Craig Ranch Pediatrics

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Date of Initial Consultation: _____ Who is present at initial consult: _____

[The above is for office use only]

Name of patient: _____ ____ Male ____ Female

Date of birth: _____ Age ___

Physician/Pediatrician: _____ Allergies: _____

Who has legal custody?

_____

Name of parent: _____ Parent's employer: _____

Parent's home phone: _____ Work: _____ Cell: _____

Email address:

_____

Address:

_____

Name of second parent: _____Parent's employer: _____

Parent's home phone: _____ Work: _____ Cell: _____

Address:

_____

Mother's social security #: _____Father's social security #:_____

Name of Specialist(s): _____

Institution(s): _____

List any diagnoses or explanations you have been given for your child:

_____

Who provided the diagnosis?: _____

Age at time of diagnosis: ___

Do the biological siblings have any diagnoses? _____

What are your top 3 goals with us today? _____

Please bring copies of any tests or lab work that have been done for your child.

Please attach a toddler photo and a current photo if possible.

A. Maternal Health (Biological Mother)

1. Y__ N__ Is this your biological child?(If no, please answer numbers 2-7 for the biological mother if you have the Information; otherwise go on to Section B)
2. Y__ N__ History of miscarriages. If yes, how many? _____
3. _____ Number of "silver" dental fillings (amalgams) at time of pregnancy
4. Y__ N__ Did you have any new silver fillings put in, or any old ones repaired or removed during the pregnancy?
5. Y__ N__ Use of any hormonal therapy before the pregnancy?
6. Y__ N__ Did you receive any vaccinations during the pregnancy?
7. Y__ N__ Did you receive any flu shots during the pregnancy? How many?
8. _____ Mother's Rh status, if known (+ or -)
9. Y__ N__ Did you ever receive Rhogam shots? How many? _____
10. Y__ N__ Mother's thyroid status: (Circle) Normal Hyperthyroid Hypothyroid (Low)
11. Y__ N__ Diabetic
12. Mother's occupation before and during pregnancy: _____
13. During the pregnancy, did you use any: (All answers are kept strictly confidential?)

    Y__ N__ Street Drugs Please list:

    Y__ N__ Alcohol

    Y__ N__ Cigarettes. How many packs a day? _____

    Y__ N__ Prescription Drugs. Which ones: _____

    Y__ N__ Were you on SSRI's? (For depression or anxiety)

B. The Pregnancy

1. Any problems with the pregnancy? Y__ N__

   If yes, please describe: _____
2. Y__ N__ Bacterial Infections
3. Y__ N__ Antibiotics
4. Y__ N__ Hospitalized during the pregnancy?
5. Y__ N__ Use of fertility drugs
6. Y__ N__ In-vitro fertilization

C. The Birth

1. __Vaginal

   __C-Section Reason:_____

   __VBAC (Vaginal Birth after C-Section)

2. Y__ N__ Was labor induced?
3. Y__ N__ Medications used during labor: _____
4. Y__ N__ Medications used during delivery: _____
5. Y__ N__ Full term
6. Y__ N__ Premature If yes, how many weeks early? _____
7. ___/___ APGAR Scores (Or do you remember if they were they good or poor? _____)
8. Birth weight: _____
9. Complications:_____

   _____

   _____

10. Y__ N__ Was there any concern for birth trauma?
11. Medications given to baby at the hospital: _____

    _____

12. Y__ N__ Did the baby receive any antibiotics at the hospital?
13. Y__ N__ Did the baby receive the Hepatitis B vaccine while in the hospital?

D. Infancy/Toddler Years Birth to 2 years of age (attach 2 photos if possible)

1. Y__ N__ Breastfed? For how long?
2. Y__ N__ Bottle-fed?
3. Y__ N__ Difficulty latching on?
4. Y__ N__ Difficulty swallowing? _____
5. _____ at what age were foods introduced?
6. Y__ N__ Excessive drooling?
7. Y__ N__ Poor head control - “Floppy baby”? (Low muscle tone)
8. Y__ N__ Colic or reflux
9. Y__ N__ Would “crash” when sick. Got dehydrated or even hospitalized.
10. Y__ N__ History of thrush? (White overgrowth in mouth) How many times?___
11. Y__ N__ History of strep? How many times?

12. Y__ N__ Sinus infections? How many times?
13. Y__ N__ Seizures? ___
14. Y__ N__ Antibiotics__ Y__ N__ Vaccine reactions. Describe:
15. Y__ N__ Asthma_____
16. Y__ N__ Known allergies List: _____
17. Y__ N__ Prone to diaper rash
18. Y__ N__ Prone to body rashes Location: _____
19. Y__ N__ Red ring around the anus/cracking/bleeding
20. Describe sleep habits as an infant and as a toddler:

    _____

    _____
21. Texture of bowel movements: (Age 2 years and younger)

    __ hard "rabbit pellets"

    __ enormous rock hard bowel movements

    __ formed, hard

    __ formed, soft (normal)

    __ “mashed potatoes"

    __ diarrhea

    __ diarrhea and constipation
22. How often were the bowel movements as an infant? _____
23. Y__ N__ Had to use laxatives or stool softeners
24. Y__ N__ Hospitalized for constipation at age 2 years or younger
25. Y__ N__ Bowel movements were very foul smelling
26. Y__ N__ Excessively gassy
27. Y__ N__ Gas was very foul-smelling
28. Y__ N__ Caught a lot of colds as an infant
29. List any surgeries or procedures, age 2 or younger: _____ _____
30. CDC’s Developmental Health Watch (by 12 months) **Circle all that apply.**
    - Does not crawl
    - Drags one side of body while crawling (for over one month)
    - Cannot stand when supported
    - Does not search for objects that are hidden while he or she watches

- Says no single words ("mama" or "dada")
- Does not learn to use gestures, such as waving or shaking head
- Does not point to objects or pictures
- Experiences a dramatic loss of skills he or she once had.

31. CDC's Developmental Health Watch (by 24 months) **Circle all that apply.**

- Did not walk by 18 months
- Failed to develop a mature heel-toe walking pattern after several months of walking, or walked only on the toes
- Did not speak at least 15 words
- Did not use two-word sentences by age 2
- By 15 months, did not seem to know the function of common household objects (brush, telephone, bell, fork, spoon)
- Did not imitate actions or words by the end of this period
- Did not follow simple instructions by age 2
- Could not push a wheeled toy by age 2
- Experienced a dramatic loss of skills he or she once had

32. Choose from the following three scenarios:

____ Your child hit milestones and spoke on time, then abruptly changed and was "lost".

____ Your child was never really right from birth, didn't hit milestones or speak on time.

____ Your child was developing normally, and then just hit a plateau. (no abrupt change)

____ Other: _____

33. Y__ N__ If your child had speech and then lost it at some point

Age when speech was lost: _____

Describe: _____

_____

34. Please describe any illness, surgery, vaccines, antibiotics, etc. that occurred at the time of the speech loss: _____

_____

35. If vaccine related, what happened? _____

_____

36. Y__ N__ Was your baby ever accidently double vaccinated?

37. Y__ N__ Did you ever have to “catch up” on vaccinations?

38. Y__ N__ Good eye contact? Circle one: Excellent Good Fair Poor None

39. Y__ N__ Known genetic disorders

40. Y__ N__ Known metabolic disorders

E. Older childhood (2 years of age and up)

1. What is your child’s primary form of communication? (example: speaking, pointing, PECS, etc.)

_____

2. Please check all that apply:

__ Does your child speak now?

__ Does your child understand what is being said to him?

__ Does he/she express needs and wants?

__ Does he use “I want” statements?

__ Will he/she go get items that you ask for?

__ Does he answer by repeating your question?

__ Does he/she initiate conversations?

3. Describe his speech: (Check all that apply.)

__ 0 words, mumbles, makes some noises

__ 1-2 words in a row

__ 3-4 words in a row

__ 1 sentence at a time

__ 2-3 sentences in a row

__ Many sentences in a row

__ Language is highly developed, and appropriate

__ A "wall" of one-way conversation, always talking, doesn’t need you to answer

__ Can sustain a back-and-forth conversation, not just reply to questions

4. Y__ N__ Repeats stories he/she has heard on TV (scripting)

5. Y__ N__ Echoes or repeats what you say

6. Y__ N__ Repeats some words or phrases over and over all day
7. Y__ N__ Speaks in a mechanical voice
8. Y__ N__ Speaks in a singsong voice
9. Y__ N__ Concrete thinking (does not understand slang phrases, takes words literally)
10. Y__ N__ Has a sense of humor and easily understands jokes
11. Y__ N__ Has a sense of humor, but does not get jokes most of the time

Learning:

1. How is your child doing in school? _____
2. Y__ N__ Has learning difficulties
3. Y__ N__ Fine motor skills are poor (difficulty writing letters, e.g.)
4. Y__ N__ Performs work on his/her grade level?
5. Y__ N__ Has been held back a grade before
6. Y__ N__ Is currently being homeschooled
7. Y__ N__ Has been homeschooled in the past
8. Y__ N__ Is your child in an Autism or Special Education class?
9. Y__ N__ Does your child hit, kick, bite, etc. other students or teachers?
10. How is your relationship with the school? _____

Sensory:

1. Y__ N__ Any rocking, hand flapping, swinging, twirling?
2. Y__ N__ Sensitive to noise/sounds

   Describe: _____
3. Y__ N__ Does not like the texture of finger paints, odor of Playdoh, etc.
4. Y__ N__ Sensitive to textures of food
5. Y__ N__ Sensitive to hot or cold foods
6. Y__ N__ Does not like to have teeth brushed
7. Y__ N__ Sensitive to smells
8. Y__ N__ Sensitive to light
9. Y__ N__ Bothered by seams and tags on clothing
10. Y__ N__ Likes to be hugged or touched

11. Y__ N__ Pressure is calming
12. Y__ N__ Sensory seeker (Loves to swing, twirl, jump, textures no problem)
13. Y__ N__ Sensory avoider (avoids the playground equipment, textures are a problem)
14. Y__ N__ Gets overwhelmed by crowds, Wal-Mart, the mall, parties, etc.
15. Y__ N__ High pain tolerance Describe: _____

Vision Therapy Screening Section:

1. Y__N__ Good eye contact Circle one: Excellent Good Fair Poor None (1a)
2. Y__N__ Finger stimming/flapping right in front of eyes
3. Y__N__ Does he or she do any sideways glancing?
4. Y__ N__ Holds toys up very close to eyes, or just above or to the side of eyes

GI and Immune:

1. Y__N__ Skin is very pale
2. Y__N__ Dark under-eye circles Circle: mild moderate dark very dark
3. Y__ N__ Puffiness under lower lashes
4. Y__ N __ Frequent runny nose / Seasonal allergies
5. Y__ N__ Frequent, brief grabbing at penis or vaginal area, as if felt a sharp pain
6. Y__ N__ Cheeks and ears sometimes flush bright red for no reason (Not when exercising or has a fever, just at odd random times)
7. Y__ N__ Eats inedible things (pica)
8. Y__ N__ Known or suspected allergies or sensitivities

   Please list: _____
9. Y__ N__ Celiac disease
10. Y__ N__ Never gets sick
11. Y__ N__ Catches every cold “coming and going”
12. Y__ N__ Sinus infections How many? ___ Antibiotics: Y__ N__
13. Y__ N__ Ear infections over the age of 2? Y
14. Y__ N__ Do any smokers live in the home? How many? _____
15. Y__ N__ Does your child seem less autistic when they have a fever?

16. Y__ N__ Strep infections
17. Y__ N__ Currently has some warts
18. Y__ N__ Molluscum contagiosum
19. Y__ N__ Cold sores (fever blisters)
20. Y__ N__ Asthma
21. Y__ N__ Eczema
22. Y__ N__ Rashes
23. Y__ N__ Hives
24. Y__ N__ Dermatographism
25. Y__ N__ Ringworm

Yeast Screening:

1. Y__ N__ Silly, "drunken" laughter that is inappropriate
2. Y__ N__ Cheeks have bumpy red patches.
3. Y__ N__ Red ring right around the anus
4. Y__ N__ Rectal or vaginal itching
5. Y__ N__ Cracking or peeling hands or feet
6. Y__ N__ Ridged, discolored nails or toenails
7. Y__ N__ Jock itch or athlete's foot
8. Check all that apply:

   ___ Wet hair smells funny or like a wet dog

   ___ Scalp is crusty or flaky

   ___ Dry flaky skin around the ears, eyebrows or nose

   ___ Persistent cradle cap
9. Y__ N__ Geographic tongue (map-like)
10. Y__ N__ Toe-walking
11. Y__ N__ Urinary tract infections How many? ___
12. Y__ N__ Kidney infections
13. Y__ N__ Frequently grabs penis or vaginal area
14. _____ How many rounds of antibiotics has your child had in their entire life?
15. Y__ N__ Has used Diflucan, Nystatin or other antifungals. How many times? _____

16. Y__ N__ Spaced out, foggy, in a different world
17. Y__ N__ Cravings for desserts and sugary foods
18. Y__ N__ Depression or irritability
19. Y__ N__ Poor memory
20. Y__ N__ Lethargy or tiredness
21. Y__ N__ Strong Foot or body odor

Tics and Obsessive Tendencies:

1. Y__ N__ Sudden, brief involuntary muscle movements or jerks
2. Y__ N Repetitive blinking, snorting or coughing, touching the nose, smelling objects
3. Y__ N__ Picking at skin until it is raw
4. Y__ N__ Sudden, brief involuntary vocalizations or sounds
5. Y__ N__ Has a known tic disorder such as Tourette syndrome, for example
6. Y__ N__ Has rigid, inflexible routines
   - Routines are functional (Useful but rigid routines) _____
   - Routines are non-functional. (Strange obsessive/compulsive type) _____

Miscellaneous:

1. What is your child's exercise level?
   Y__ N__ Completely sedentary
   Y__ N__ Not much exercise
   Y__ N__ Moderate level of exercise
   Y__ N__ High level of exercise
   Y__ N __ Plays on a sports team Which sport? _____
2. Y__ N__ History of being sexually, physically or verbally abused (Circle all that apply)
3. Y__ N__ Headaches Describe: _____
4. Y__ N__ Visual Hallucinations
5. Y__ N__ Auditory Hallucinations

Sleep Patterns: (check all that apply) Usual Bedtime: _____

Wake-up Time: _____

__ Falls asleep easily

__ Difficulty falling asleep most of the time

__ Difficulty falling asleep occasionally

__ Once asleep, stays asleep all night and body is peaceful and calm

__ Stays asleep all night but body is restless, tosses and turns (covers all torn up)

__ Awakens maybe once a night, and goes right back to sleep

__ Frequent night awakenings, does not go back to sleep easily

__ Not unusual to “be up for the day” at extremely early hour, e.g. 2 or 3 a.m.

__ Other, describe _____

__ Sleeps in own bed

__ Sleeps with parents

__ Sleeps more than normal

__ Sleeps less than normal

1. Y__ N__ Moans or cries in sleep
2. Y__ N__ Sweat at night
3. Y__ N__ Nightmares
4. Y__ N__ Night terrors
5. Y__ N__ Sleep walks
6. Y__ N__ Takes melatonin How much? _____
7. Y__ N__ Takes Clonidine or medication for sleep
8. How many caffeinated drinks are consumed each day? _____

Dietary History: ☐ Organic Foods ☐ Non-organic Foods ☐ Partially organic diet

Vegetables: _____ Fruits: _____

_____ _____

_____ _____

Dairy: _____ Meats: _____

_____ _____

_____ _____

Snacks: _____ Other: _____

_____ _____

_____ _____

Breads, pastas, pizzas, etc: _____

_____

_____

1. Y__ N__ Difficulty swallowing
2. Y__ N __ Difficulty chewing
3. Y__ N__ Picky eater
4. Y__ N__ Artificial sweeteners
5. Y__ N__ Attitude or mood changes after meals

6. Foods that are demanded or wanted every day: _____

7. If your child were on a desert island, which 3 foods would he take with him?

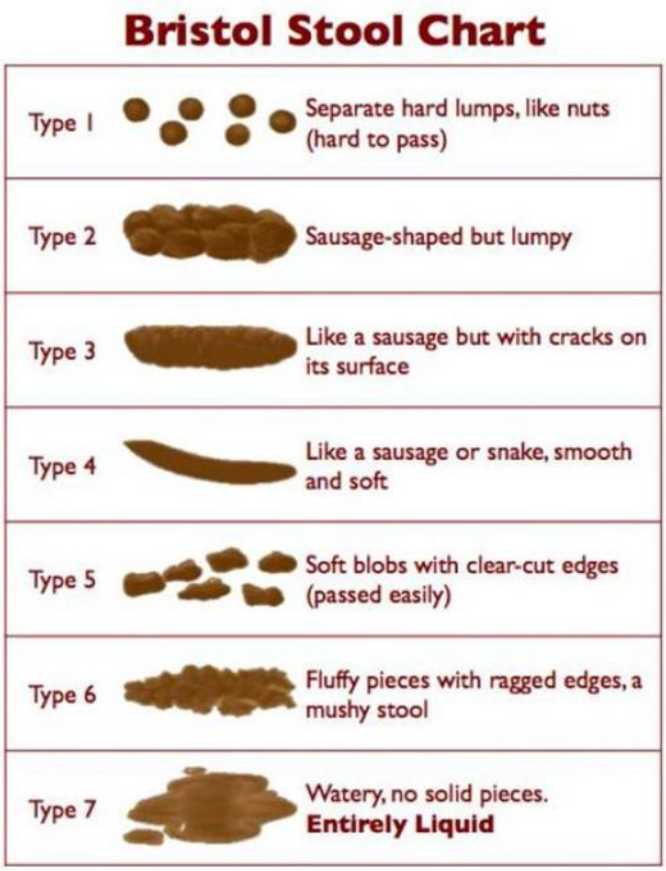
8. Y__ N__ Drinks a lot of milk. (white / chocolate / strawberry) # of glasses per day: _____
   How much would he/she drink if you let him have all he wanted?_____

9. Y__ N__ Ever been on the Gluten-free/Casein-free Diet For how long?_____
   Was it done strictly? _____ What happened?_____

10. Y__ N__ Any other diets? (Specific Carbohydrate, Feingold Diet, Low Oxalate Diet, Candida)

Bowel Habits:

Use the following chart to describe your child's stools: **Circle all that apply.**



Check all that apply:

__ Enormous bowel movements

__ Diarrhea and constipation

__ Don't know, don't go in with him/her anymore

__ Undigested food present in stools

__ Mucus in the stools

__ Sandy or gritty-looking stools

__ Sticky stools, or child has trouble cleaning self after BM, uses too much toilet paper

12. Y__ N__ Do you give any enemas, suppositories, laxatives, etc?

13. Y__ N__ Does your child have to crouch/perch on the toilet seat to have a bowel movement?
14. How often does he or she have a bowel movement? _____
15. Y__ N__ Foul-smelling bowel movements (more than “normal”)
16. Y__ N__ Gassiness
17. Y__ N__ Foul-smelling gas

18. What does his/her breath smell like? __ Not bad
    __ Like freshly baked bread
    __ Stinky, bad
    __ Just like poop

19. Y__ N__ Abdominal bloating?
20. Y__ N__ Does he/she drape their tummy or lean over tables, chairs, or arms of couches?
21. Y__ N__ Presses tummy up against the edges of tables or stands?
22. Y__ N__ Self-injuring behavior___Only when angry___ Random, no reason
23. Y__ N__ Random sadness or crying, or unexplained tantrums
24. Y__ N__ Head-banging ___Only when angry ___ Random, no reason
25. Y__ N__ Has inflammation of the esophagus, stomach or intestinal tract
    How was this confirmed? _____
26. Y__ N__ Does he/she grind her teeth at night?
27. Y__ N__ Are there pets in the home now? Describe: _____
    Are they indoor or outdoor pets?: _____
    Were there pets around when your child was a baby?
28. Y__ N__ Spotting of feces in underwear
29. Y__ N__ Potty-trained At what age?_____
30. Y__ N__ Stays dry at night
31. Y__ N__ Seems to urinate excessively

Reflux screening section:

Y__ N__ Has known reflux

Y__ N__ Swallows or clears throat frequently

Y__ N__ Has the tooth enamel been eroded by gastric acid?

Y__ N__ Facial grimacing

Y__ N__ Gritting teeth

Y__ N__ Wincing

Y__ N__ Sighing, groaning

Y__ N__ Burping

Y__ N__ Pacing around the house, hyperactive, jumping up and down

Y__ N__ Puts off going to sleep

Y__ N__ Frequent waking at night

Y__ N__ Falls asleep propped up in bed, propped up on couch, or bent over a pillow

Seizures:

1. Y__ N__ Staring spells
2. Y__ N__ Seizures

Type of seizures: _____

Frequency of seizures: _____

Date of last seizure: _____

Do you carry the Diastat suppository?___Y___N

Signs of zinc deficiency:

Y__ N__ Has white dots or lines on fingernails

Y__ N__ Acne/sparse hair/psoriasis

Y__ N__ Canker sores

Y__ N__ Chews on toys, objects, clothing

Signs of an essential fatty acid deficiency:

Y__ N__ Keratosis pilaris Y__ N__ Dry, coarse hair

Signs of a magnesium deficiency:

Y__ N__ Muscle twitches/tingling

Y__ N__ Sighing

Y__ N__ Salt craving

Y__ N__ Chews on toys, objects, clothing

List any therapies your child has now or in the past:

___ Speech ___Son Rise

___ Physical Therapy ___Vision Therapy

___ Occupational ___ Social Skills

___ ABA ___Sensory Integration

___ Counseling ___Light Therapy

___ Anger Management ___Music Therapy

___Floor Time ___Listening therapy

___Other ___Relationship Development Intervention

Which therapies have helped the most? _____

_____

_____

Dental:

Y__ N__ Does your child have regular dental visits? Y__ N__ Does your child tolerate visits to the dentist?

Y__ N__ Does your child have cavities now? How many?_____

Y__ N__ Has your child had cavities in the past? How many? _____

Y__ N__ Has the tooth enamel been eroded by gastric acid?

Y__ N__ Have steel caps been placed on the teeth?

Y__ N__ Is your child sedated for procedures?_____

Y__ N__ Does your child have an unusually large number of cavities?

Y__ N__ Tolerates brushing?

Y__ N__ Brushes his or her own teeth?

Y__ N__ Regular flossing?

Y__ N__ Has had molars sealed?

Y__ N__ Uses xylitol products for the oral/nasal cavity?

Circle the xylitol products used: Toothpaste Mouthwash Gum Candy Nasal spray

Y__ N__ Uses a probiotic toothpaste?

Focus, Attention and Impulsivity:

Y__ N__ Has been diagnosed with ADD or ADHD

Y__ N__ Poor self-control

Y__ N__ Impulsive, acts before thinking

Y__ N__ Poor memory for directions and instructions

Y__ N__ Dreamy, distracted type

Y__ N__ Needs special seating in the classroom

Y__ N__ Trouble following directions

Y__ N__ Frequently interrupts

Y__ N__ Is the class clown

Y__ N__ Acts before thinking

Y__ N__ Disorganized

Y__ N__ Poor planning

Activity:

Y__ N__ Restless, roams around

Y__ N__ Fidgety

Y__ N__ Difficulty staying seated

Y__ N__ Hyperactive

Y__ N__ Talks excessively

Y__ N__ Touches everything

Y__ N__ Easily excited

Y__ N__ Lethargic/fatigued

Compliance:

Y__ N__ Has difficulty following the rules

Y__ N__ Argumentative

Y__ N__ Engages in negative behavior to get attention

Y__ N__ Destruction of household items, furniture or walls

Y__ N__ Gets physically aggressive with family members

Y__ N__ Gets physically aggressive with classmates, teachers or aides

Peer Relationships and Behavioral Difficulties:

Y__ N__ Would like to have friends

Y__ N__ Truly prefers to be alone

Y__ N__ Parallel play (plays near other children, not with them)

Y__ N__ Has trouble with group activities

Y__ N__ Blames others

Y__ N__ Is a “provocative victim”

Y__ N__ Bullies or bosses other children

Y__ N__ Teases excessively

Y__ N__ Unpredictable behavior scares other children away

Y__ N__ Is rejected or avoided by others

Unusual Behaviors:

Y__ N__ Opens and closes doors, or sliding doors, for long periods of time

Y__ N__ Plays with parts of toys, not the whole toy (spins the wheels, but doesn't play trains)

Y__ N__ Stares at fans

Y__ N__ Meticulously lines up or stacks toys

Y__ N__ Has imaginary play (makes up storylines, makes car noises, etc.)

Y__ N__ Gets obsessed with certain topics, toys, movies, TV shows, appliances, etc.

Y__ N__ Would play video games all the time, if allowed to do so

Intellectual Status: (Your best estimate)

__ Has a diagnosis of “MR” or Mental Retardation

__ Below average intelligence

__ Average intelligence

__ Above average intelligence

__ Superior intelligence

__ Genius

Female Health:

1. Y__ N__ Regular gynecological visits

2. Age of first menses: _____

3. Y__ N__ Birth Control Type: _____

4. Please describe any premenstrual symptoms: _____ 5. Please describe any problems or concerns:_____

Emotional Difficulties:

1. Y__ N__ Has been diagnosed with a mood disorder Specify:

   Y__ N__ Frequent mood swings

   Y__ N__ Irritable

   Y__ N__ Easily frustrated

   Y__ N__ Easily angered

   Y__ N__ Tantrums or outbursts

   Y__ N__ Often anxious

   Y__ N__ Depressed or unhappy

2. Y__ N__ Ever had full psychological testing and evaluation? Please include a copy of the report.

3. Y__ N__ Does he/she ever run away? How often? _____

4. Y__ N__ Ever been in a residential treatment center?

Name of facility _____

Reason: _____

5. Y__ N__ Ever been arrested?

How many times?_____Reason:_____

Maturity:

Y__ N__ Behavior resembles that of a younger child Y__ N__ Prefers younger relationships

Y__ N__ Prefers the company of adults

Home Situation:

1. How many homes does the child live in, or divide time between? _____
2. In which city was the child born? _____
3. How many times have you moved since his/her birth? _____
4. If more than one home, will both homes be cooperative with treatment plans? _____
5. Please describe any difficult family situations which may hinder treatment:
6. Who lives in the primary home?

__ Mother __ Grandmother

__ Father __ Grandfather

__ Stepmother __ Others List: _____

__ Stepfather _____

__ Girlfriend _____

__ Boyfriend _____

__ Brothers Ages: _____

__ Sisters Ages: _____

7. Full name, address and phone number of Preschool/School:

_____

_____

_____

_____

8. What county is the school in? _____

Family history: (Please check all that apply)

__ Allergies __ Multiple Sclerosi

__ Alzheimer's __ Obsessive Compulsive disorder

__ Asthma __ Parkinson's

__ Autism __ Seizures

__ Celiac disease __ Tic disorders

__ Chronic Fatigue syndrome __ Thyroid disorders

__ Crohn's disease __ Tourette disorder

__ Eczema Yeast problems __ Ulcerative colitis

__ Fibromyalgia __ Wheat (gluten) sensitivity

__ Genetic disorders

__ Irritable Bowel Syndrome

__ Lupus

Medication Log Date:_____

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10._____

Please list any surgeries from the age of 2 and older:

_____