

PEDIATRIC PATIENT INITIAL CONTACT FORM

Please indicate your interest in being evaluated by Dr. Donald Gerken & Gerken Family Chiropractic and becoming a patient of the practice by completing and signing the form below and returning it to the address above. Please note that Dr. Donald Gerken & Gerken Family Chiropractic is a specialized consultation-based practice and you must maintain a separate primary care physician for your child's general health care needs and follow-up needs.

Name: _____ Date: _____

Street: _____

City: _____ State: _____ Zip: _____

Country: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Child's Name: _____ Sex: _____ Age: _____

In order to schedule a new patient pediatric consultation with Dr. Donald Gerken & Gerken Family Chiropractic, you must send (or bring) the following items to the above address:

- This Pediatric Patient Initial Contact Form – which MUST be signed by both parents (first 2 pages)
- A check for the \$150 nonrefundable deposit, made payable to Gerken Family Chiropractic
- The HIPPA Notice of Privacy Practices – form MUST be signed by both parents (Page 3-6)
- The Practice Policy – form MUST be signed by both parents (pgs 7-8)
- Pediatric Consent Form (Pgs 9-11)
- A completed Pediatric Patient Questionnaire (pgs 12-33)

Your paperwork must be complete as listed above to schedule your consultation. Consultations are not scheduled on the same day the paperwork is turned in to allow the doctor time to review. The fee for your initial consultation is \$150 which would cover:

- Comprehensive review of your child's history and questionnaire.
- ½ hour consultation with Dr. Donald Gerken.
- Basic Treatment outline and recommendations.

Helping Children, Adults and Families Reach Their Full Potential

Donald G. Gerken, DC, DACCPC, CST, Adrienne L. Young, DC, Diane Gerken, DC, Claudette Robbins, LMT
Visit our Website at GerkenFamilyChiropractic.com

If the child and parents meet the requirements of care, are committed to the treatment program prescribed, and it is determined our facilities would meet your child's needs, than an examination can be scheduled. The fee for the pediatric examination is \$400 which would include:

- 1-2 hour physical exam with Dr. Donald Gerken
- Chiropractic assessment
- Motion evaluation
- Craniosacral evaluation
- Behavioral evaluation
- Treatment outline

Please sign below to indicate that you:

- Understand the fee for the initial consultation and examination
- Understand what the initial consultation and examination includes
- Understand that Dr. Donald Gerken & Gerken Family Chiropractic is a specialized consultation-based practice and will not become your primary care physician

Parent Signature: _____ **Date:** _____

Parent Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES (HIPPA)

Effective date: April 14, 2003

This notice describes how health information may be used and disclosed and how you can get access to this information. Please review it carefully.

We understand that your medical and health information is personal and private. In order to provide you with quality care and to ensure compliance with certain legal requirements, we create a record of the care and services you receive in our office. We respect the privacy and confidentiality of medical and health information about you and that can be identified with you. This is called "protected health information". Your protected health information is contained in the medical and billing records maintained by this practice. It includes demographic information and information that relates to your present, past or future physical or mental health and related health care services.

Our Legal Duty:

We are required by Federal and State law to maintain the privacy of your health information which we have either created in our practice or received from another healthcare provider. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices outlined in this notice while it remains in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. If we make a significant change in our privacy practices, we will revise this Notice appropriately and make the new Notice available to you. You may request a copy of our notice at any time.

Uses and Disclosures of Health Information:

Treatment: How we may use and disclose your health information to a physician or other healthcare provider for treatment or payment. For example, our health care providers may disclose information about your health condition to your referring physician, a pharmacist who needs the information to dispense your prescription, or a laboratory that requires it to perform testing.

Insurance: We may inform your insurance company about a treatment that we intended to provide so that we may obtain the appropriate approvals. All medical records required by your insurance company for payment will be sent to you first.

Health Care Operations:

We may use and disclose your protected health information:

- To review and improve the quality of care you receive;
- To our accountants who are auditing our billing records
- In order to compare your information with that of several other patients to determine if we should offer new services or if new treatments were effective;
- To identify groups of patients who have similar health problems to give them information about treatment alternatives, programs or new procedures;
- To organizations that assess the quality of care we provide to our patients (such as government agencies or accrediting bodies)

Your authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your

health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by you while it was in effect. Unless you give written authorization we cannot use or disclose your health information for any reason except those outlined in this Notice or as otherwise permitted by HIPPA regulations.

Required By Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to the appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert serious threat to your health or safety or the health or safety of others.

Voice Messages: We may use or disclose your health information to provide you with appointment reminders or other medical treatment information on your voice mail or by mail or email.

To Your Family and Friends: We must disclose health information to you. We may disclose your health information to a family member, friend or other person to the extent necessary to help with our health care.

Patient Rights:

Access: You must make a request in writing to obtain access to your health information. Under current state law, we may charge you no more than 0.45 cents per page if we make a copy/copies of your medical records, If you request an alternate format, we will charge you a cost-based fee for providing your health information in that format. If you prefer we will prepare a summary or an explanation of your health information for a fee.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions but if we do, we will abide by our agreement except in the case of an emergency.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. *You must make your request in writing.* Your request must specify the alternative means and/or location, and provide satisfactory explanation how payment will be handled under the alternative means/location you request.

Amendment: You have the right to request that we amend your health information. *Your request must be in writing,* and it must explain why the information should be amended. We may deny your request under certain circumstances.

Questions and Complaints:

If you want more information or have questions or concerns, please contact us.

Dr. Donald Gerken, 88 E Bonita Rd., #E, Chula Vista, CA 91910.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information to have us communicate with you by alternate means or locations, you may complain to us using the contact information listed within this notice or you may submit a written complaint to the U.S. Department of Health and Human Services. You will not be penalized or retaliated against in any way for making a complaint to the U.S. Department of HHS or to this physician's office. *We support your right to the privacy of your health information.*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**This document is to be signed by a person legally responsible for the patient's
medical decisions relative to treatment.**

I, _____, have received a copy of Dr. Donald Gerken & Gerken Chiropractic Notice of Privacy Practices describing how medical and health information about me may be used and disclosed. I understand that if I have questions or complaints I may contact the office at (203) 8342813 and speak with the privacy contact.

Patient Name

Your signature

Relationship to Patient

Date

PRACTICE POLICIES

Effective January 1, 2008

OFFICE POLICY:

We require a credit card number on file for all patients in order to schedule appointments.

To be considered an active patient and receive ongoing care, we require that a child be seen in our office at least once per calendar year.

CANCELLATION POLICIES:

As part of our continued effort to provide you with the very best care and to accommodate all appointment requests, we are requiring a valid credit card be on file to reserve your time with our clinicians. Our clinicians meticulously prepare for each appointment prior to the time of your appointment. This ensures that we achieve the high standard of care and treatment we pride ourselves on.

All services are provided by appointment only and this scheduled time is reserved for your exclusive use. The cancellation policy differs by the type of appointment, as documented below.

Cancellation of an Initial Consult and Examination

All new patient appointments must be canceled 7 days prior to your scheduled appointment. Appointments not cancelled within 7 days of the scheduled appointment will be billed at 50% of the standard initial consultation fee.

25% of the fees paid for non-cancellation of an initial consultation may be applied to a rescheduled initial consultation.

Follow-up Appointment Cancellation

We require 48 hours notice for follow-up appointments, which includes office visits or telephone consults with any of our clinicians. Appointments not cancelled within 48 hours of the scheduled appointment will be billed at 50% of the standard fee for the follow-up service

Fees for non-cancellation of follow-up appointments are nonrefundable and may not be used as credit to a future consultation or procedure.

To cancel an appointment, please call 619 422-3088. Our general office hours are Monday, Wednesday, Friday 8am – 11am and 2pm – 6pm and Tuesdays and Thursdays by special appointment only. All cancellations must be stated via telephone. If you cannot reach us in person by phone, you can leave a detailed voicemail message with your name, patient's name, date and time of your scheduled appointment.

In the case of a true medical emergency or an act of God (natural disaster) our cancellation policy does not apply but may require documentation in writing.

EMAIL POLICIES:

As part of our continued effort to provide you with the very best medical care, our clinicians use email as a form of communication within our practice.

Email Guidelines

- Email communication is viewed as billable time, as is an office visit or telephone consultation.
- Any email that requires at least 15 minutes of clinician time will be billed as per that clinician's hourly rate
- Brief emails will not be billed BUT frequent emails will be cumulative and left to the clinician's sole discretion when billing time is necessary
- All emails will be returned within 48 hours of receipt.

If you have any questions regarding any of these policies, please call our office at (619) 422-3088.

Your cooperation and understanding in this matter are greatly appreciated.

Thank you.

I, _____ have read and understand the above outlined policies.

_____ Parent/Guardian Signature _____ Date

_____ Parent/Guardian Signature _____ Date

PATIENT CONSENT FORM

To Whom It May Concern:

May I ask that you sign a copy of this document and return it to me? Your signature will document your understanding and consent of the following principles and practice.

There has been a rising incidence in the US and elsewhere of problems in children that fall diagnostically within a spectrum of autistic disorders (ASD) and possibly related attention problems (ADHD). To the extent that any individual displays symptoms of ASD and ADHD, he or she may be a participant in the rising incidence of these problems. To the extent that these problems are increasing in incidence beyond any measure that could be attributed to a purely genetic cause (which would be stable in incidence over long periods) any participant in the increase may be assumed to have causes consistent with environmental factors. Based on such considerations I would like to have such causes considered in the evaluation of my child.

In asking Dr. Gerken for help in optimizing the options for my child I have been aware that my child's syndrome includes many features that are not necessary to diagnose ASD or ADHD in a given child and may include symptoms related to other body systems than behavior, cognition and socialization. These symptoms are indicated on the questionnaire and other documents introduced at the initial visit. I was not seeking a treatment or cure for a disease such as Autism, but rather an approach focusing on my child as an individual.

Is there something of which this person should be rid, which would result in better function?

I understand that as a matter of public policy, no environmental cause has been proven link to ASD or ADHD or related problems in children or adults. I grasp the difference between public and private health policy and insist that the threshold for reasonableness in decisions applied to any given individual may be lower than that required for proof as applied to large groups of individuals. Moreover I insist that my child be treated as an individual, not solely on the basis of his or her diagnostic grouping. Therefore, borrowing from a list of possible environmental factors that have been suggested as causative of the rise of incidence in ASD, ADHD and possibly related problems I desire that such factors be considered in the investigation of the biochemical, immunological and toxicological aspects of my child's problems.

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, Biomedical Assessment Options For Children with Autism and Related Problems, by Pangborn, J and Baker, SM. Published by The Autism Research Institute, Biological Treatments for Autism and PDD, by William Shaw, PhD,

Children With Starving Brains: A Medical Treatment Guide for Autism Spectrum Disorder, Second Edition, by Jaquelyn McCandless, MD, the syllabi of the meetings of the Defeat Autism Now! (DAN!) Organization, The Chemistry of Autism, by Baker, SM et all presented at the Autism Research Institutes'™s DAN! Conference in Philadelphia PA, May 15-18, 2003, as well as various postings on the Internet that refer to the questions and theories expressed in these writings.

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 above publications or in the references cited by them. These factors include possible responsiveness to:

- Nystatin, Sporanox, Nizoral, Diflucan, Lamisil, oral amphotericin B, Saccharomyces boulardii, and other over the counter antifungal substances.
- Diet excluding yeasts, molds, and sugars
- Diet excluding casein and gluten
- Diet excluding starches (Specific Carbohydrate Diet as described in Breaking the Vicious Cycle by Elaine Gottschall)
- Diet excluding potentially allergenic foods.
- Administration of various sulfur-bearing substances that are broadly considered to be useful in the detoxification of heavy metals but may also be effective in providing support to the chemistry of sulfation in its other roles in human biochemistry. These compounds are reduced glutathione, thiamine tetrahydrofurfuryl disulfide (TTFD), and alpha lipoic acid, n acetyl cysteine, and Epsom salt baths.
- Vitamin and mineral supplements
- Supplements of certain amino acids, which may, depending on diagnostic evidence, address problems of maldigestion of proteins, malabsorption of essential amino acids, abnormalities of precursors of neurotransmitters, and deficits of sulfur amino acids.
- Supplements of omega 3 oils
- Methylcobalamin (methylB12) the chemistry of which is intimately involved in the core chemistry of the autism epidemic as we now begin to understand it.
- Folic acid, folinic acid (leucovorin), 5methyltetrahydrofolate (Folapro)
- Vitamin B6 and Magnesium
- Vitamin A
- Acyclovir or related antiviral compounds
- Probiotics
- Oral transfer factor
- Digestive enzymes
- Oral immune globulin
- Intravenous Immune globulin if I request referral to a doctor who gives it.
- Secretin
- Aricept

I understand that none of the above constitutes treatment for a disease but in each case, if administered to my child, is a diagnostic measure designed to determine effectiveness.

Only on the basis of initial persuasive evidence of effectiveness would any of these measures constitute more than a diagnostic test. I understand that the judgment of such effectiveness may be based on changes in signs, symptoms and laboratory tests. I further understand that there are scientifically plausible links implied among the various causative factors in the above list and that combinations of these measures may be helpful when single measures may fail. I understand that in my child's record, where any of these measures is listed in a section labeled treatment that the measure constitutes a therapeutic trial and as such is a diagnostic test of efficacy.

I understand that essentially all of the above factors have been declared unproven. I understand that essentially all of the above factors may be considered unproven or experimental by third party payers.

My acknowledgement below constitutes my consent to the diagnostic approach embodied in this document. 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 diagnostic 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 then than at the time of signing this document. At no time in the course of my child's care did Dr. Gerken lack my completely informed consent.

_____ (parent)

_____ (parent)

date _____

PERSONAL INFORMATION

Date Questionnaire Received: ___ / ___ / ___		Date of Initial Consult: ___ / ___ / ___	
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
Social Security Number (Optional): — —			
Primary Care Physician: Name: _____			City: _____
State: _____	Zip: _____	Phone #: ()	Cell #: ()
Referred by: _____			
Siblings: Name: _____	Sex: (Circle One) Male/Female	Birth Date: Month: Day:	
Year: _____	Male/Female	Month: _____	Day: _____
Year: _____	Male/Female	Month: _____	Day: _____
Year: _____	Male/Female	Month: _____	Day: _____
Year: _____	Male/Female	Month: _____	Day: _____
Year: _____	Male/Female	Month: _____	Day: _____
Parent's occupation(s): _____			
Note: Please bring a fairly recent picture of your child that we may keep plus a baby picture that we may look at and return.			
Diagnoses or explanation given to you about your child (Date of diagnoses: ___ / ___ / ___): _____			
Other problems to be addressed: 			

Describe your child to me, including his/her history. Please be as detailed as possible.
• When did you first notice your child's problem?
• What did you first notice?
• Was the onset of your child's problem sudden or gradual?
• Was there any event or illness that you or others think brought on your child's symptoms?
Please make notation of any other event, action, etc. that you think may have some bearing or 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):

CHILD'S MEDICAL HISTORY

PRIMARY DOCTOR (S)

Name	Phone Number	City

THERAPIST(S)

Speech - Occupational - Physical - Other

Name	Type of Therapist	Phone	City	Hours/Week

Other Care-Givers

Name	Phone	City	Date of Evaluation

Specialist(s)

Naturopath(s)/Homeopath(s)

Nutritionist

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Other

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?
Medications given to child during hospital stay?
Other:

DIETARY/NUTRITIONAL HISTORY

Breast-fed?	Yes/No (Circle One)	If yes, how long?			
Bottle-fed?	Brand of formula?	Begun at what age?		For how long?	
Foods? Begun at what age?		First foods?			
Whole milk? Yes/No (Circle One) If yes, begun at what age?					
Known allergies to food? (Please list):					
Suspected sensitivities to foods? (Please list):					
Food cravings? (Please list):					
Foods my child eats: (Place (√) in appropriate column)					
Food	Daily	3-5 times per week	1-3 times per week	Never or almost never	Used to eat but no longer does
Cookies:					
Candy:					
Sweet foods:					
Caffeine (soda, tea, etc.):					
Chocolate:					
Milk: Whole:					
2 % :					
1 % :					
Skim:					
Cheese:					
Ice Cream:					
Salty Foods:					
Meat:					
Pasta:					
Bread: White:					
Wheat:					
Other:					
Cookies:					
<p>Check (√) the most appropriate description below of your child's diet:</p> <p>_____ Mostly baby foods</p> <p>_____ Mostly carbohydrates (bread, pasta, etc.)</p> <p>_____ Mostly dairy (milk, cheese, etc.)</p> <p>_____ Mostly meat</p> <p>_____ Mostly vegetarian (vegetables, fruits, grains, etc.)</p> <p>_____ Other. Describe:</p>					
Please describe your child's stool pattern (Examples: daily, foul, large, mushy, etc.):					

DIET DIARY

Please list the foods and beverages normally consumed by your child for six typical days:

DAY 1

Breakfast:

Morning snack(s):

Lunch:

Afternoon snack(s):

Dinner:

Other:

DAY 2

Breakfast:

Morning snack(s):

Lunch:

Afternoon snack(s):

Dinner:

Other:

DAY 3

Breakfast:

Morning snack(s):

Lunch:

Afternoon snack(s):

Dinner:

Other:

DAY 4

Breakfast:

Morning snack(s):

Lunch:

Afternoon snack(s):

Dinner:

Other:

DAY 5

Breakfast:

Morning snack(s):

Lunch:

Afternoon snack(s):

Dinner:

Other:

DAY 6

Breakfast:

Morning snack(s):

Lunch:

Afternoon snack(s):

Dinner:

Other:

FAMILY HISTORY

List any allergies, major illnesses, genetic diseases or problems for each of the following family members of your child:

Mother:

Father:

Siblings:

Maternal Grandparents:

Paternal Grandparents:

Others:

SOCIAL HISTORY

Who lives in the home with your child?

Are any children in your family adopted?

Pets in the house:

Caregivers besides parents:

List the people most important in your child's life:

Recent changes, losses, births, deaths, divorce, remarriage or moves:

Recent travel:

Child's response to these changes:

Is your child involved in any sports, music or other activities? Please describe:

How does your child interact with other children?

•With adults:

•What makes your child happy?

•Sad?

•Angry?

•Stressed?

•How do you as a parent deal with these emotions in your child?

ENVIRONMENTAL HISTORY

Do you, your child, or any family members practice any relaxation/stress management techniques? Please describe:

CIRCLE THE APPROPRIATE ANSWERS TO THE FOLLOWING QUESTIONS:

Location of home: City/Suburban/Wooded/Farm Other (describe):

Water: City/well Purification system: Yes/No If yes, please describe:

Type of heat: Electric/gas/oil/other If other, please describe:

Do you live near: Power lines/woods/industrial areas/water?

If you live near water, list type: Swamp/river/ocean/other If other, please describe:

Does your home have a lot of: Dust/mold/down or feather items (pillows, upholstery, stuffed animals?) If, so, please give details:

Describe your child's bedroom (Circle appropriate response):

Bedding: Synthetic/down/feather? Mattress cover: Yes/No Crib/Junior Bed/Adult Bed

Flooring: Carpet: Wall-to-wall or area rug? Wood? Glued down? Synthetic pad?

Window treatment: Shades/blinds/thin curtain/heavy curtain/valance/other? If other, describe:

Other items in room including furniture, toys, stuffed animals:

Flooring in other rooms:

Child's bathroom?

Living room?

Family room/play room?

Is your child sensitive to or bothered by any of the following? Please check where appropriate and list specific products if possible:

_____ Perfumes/cosmetics?

_____ Cleaning products?

_____ Soaps?

_____ Detergents?

_____ Dust?

_____ Other?

_____ Mold?

_____ Pollens/grasses?

_____ Animals (dander)?

_____ Gasoline?

_____ Paint?

Please list known allergies:

DEVELOPMENTAL HISTORY

Please list age when the following skills were mastered and any problems associated with these skills:

First words: (Age: _____)

Phrases or sentences: (Age: _____)

Pulling to stand: (Age: _____)

Walking: (Age: _____)

Sitting up: (Age: _____)

Crawling: (Age: _____)

Running: (Age: _____)

Walking up/down steps without help: (Age: _____)

Jumping: (Age: _____)

Learned to pedal: (Age: _____)

Rode 2-wheel bicycle: (Age: _____)

Put on clothing: (Age: _____)

MEDICAL HISTORY

Please mark which tests have been done and provide date and results		
Evaluation/Test	Date(s)	Results (normal, abnormal or unsure)
24 Hour Amino Acids		
Amino Acid Screen		
Blood Chemistry Screen		
Blood Count (CBC)		
Blood Test—Fatty Acid		
Blood Test—Food Allergies		
CT Scan (specify area)		
Colonoscopy		
DMSA Loading Study		
EEG		
Folic Acid		
Fragile X Chromosome Study		
Hair Elements		
Hearing Test		
Immune Profile		
Intestinal Permeability		
Liver Detox Profile		
MRI (specify area)		
Organic Acids—fungal/bacteria		
Organic Acids—Metabolism		

Please mark which tests have been done and provide date and results		
Evaluation/Test	Date(s)	Results (normal, abnormal or unsure)
PET Scan		
Pinworm Prep		
Plasma Amino Acids		
Plasma or Serum Zinc		
RBC Elements		
Serum Ferritin (Iron stores)		
Serum Methylmalonic Acid		
Serum Vitamin A		
Small Bowel Biopsy		
Stool Culture		
Stool Parasites		
Thyroid Profile		
Uric Acid (blood or urine)		
Urinary Peptides		
Urine Elements		
Urine Kryptopyrrole		
X-Rays (specify)		
Other:		

Major surgeries – Please describe and give dates:		
SURGERY	DATE(S)	RESULTS
Major injuries – Please describe and give dates:		
INJURY	DATE(S)	RESULTS
Illnesses – Please list appropriate dates and any complications		
ILLNES	DATE(S)	COMPLICATIONS
Ear infections		
Sinus infections		
Bronchitis		
Pneumonia		
Thrush		
Chicken Pox		
Seizures		
Mono		
Other: (Please list):		
_____	_____	_____
_____	_____	_____
_____	_____	_____

Immunizations

Please indicate date and any reactions for those immunizations that your child has received. If exact date isn't known, please approximate. "Bowel" refers to any bowel symptom such as diarrhea. "Swelling" refers to the site of the injection.

Diphtheria/ Pertussis/ Tetanus	Date	Bowel	Swelling	Crying	Seizure	Irritable	Fever	Other
DPT 1								
DPT 2								
DPT 3								
DPT 4								
DPT 5								
Adult Diphtheria/Tetanus								
Pediatric Diphtheria/Tetanus								
H Influenza Type B								
Hib 1								
Hib 2								
Hib 3								
Hib 4								
Polio (circle oral or Injection.)								
OPV 1 / Injection 1								
OPV 2/ Injection 2								
OPV 3/ Injection 3								
OPV 4/ Injection 4								
OPV 5/ Injection 5								
Measles/Mumps/R ubella								
MMR 1								
MMR 2								
Hepatitis b Vaccine								
HBV 1								
HBV 2								
HBV 3								
Prevnar (pneumococcal)								
Miscellaneous								
Varivax (chicken Pox)								
Tine Test								
Flu Vaccine								
Other								

Medications or Supplements									
Please check (✓) substances taken now or in the past and mark the appropriate reaction									
No w	Pas t	Medication or Supplement	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments
		Clozaril (clozapine)							
		Haldol							
		Prolixin							
		Risperdal							
		Seroquel							
		Stelazine							
		Thorazine							
		Zyprexa							
		Clonidine							
		Cogentin							
		Deanol (deaner, DMAE)							
		Dextromethorphan							
		Lithium							
		Naltrexone							
		St. John's Wort							
		Anafranil							
		Depakene for behavior							
		Depakene for seizures							
		Depakote for behavior							
		Depakote for seizures							
		Dilantin							
		Felbatol							
		Gabitril							
		Keppra							
		Klonopin							
		Lamictal							
		Luvox							
		Mysoline							
		Neurontin							
		Paxil							
		Phenobarbital							
		Strattera							
		Tegretol							
		Topamax							
		Trileptal							
		Valium							
		Zarotin							
		Zonegran							

Now	Past	Medication or Supplement	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments
		Adderall							
		Prozac							
		Zoloft							
		Amphetamine							
		Cylert							
		Dexedrine, dextroamphetamine							
		Fenfluramine							
		Focalin							
		Ritalin							
		Buspar							
		Chloral hydrate							
		Valium							
		Desipramine							
		Mallaril							
		Tofranil							
		Klonopin							
		Antihistamines							
		Benadryl							
		Claritin							
		Singular							
		Zyrtec							
		Digestive Flora							
		Antibiotics (specify type and number of times):							
		Bactrim (septra)							
		Diflucan							
		Humatin							
		Lamisil							
		Nizoral							
		Nystatin							
		Saccharomyces boulardii							
		Sporonax							
		Transfer Factor (oral)/ Colostrum							
		Yodoxin							
		Digestion							
		Bethenecol							
		Digestive enzymes							
		Pepsid							
		Peptidase enzymes							
		Probiotics							

Now	Past	Medication or Supplement	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments
		Detoxification							
		DMPS							
		DMSA (succimer, chemet)							
		Reduced glutathione (TTFD)							
		Reduced glutathione (IV)							
		Reduced glutathione (oral)							
		Folic Acid							
		Melatonin							
		Nutrition and Metabolism							
		Multivitamin (Specify)							
		Vitamin A							
		Vitamin C							
		Vitamin B3 (Niacin)							
		Vitamin B6							
		5 HTP							
		Alpha Keto Glutarate (AKG)							
		Amino Acid Mix							
		Deanol							
		Dimethylglycine (DMG)							
		GABA							
		Glutamine							
		SAMe (SAM, Samyr)							
		TMG							
		Tryptophan							
		Tyrosine							
		Calcium							
		Magnesium							
		Manganese							
		Selenium							
		Zinc							
		Human Growth Factor							
		IV Immune globulin							
		Kutapressin							
		Oral Immune globulin							
		Secretin (IV)							
		Secretin (transdermal/sublingual)							
		Steroids (oral)							

Therapies and Diets									
Please indicate therapies and diets you have used and/or are using									
Now	Past	Medication or Supplement	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments
		Therapies							
		Acupuncture							
		Auditory Training							
		Craniosacral							
		Chiropractic							
		Energy Therapy (Specify)							
		Homeopathy							
		Lovaas (ABA)							
		Naturopathy							
		Neural Therapy							
		Occupational Therapy							
		Osteopathy							
		Physical Therapy							
		Sensory Diet							
		Speech Therapy							
		Other:							
		Diets							
		Gluten Free							
		Casein Free							
		Yeast Free							
		High Protein/ Low Carb							
		Salicylate Free							
		Low Phenolics							
		IgG reactive food avoidance							
		Specific Carbohydrate Diet							
		Other:							

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	Stemming (repetitive actions or movements)					
2	Rocking					
3	Head banging					
4	Self-mutilation					
5	Nail biting					
6	Hand/arm biting					
7	Nail/skin picking					
8	Aggressiveness (hitting, kicking, biting others)					
9	Mood swings					
10	Irritability/tantrums					
11	Fears/anxieties					
12	Hyperactivity					
13	Inability to concentrate/focus					
14	Always fidgety in his/her seat					
15	Impulsive					
16	Breath holding					
17	Dizziness					
18	Seizures					
19	Poor coordination					
20	Problems with buttons, ties, snaps or zippers					
21	Processing problems - visual, motor, or language					
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					
30	Recurrent/chronic fever					
31	Flushing					
32	Difficulty falling to sleep					
33	Night waking					

No.	Description	Mild	Moderate	Severe	Duration	Unique details
34	Nightmares					
35	Difficulty waking					
36	Bed wetting/soiling					
37	Day time wetting/soiling					
38	Numbness/tingling in hands/feet					
39	Headache					
40	Blinking					
41	Tics					
42	Eye discharge					
43	Dark circles/puffiness under eyes					
44	Night-blindness in child/family					
45	Congestion					
46	Dripping nose					
47	Sensitivity to bright lights					
48	Earaches					
49	Ringing in ears					
50	Sensitive to sounds/noise					
51	Bad breath					
52	Nose bleeds					
53	Acute sense of smell					
54	Sore throats					
55	Hoarseness					
56	Cough					
57	Wheezing					
58	Geographic tongue					
59	Swollen gums					
60	Canker sores					
61	Dry lips/mouth					
62	Diarrhea					
63	Constipation					
64	Bloating					
65	Passing gas					
66	Belching					
67	Stomach ache					
68	Refusal to eat					
69	Sensitive to texture of food					
70	Difficulty swallowing					
71	Food Craving					
72	Grinding teeth					

No.	Description	Mild	Moderate	Severe	Duration	Unique details
73	Mucous/blood in stools					
74	Anal itching					
75	Calf cramps					
76	Other muscle cramps/spasms					
77	Tremors					
78	Weakness					
79	Stiffness					
80	Eczema					
81	Psoriasis					
82	Hives					
83	Acne					
84	Seborrhea (cradle cap)					
85	Other rashes					
86	Easy bruising					
87	Itchy scalp					
88	Dry skin					
89	Oily skin					
90	Pale skin					
91	Sensitivity to insect bites					
92	Sensitive to texture of clothes					
93	Cracking/peeling hands					
94	Cracking/peeling feet					
95	Strong body odor					
96	Strong urine odor					
97	Strong stool odor					
98	Soft nails					
99	Thickening of nails					
100	Ridges/pitting of nails					
101	White spots/lines on nails					
102	Brittle nails					
103	Any OCD (obsessive compulsive) behaviors					
104	Strategies to put pressure On abdomen					
105	Reflux					
106	Persistent colic					
107	Toe Walking					

Describe any other symptoms you would like me to know about your child:

List any other history, pertinent thoughts or questions that you want to address: