Lifetime Development

Intake Medical History

Name:__________________ Child & Adolescent Date of Birth:______________

Today's Date:______________

Diagnosis at Intake

____
____
____

by: __________________________

Current Medications (incl. dosage)

____
____
____

Past Medications

____
____
____
____

Diagnostic Tests

(chromosomes, MRI, EEG, x-ray.. please give dates)

____
____
____
____

REFERRAL SOURCE & contact **info**

Name__________________________
City__________________________
Tel___________________________

General

- □ Abnormal sensitivity to cold/heat
- □ Lowered resistance to infection
- □ Excessive activity level
- □ Excessive fatigue
- □ Excessive thirst
- □ Other:______________________

____
____

Nutrition

- □ Major food cravings
- □ Overweight
- □ Increased appetite
- □ Recent weight gain
- □ Underweight
- □ Poor appetite
- □ Recent weight loss
- □ Concerns about child diet and/or eating habits

Nutritional supplements your child regularly tasks:

____
____
____
____

Supplements believed to be most beneficial to your child:

____
____
____

Types of cookware used:

- □ Aluminum □ Stainless steel
- □ Pyrex □ Glass
- □ Enamel □ Teflon
- □ Cast Iron □ Copper

Drinks tap water □ Yes □ No

Toxin Exposure

- □ Exposure to mercury, lead, toxic chemicals, radiation, etc. (describe)

____
____
____

Towns/cities where child has lived:

____
____

- □ Lived in home remodeling project □ Yes □ No

Gastrointestinal and Hepatic

- □ Difficulty swallowing
- □ Nausea or vomiting:
- □ Abdominal (stomach)/belly) pain
- □ Anal itching

Bowel Movements

Frequency: ____ times per day
____ times per week

- □ Painful
- □ Infrequent
- □ Irregular
- □ Constipation
- □ Liquid bowel movements
- □ Loss of bowel control

- □ Frequent belching or gas
- □ Rectal bleeding (red or black blood)
- □ Vomiting blood
- □ Jaundice (yellowing of skin)
- □ Other ____________________

Neurological

- □ Dizziness; balance problems
- □ Drowsiness
- □ Muscle spasms or tremors
- □ "Tics" (if so, describe: ____________

____

- □ Headaches
- □ Numbness
- □ Convulsions/fits/seizures
- □ Weakness in muscles
- □ Unexplained loss of sensation
- □ Handedness □ R □ L □ Ambi
- □ Memory problem(s)
- □ Pacing

Other:

____

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Sleep Patterns

Hrs/night sleep (average): ________

Normal bedtime: __________M

Normal waking Time: ______M

- □ Difficulty falling asleep
- □ Difficulty sleeping
- □ Excessive sleeping
- □ Difficulty Awakening
- □ Awakening in the night due to:
  - □ Urination
  - □ Hunger
  - □ Pain
  - □ Apnea
  - □ Other/unknown
  - □ How long to return to sleep: ____________________
- □ Sleepwalking
- □ Night Sweats?
- □ Sleep aids, medications, including natural nutritional supplements.

____

____

Accidents, Trauma, and Surgical procedures

____________________Age______

____________________Age______

____________________Age______

____________________Age______

____________________Age______

Genitourinary

- □ Itchy privates or genitals
- □ Painful urination
- □ Excessive urination
- □ Difficulty in starting urine
- □ Accidental wetting of self
- □ Pus or blood in urine

Toileting:

Is your child potty trained?

____□ Yes □ No

If yes, at what age?_________

Bedwetting□ Yes □ No

Encopresis (soiling)

□ Yes □ No

Other:______________________

____

Musculoskeletal

- □ Back pain or stiffness
- □ Joint pain
- □ Leg pain
- □ Muscle cramps or pain (describe)
- □ Neck pain or stiffness
- □ Other______________________

Respiratory

- □ Asthma, wheezing
- □ Cough
- □ Coughing up blood or sputum
- □ Shortness of breath
- □ Rapid breathing
- □ Other:______________________

Head, Eye, Ear, Nose & Throat

- □ Facial pain
- □ Headache
- □ Head injury
- □ Frequent sore throat
- □ Blurred vision
- □ Double vision
- □ Overly sensitive to light
- □ See spots or shadows
- □ Hearing loss
- □ Ear ringing
- □ Disturbances or sensitivity in smell
- □ Repeated nose or chest colds
- □ Runny nose
- □ Dry mouth
- □ Sore tongue
- □ Frequent ear infections

  Age of 1st ear infection:_______
- □ Has (or had) ear tubes

  If so, at what ages?

  ____
- □ Other head, eye, ear, nose, throat:_________________

____

Chest and Cardiovascular

- □ Rapid/irregular pulse
- □ Chest pain
- □ High blood pressure
- □ Low blood pressure
- □ Other:____________________

____

Skin, Hair

- □ Dry hair or skin
- □ Itchy skin or scalp
- □ Easy bruising
- □ Hair loss
- □ Excessive sweating
- □ Sun sensitivity
- □ Acne
- □ Other:____________________

Child & Adolescent

Father's Health:

(***kindly review & note below any previous items on this checklist for cues to any past & current health issues of father)***

Past:________________________

____

____

Current:_____________________

____

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____
____
____

Mother's Health:

(***kindly review & note below any previous items on this checklist for cues to any past & current health issues of father)***

Past:__________________________
____
____

Current:_______________________
____
____
____
____

Mother's Pregnancy Information:

□ Thyroid problem
□ Autoimmunity
□ Drug, alcohol or substance use
□ Supplements taken during pregnancy
□ Flu shot during pregnancy
□ Unusual prenatal circumstances
____

□ Did you or your spouse engage in any unhealthful practices such as drugs, smoking etc. before conception that may have affected your child? ____________________
____
____
____
____

, traumatic events, & unusual stress during pregnancy:
____
____
____

□ Miscarriages (please give dates):

____

Labor & Delivery:
□ Normal
□ Unusual Labor:______________
____
□ Unusual delivery:_____________
____
□ C-section
Apgar score: 1 min.____ 5min____
□ Neonatal distress
□ Neonatal jaundice
□ Other neonatal abnormality
____

Infant Feeding & Nutrition

□ Breastfeeding
□ Goat's Milk
□ Milk Intolerance
□ Formula
□ Other
□ Colic after eating
□ Age food introduced
□ Early food intolerance
□ Reactions to non-tolerated foods
____

Motor Development:

Age of learning to do the following:
Turning over ________mos.
Sitting up ________mos.
Crawling ________mos.
Pulling up________mos.
Walking unassisted______mos.
Running ________mos.
Difficulty or delay in coordination:
□ Fine (hands, fingers)
□ Gross (legs, arms, trunk)
□ Unusual motor features
____
____
____

Language Development:

Does your child make sounds?
□ Yes □ No
Does your child speak?
□ Yes □ No
Age of language acquisition
one word________mos.
sentences________mos.

Did child lose previously spoken words? □ Yes □ No

Describe any speech regression:
____
____

Social Interaction:

Date or age of any delay or of any suspected social abnormality or the beginning of plateau or regression in social development___________

Please describe circumstances (for example, did this occur following illness, immunization, toxic exposure, or travel?
____
____

Does your child have at least one friend outside the family with whom s/he plays reciprocally?
□ Yes □ No

Does your child engage you or any other person to share in his or her interests or play?
□ Yes □ No

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Describe your child's current social behavior:

____

____

____

____

If child is a toddler:

Does s/he take an interest in other children? □ Yes □ No

Does s/he enjoy being swung, bounced on the knee, etc.? □ Yes □ No

Does s/he like climbing on things, such as up stairs? □ Yes □ No

Does s/he enjoy playing peek-a-boo & hide & seek? □ Yes □ No

Does s/he ever pretend, for example, to make a cup of tea using a toy cup & teapot, or pretend other things? □ Yes □ No

Does s/he ever use his/her index finger for pointing to ask for something ? □ Yes □ No

Can s/he play properly with small toys (cars, bricks, or blocks) without just mouthing, fiddling, or dropping them? □ Yes □ No

Does your child look you in the eye for more than a second or two? □ Yes □ No

Does your child ever bring objects over to you (parent) to show you something? □ Yes □ No

Does your child seem overly sensitive to noise? (*e.g.,* plugging ears) □ Yes □ No

Does your child smile in response to your face or your smile? □ Yes □ No

Does your child imitate you? (*e.g.,* you make a face & child imitates) □ Yes □ No

Does your child respond to his/her name when called? □ Yes No

Does your child look at things you are looking at? □ Yes □ No

Does your child make unusual finger movements near his/her face? □ Yes □ No

Does your child try to attract your attention to his/her own activity? □ Yes □ No

Have you ever wondered if your child is deaf or has a hearing problem? □ Yes □ No

Does your child understand what people say? □ Yes □ No

Does your child sometimes stare at nothing or wander with no purpose? □ Yes □ No

Does your child look at your face to check your reaction when faced with something unfamiliar? □ Yes □ No

For children age 4 & older:

Please rate the following moods/behaviors for your child on a scale from 1 to 10, where 10 = very poor or having great difficulties and 1 = best imaginable for child's age

Activity Level_____
Home behavior_____
Self-esteem_____
Diet_____
Headaches_____
Grinding teeth_____
Worry/fear/anxiety
Body tension_____
Withdrawal/avoidance_____
Mood swings____
Irritability_____
Anger/temper
Aggression_____
Eye Contact_____
Stubborness/resistance to requests_____
Frustration tolerance_____
Contentment/Happiness_____
Following directions_____
Concentration_____
Impulsivity_____
Attention _____
Distractibility_____
Following directions_____
Memory_____
Drawing ability_____
Handwriting_____
Math performance_____
Reading skills_____
Speech level for age_____
Speech enunciation_____
Voice (normal tone, volume)_____
Conversation/ verbal expression_____
Reciprocal play_____
Social skill_____
Social awareness_____
Imaginative play_____
Large motor/muscle coordination___

Sensory:

Vision problems, sensitivity____
Hearing difficulties, sensitivity
□ Touch abnormalities
□ Fragrance sensitivities
□ Difficulties with gauging distance and/or height,
□ Orientation in space

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- ☐ Large motor/muscle coordination___

Behavior:

- ☐ Toe Walking
- ☐ Rituals
- ☐ Tantrums
- ☐ Hand Flapping
- ☐ Self-stimulatory behavior:
- ☐ Rocking
- ☐ Spinning

Please comment on your child's sense of humor: ________________

Aspects of child's behavior most troubling to you: ________________

***Adolescent Female*:**

- ☐ No menses
- ☐ Menstrual Irregularity

Premenstrual:

- ☐ Moodiness
- ☐ Irritability
- ☐ Anger
- ☐ Tension
- ☐ Bloating
- ☐ Breast tenderness
- ☐ Cramps
- ☐ Menstrual Headache

Goals for your child's care:

Professionals who have diagnosed, worked with, or helped your child (*please give names & approx dates):*

What else is important for us to know about your child or your family?________________

Has a school IEP been established for this child patient?

☐ Yes ☐ No

Notes & Additional Information: