Donald G. Gerken, D.C. DACCP
88 E Bonita Rd. #E Phone: (619) 422-3088
Chula Vista, CA 91910 Fax: (619) 422-3988

Parent's Last Name:	
Child's First Name:	

SIGNS AND SYMPTOMS

Please give a number under each sign and symptom.
0=Never, 1=Rarely, 2=Sometimes, 3=Often, 4=Regularly, 5=Constantly

No.	Description	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
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									

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No.	Description	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
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									
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									

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No.	Description	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
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									
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									

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No.	Description	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
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									