills Delayed gross motor (eg. climbing, running) Delayed fine motor (eg. printing)
Uncoordinated/clumsy
Sleep Normal Difficulty falling asleep Frequent waking
Nightmares Wakes crying/screaming
Digestive Health:
Loose stools or diarrhea ___ Yes ___ No Constipation ____Yes ____No
Offensive/excessive gas ___Yes ___No Bad breath ___Yes ___No
Undigested food in stools ___Yes ___No Mucous or blood in stools ____Yes ____No
Does your child produce formed stools ___Yes ___ No Stomach aches/pain ____ Yes ____No
Bowel movements: # per day _____

Is you child toilet trained? ___Yes ___No
Antibiotic History:
How many courses of antibiotics has your child received: ___ 0-5 ___5-10 ___10-15 ___15-20 ___20+
Reason(s) for antibiotic use: ___Ear Infections ___Bronchitis/Pneumonia ___Sinus Infection
___Intestinal Infection ___Other (please explain)_____
Home Environment:
How old is your current home ____ years
Has your child lived in a home with lead-based paint ___No ___Yes
Has there been exposure to molds ___No ___Yes, explain_____
Is child exposed to outside pesticides or fungicides ___No ___Yes
Please list pets/animals your child is exposed to _____
Mother's Pregnancy and Labor:
Any complications during pregnancy? ___High Blood Pressure ___ Seizures ___ Diabetes
___Infections treated by antibiotics ___Viral Infections (Flu, Mono) _____
Rh status ___ (+ or -) Blood Type _____ Rhogam shot given during pregnancy? ___No ___Yes
Any vaccinations during pregnancy ___No ___Yes, which ones _____
Any vaccinations after pregnancy while breastfeeding ___No ___Yes
Was your child delivered _____ vaginal ___ or C-section Forceps or suction used _____
Was birth premature ___ No ____ Yes. If yes, how many weeks gestation _____
Any birth trauma? Describe_____
Complications/infections of baby? _____
Did Mom have silver fillings present during pregnancy? ____ No ____ Yes. If yes, how many?_____
Did Mom have any dental work done during pregnancy ___No ___Yes
Did mom have any fillings removed while breastfeeding child ___No ___Yes
Does child have amalgam/silver fillings? ___No ___Yes

Vaccination Status:
Has child received all recommended vaccinations for their age? ____ No ____ Yes
If no, has child received any of the following: ___DPT ___Hib ___Hep B ___Polio ___ MMR
___Pneumococcal ___Varicella (Chicken Pox) ___Flu shot ___Meningococcal
Did your child receive any vaccinations when they were sick ___No ___Yes, please explain_____
Did your child suffer any vaccine reactions: ___Fever ___ Inconsolable screaming ___Rash
___Excessive lethargy ___Vomiting ___Seizures ___Behavior change
Medication Usage:
List medication child is currently taking: _____
Has child received chelation therapy ___No ___Yes, Any benefits?_____
Has child ever had steroid or anti-fungal drugs? ____ No ___Yes
Supplements:
Please list all supplements (herbal, vitamins, minerals, homeopathic) child is currently taking, including dosages: _____
_____
_____
Diet:
Has child been on a Gluten/Casein Free Diet? ___No ___Yes, if so how long?_____
Was any benefit observed from GF/CF diet? ____No ___Yes
Have any other special diets been tried? Describe _____
Please describe your child's typical daily diet:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____

Drinks: _____ _____
Cravings/ favorite foods _____
Current Height _____ Weight _____ (lb/ kg)

Family History: Check if a blood relative had any of the following and indicate relationship to child.

Allergies_____
Anxiety_____
Asthma_____
Autoimmune disease (eg. lupus, rheumatoid arthritis) _____
Autism/Aspergers_____
Blood disorders eg. hemophilia, stroke _____
Cancer_____
Celiac disease _____
Crohn's/ulcerative colitis _____
Depression_____
Epilepsy/Seizures_____
Genetic Disorders _____
Heart Disease_____
High Blood Pressure_____
Kidney Disease_____
Learning/Developmental disabilities _____
Bipolar Disorder_____
Diabetes _____
Headaches/Migraines _____

Obsessive-Compulsive _____

Multiple Sclerosis _____

Schizophrenia_____

Syphilis _____

Tuberculosis_____

What are your goals in seeking treatment?

1._____
2._____
3._____

Thank you. I look forward to working together to help your child.