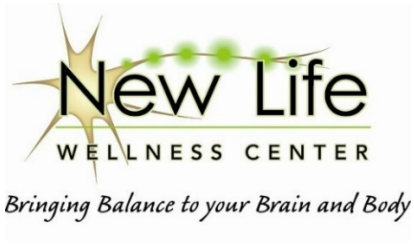


PATIENT REGISTRATION

Who may we thank for referring you to New Life Wellness Center?			Date:
Full Name	DOB	Age	☐ Male ☐ Female
Address			
City	State		Zip Code
Home Telephone ☐ Primary Contact	Work Telephone ☐Primary Contact		Mobile ☐Primary Contact
Social Security Number	Email Address		
Emergency Contact Name	Relationship		Emergency Contact Number

INSURANCE INFORMATION ☐ **MEDICARE**

Primary Insurance Carrier	Group Number	ID Number
Primary Insured	Employer Name	
Business Address		
Employee Social Security Number	Employee Date of Birth	

FINANCIAL RESPONSIBILITY

Person Responsible for Account: ☐ Self ☐Spouse ☐ Parent ☐Other	
Name	Social Security Number
Address	
Telephone	Email Address

OPTIONAL CREDIT CARD PAYMENT AUTHORIZATION

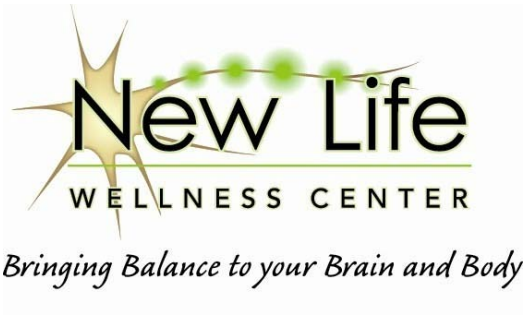
I _____, hereby authorize New Life Wellness Center and/or staff at 323 Middle Country Road, Smithtown, NY 11787 or 146 Central Park West, NYC 10023, to change my credit card for services rendered and/or products supplied for a period of one year from the date below. It is my responsibility to notify New Life Wellness Center of any changes regarding this credit card authorization.

Name on Card	Signature/Date
Credit Card Type ☐ MasterCard ☐Visa ☐American Express ☐Discover	Credit Card Number

Expiration Date	Security Code	Billing Zip Code

I attest, to the best of my knowledge, the above information is accurate and true.

Signature:_____ Date: _____



AUTHORIZATIONS & ACKNOWLEDGEMENTS

While it is never our intention to bring anything of a potentially negative bent into a health and healing relationship, we, along with other health care providers and hospitals, are obliged by the state of New York to ask that you read and sign the following:

TREATMENT AUTHORIZATION: I (print name) _____ authorize Chiropractic Care, including spinal adjustment, of myself or my minor child by the Doctors and staff at New Life Wellness Center.

INFORMED CONSENT: Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care at this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall wellbeing. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications and procedures given for the same symptoms.

PRIOR CHIROPRACTIC TREATMENT INFORMATION

Name of Chiropractor:_____ Location (city):_____

When was your last treatment: _____ Have you had x-rays taken? _____

MEDICAL DOCTOR: New Life Wellness Center believes your medical doctor is a vital part of your healthcare team. As such, upon your request, we will send evaluations and progress reports to the physicians listed below:

NAME:_____ **SPECIALTY:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

REFERRAL AUTHORIZATION: Your insurance carrier may require a referral from your primary care physician for our services. Please be aware that it is your responsibility to obtain all necessary referrals prior to therapy. If your insurance carrier requires and authorization for service, no service will be rendered until the authorization is obtained.

Patient Name: _____

CANCELLATION AND/OR NO-SHOW POLICY: New Life Wellness Center urges you to keep every appointment, as consistent treatment provides optimal benefit. In the event you need to cancel an appointment, we require at least 48 hours' notice for new patients, 24 hours for existing patients, excluding Sunday. Patients who cancel without proper notice or fail to show for a scheduled appointment will be subject to a $100 charge (new patients) or $50 charge (existing) for each occurrence. Arrival more than 15 minutes after the time of your scheduled appointment may be considered a failed appointment.

ASSIGNMENT OF BENEFITS: I authorize payment of my Medicare and/or Insurance benefits to be made directly to New Life Wellness Center on my behalf for services rendered. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me, I will endorse such payments to New Life Wellness Center within five (5) days of receipt of payment.

FINANCIAL/INSURANCE RESPONSIBILITY FOR ALL NEW LIFE WELLNESS SERVICES: I understand and agree to the following policies regarding financial and insurance responsibilities. Payment is required at or before each visit. I am responsible for charges incurred for all treatment rendered. This responsibility includes co-pay, co-insurance, deductible amounts, non-covered and excluded items not paid for by my insurance carrier or other party responsible for coverage of my medical expenses. I agree that I am responsible for any payments for services my insurance carrier determines, either now or at a later date, to be unreasonable or not medically necessary. I further understand, New Life Wellness Center will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for New Life Wellness Center to take action to secure payment of an outstanding balance owed.

FURTHER NOTICES AS TO POLICIES REGARDING MEDICARE: New Life Wellness Center is a participating provider of Medicare; as such we will handle all billing to Medicare and any secondary insurance. Medicare requires you to satisfy a yearly deductible before they will begin paying benefits. Medicare will deduct the deductible amount from the first claim they receive each calendar year. Unless you have satisfied your annual deductible with another Medicare provider's office, you are responsible to pay your deductible to New Life Wellness Center. After your deductible is satisfied, Medicare will reimburse us 80% of their standard fee for Chiropractic Adjustments Only. Therefore, your payment responsibility is 20% of the standard Medicare fee for Chiropractic Adjustments, along with any additional products or services you have consented to and received.

I understand that, in certain circumstances, Medicare may find that Chiropractic treatments are not "reasonable and/or medically necessary" for the illness, injury or condition for which I am seeking treatment. I understand that Medicare bases this ruling on the diagnosis provided by my physician and their standards for that diagnosis. I understand, in this case, I will be responsible for any and all charges incurred.

NO GUARANTEES: I recognize that the practice of Chiropractic is as much an art as a science, and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcome of any treatment and/or therapy rendered at New Life Wellness Center.

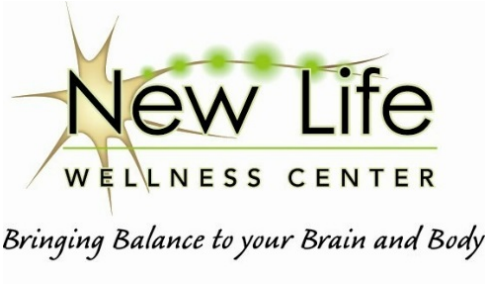
REVOCATION OF AUTHORIZATIONS: These authorizations may be revoked by me, in writing, at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

PATIENT ACKNOWLEDGEMENT: I certify that the information I provide to my doctors, therapists, and insurance company is correct. I certify that I am here to receive medical care and for no other purposes. I do not represent a third party.

By signing and dating this form I acknowledge I have discussed, or have had the opportunity to discuss, with my doctor the nature and purpose of Chiropractic treatment in general and my treatment in particular (including my individualized Plan of Care) as well as the contents of these Acknowledgements and Authorizations.

I consent to the Chiropractic treatments offered or recommended to me by my Doctor. I intend this consent to apply to all my present and future Chiropractic care.

Patient's Signature	Date
Witness	Date



Acknowledgement of Receipt

Notice of Privacy Practices

By signing and dating this form I acknowledge that I have received a copy of New Life Wellness Center's Notice of Privacy Practices:

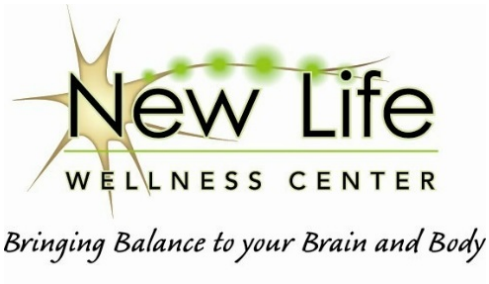
Patient's Name *(Please print)*	Last four digits of your Social Security Number:
Patient's Signature	Date

If executed by a patient's personal representative, please complete the information in the space below:

Personal Representative's Name *(Please print)*	Relationship
Personal Representative's Signature	Date

If executed by a patient's legal guardian, please complete the information in the space below:

Legal Guardian's Name *(Please print)*	Relationship
Legal Guardian's Signature	Date



HIPPA NOTIFICATION
ELECTRONIC MAIL (EMAIL) COMMUNICATIONS

The goal of New Life Wellness Center is to make communications between you and our offices as easy for you as possible. As such, you have the right to request that we communicate with you via electronic mail (email). However, prior to consenting to such communication, please take a moment to realize any and all privacy risks associated with this form of communication.

Email communications are a two-way communication. However, responses and replies to emails sent to or received by either you or New Life Wellness Center may be hours or days apart. As such, acute conditions should never be addressed using email communication.

Although New Life Wellness Center will make every effort to maintain privacy, email messages, on any device, have Internet privacy risks, as there is no way to ensure an email is completely tamper resistant. That being said, you should not use email to discuss anything you wish to remain entirely confidential.

In order to forward and/or process and/or respond to your email, individuals at New Life Wellness Center, other than the intended recipient, may have access to or read your email message. Please remember, email communication is not a means of private communication.

This document, along with any and all communications, may become part of your New Life Wellness medical record.

PATIENT REQUEST FOR EMAIL COMMUNICATION

Please complete the information below if you wish to communicate New Life Wellness Center via email, knowing there are inherent privacy risks.

Patient Name: _____ Date of Birth:_____

Email Address: _____

Please initial each line and sign below:

_____The email address contained herein is accurate, and I accept full responsibility for messages sent to or from this address.

_____I have read, reviewed, and received a copy of this HIPPA Notification: Electronic Mail Communications.

_____I understand and acknowledge that there are inherent privacy risks when communication is over the Internet.

_____ I agree to hold *New Life Wellness Center* and its agents and representatives harmless from any and all claims and liabilities arising from or related to this Request for Email Communications.

☐Patient does not consent to email communication.

Patient Signature: _____ Date:_____

Office Use Only		
CK	CA	CC

New Life CHIROPRACTIC

Bringing Balance to your Brain and Body

323 Middle Country Rd., Smithtown, NY 11787 631 265 1223;
146 Central Park West, Suite 1-D NY, NY 10023 212 721 1188;
www.newlifechiropractic.com

PERSONAL INFORMATION

Date Questionnaire Received: ____ / ____ / ____ Date of Initial Consultation: ____ / ____ /

[The above line is for office use only]

Child's Name: First: Last: Middle Initial:

Parent(s) Name(s):

Address: City:

State: Zip: Phone: ( ) —

Work Phone: ( ) — Cell : ( ) —

E-mail: 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 #: ( ) —

Health insurance provider: ID No.:

Referred by:

Siblings: Name:	Sex: (Circle One)	Birth Date:
	Male/Female	Month: Day: Year:
	Male/Female	Month: Day: Year:
	Male/Female	Month: Day: Year:

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:

PERSONAL INFORMATION (continued)

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/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 Numbers	City

THERAPIST(S)
Speech – Occupational - Physical - Other

Name	Type of Therapist	Phone	City	Hours/ Week	Date of Evaluation

OTHER CARE GIVERS

Name	Type of Care Giver	Phone	City	Hours/ Week	Date of Evaluation
Naturopath(s) / Homeopath(s)					
Nutritionist					
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? (circle one) If C-section, explain why:
If vaginal delivery, did you have forceps / vacuum?
Medications(s): during labor and delivery?
Full term / premature? (circle one) How many weeks? _____ weeks
Complications after delivery?
Medications given to child during hospital stay?

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/ week	1 - 3 times/ week	Never or almost never	Used to eat a lot 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:					

DIETARY/NUTRITIONAL HISTORY (continued)

Check (✓) the most appropriate description below of your child's diet:

_____ Mostly baby foods

_____ Mostly carbohydrates (bread, pasta, etc.)

_____ Mostly dairy (milk, cheese, etc.)

_____ Mostly meat

_____ Mostly vegetarian (vegetables, fruits, grains, etc.)

_____ Other – describe:

Please describe your child's stool pattern *(Examples: daily, foul, large, mushy, etc.):*

Please list the foods and beverages normally consumed by your child for three 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:

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 (if other please 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 water: 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 responses):

- *BEDDING*: synthetic/down/feather mattress cover: yes/no crib/junior bed/adult bed

- *FLOORING*: carpet: wall to wall /area rug? Wood? Glued down? Synthetic pad?

- *WINDOW TREATMENT*: shades/blinds/thin curtain/valance/other? (If other, please describe:)

- *OTHER ITEMS IN ROOM (*including furniture, toys, stuffed animals). Please describe:

Flooring in other rooms:

- Children'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?	**_____ Mold?**
_____ Cleaning Products?	**_____ Pollens/Grasses?**
_____ Soaps?	**_____ Animals (dander)?**
_____ Detergents?	**_____ Gasoline?**
_____ Dust?	**_____ Paint?**

_____ Other?

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**	**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		
PET Scan		

MEDICAL HISTORY (continued)

Please mark which tests have been done and provide date and results

EVALUATION/TEST	DATE	RESULTS (normal, abnormal or unsure)
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:		

MEDICAL HISTORY (continued)

Major surgeries – Please describe and provide dates:

SURGERY	DATE(S)	RESULTS

Major injuries – Please describe and provide dates:

INJURY	DATE(S)	RESULTS

Illnesses – Please list appropriate dates and any complications:

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

Parent's Last Name	
Child's First Name	

Medication or Supplements

Please check (✓) substances taken now or in the past and mark the appropriate reaction

now	past	Medication or Supplement	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments
		Central Nervous System							
		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							

Medication or Supplements (continued)

Please check (✓) substances taken now or in the past and mark the appropriate reaction

now	past	Medication or Supplement	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments
		Central Nervous System							
		Neurontin							
		Paxil							
		Phenobarbital							
		Straterra							
		Tegretol							
		Topamax							
		Trileptal							
		Valium							
		Zarotin							
		Zonegran							
		Adderall							
		Prozac							
		Zoloft							
		Amphetamine							
		Cylert							
		Dexedrine, dextroamphetamine							
		Fenfluramine							
		Focalin							
		Ritalin							
		Buspar							
		Chloral hydrate							
		Valium							
		Desipramine							
		Mallaril							
		Tofranil							
		Klonapin							
		Antihistamines							
		Benadryl							

Parent's Last Name	
Child's First Name	

Medication or Supplements (continued)

Please check (✓) substances taken now or in the past and mark the appropriate reaction

now	past	Medication or Supplement	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments
		Claritin							
		Singulair							
		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							
		Detoxification							
		DMPS							
		DMSA (succimer, chemet)							
		Reduced glutathione (TTFD)							
		Reduced glutathione (IV)							
		Reduced glutathione (oral)							
		Folic Acid							
		Melatonin							

Medication or Supplements (continued)

Please check (✓) substances taken now or in the past and mark the appropriate reaction

now	past	Medication or Supplement	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments
		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							
		Taurine							
		Tryptophan							
		Tyrosine							
		Calcium							
		Magnesium							
		Manganese							
		Selenium							
		Zinc							
		Human Growth Factor							
		IV Immune globulin							
		Kutapressin							

Parent's Last Name	
Child's First Name	

Medication or Supplements (continued)									
Please check (✓) substances taken now or in the past and mark the appropriate reaction									
now	**past**	**Medication or Supplement**	**Very Good**	**Good**	**None**	**Bad**	**Very Bad**	**Bad then Good**	**Comments**
		Nutrition/Metabolism (cont.)							
		Oral Immune globulin							
		Secretin (IV)							
		Secretin (transdermal/sublingual)							
		Steroids (oral)							
		Steroids (topical)							
		DHA rich oils							
		EPA rich oils							
		Omega 6 rich oils							
		Cod liver oil							
		Flax oil							
		Other							
		Activated Charcoal							
		Alka Gold							
		Carbatrol							
		Tranxene							
		Famvir							
		Valtrex							
		Zovirax							
		OTHER:							

Therapies and Diets

Please indicate therapies and diets you have used and/or are using.

now	past	**Therapies**	Very Good	Good	None	Bad	Very Bad	Bad then Good	**Comments**
		Acupuncture							
		Auditory Training							
		Craniosacral							
		Energy Therapy (Specify)							
		Homeopathy							
		Lovaas (ABA)							
		Naturopathy							
		Neural Therapy							
		Occupational Therapy							
		Osteopathy							
		Physical Therapy							
		Sensory Diet							
		Speech Therapy							
		Chiropractic							
		Chiropractic Neurology							
		Other:							
now	**past**	**Diets**	**Very Good**	**Good**	**None**	**Bad**	**Very Bad**	**Bad then Good**	**Comments**
		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 (✓) any signs/symptoms your child may demonstrate (note duration/details if appropriate):

No.	Description	Mild	Moderate	Severe	Duration	Unique details
1	Stimming (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, 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 (✓) any signs/symptoms your child may demonstrate (note duration/details if appropriate):

No.	Description	Mild	Moderate	Severe	Duration	Unique details
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					
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					

SIGNS AND SYMPTOMS (continued)

Please (✓) any signs/symptoms your child may demonstrate (note duration/details if appropriate):

No.	Description	Mild	Moderate	Severe	Duration	Unique details
60	Canker sores					
61	Dry lips/mouth					
62	Diarrhea					
63	Constipation					
64	Bloating					
65	Passing gas					
66	Belching					
67	Stomachache					
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					
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					

SIGNS AND SYMPTOMS (continued)

Please (✓) any signs/symptoms your child may demonstrate (note duration/details if appropriate):

No.	Description	Mild	Moderate	Severe	Duration	Unique Details
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					

SIGNS AND SYMPTOMS (continued)

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: