

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__ Did you receive any vaccinations during the pregnancy?
6. Y__ N__ Did you receive any flu shots during the pregnancy? How many? _____
7. _____ Mother's Rh status, if known (+ or -)
8. Y__ N__ Did you ever receive Rhogam shots? How many? _____
9. Y__ N__ Mother's thyroid status: (Circle) Normal Hyperthyroid Hypothyroid (Low)
10. Y__ N__ Diabetic

11. Mother's occupation before and during pregnancy: _____

12. 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? _____ Antibiotics? Y__ N__

12. Y__ N__ Sinus infections? How many times? _____ Antibiotics? Y__ N__

13. Y__ N__ Seizures?

14. 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 accidentally 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

5. Y__ N__ Head frequently tilted to one side
6. Y__ N__ History of Lazy Eye Which eye? Circle: R L
7. Y__ N__ Has had the lazy eye corrected with surgery
8. Y__ N__ Are eyes crossed? (Strabismus)
9. Y__ N__ Has dyslexia
10. Y__ N__ Other visual impairments List: _____
11. Y__ N__ Avoids homework, has been called "lazy"
12. Y__ N__ Is very intelligent, but makes poor grades in school
13. Y__ N__ Skips over lines when reading
14. Y__ N__ Dislikes or avoids reading
15. Y__ N__ Dislikes movies in 3-D
16. Y__ N__ Is careful on the stairs, holds the rail, one foot at a time, sits down to do stairs, etc.
17. Y__ N__ Catches a ball easily and accurately
18. Y__ N__ Sometimes trips or stumbles over nothing; tends to be clumsy
19. Y__ N__ Sometimes bumps into the door frame when going through a doorway
20. Y__ N__ Has had prism lenses or Vision Therapy? When? _____

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__ N__ How many? _____
14. Y__ N__ Do any smokers live in the home?
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

- Y__ N__ Joints are hyper-flexible
 Y__ N__ Expressive and Receptive speech is poor
 Y__ N__ "Crashes" when they get sick → gets dehydrated or even hospitalized?

Miscellaneous:

- 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? _____
- Y__ N__ History of being sexually, physically or verbally abused (Circle_all that apply)
- Y__ N__ Headaches Describe: _____
- Y__ N__ Visual Hallucinations
- 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
- Y__ N__ Moans or cries in sleep
 - Y__ N__ Sweat at night
 - Y__ N__ Nightmares
 - Y__ N__ Night terrors
 - Y__ N__ Sleep walks
 - Y__ N__ Takes melatonin How much? _____
 - Y__ N__ Takes Clonidine or medication for sleep
 - How many caffeinated drinks are consumed each day? _____

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

Vegetables: _____

Fruits: _____

Dairy: _____

Meats: _____

Snacks: _____

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.**

Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. Entirely Liquid

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:

- | | |
|---|--|
| <input type="checkbox"/> Speech | <input type="checkbox"/> Son Rise |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Vision Therapy |
| <input type="checkbox"/> Occupational | <input type="checkbox"/> Social Skills |
| <input type="checkbox"/> ABA | <input type="checkbox"/> Sensory Integration |
| <input type="checkbox"/> Counseling | <input type="checkbox"/> Light Therapy |
| <input type="checkbox"/> Anger Management | <input type="checkbox"/> Music Therapy |
| <input type="checkbox"/> Floor Time | <input type="checkbox"/> Listening therapy |
| <input type="checkbox"/> Other | <input type="checkbox"/> 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. If more than one home, will both homes be cooperative with treatment plans? _____

3. Please describe any difficult family situations which may hinder treatment:

4. Who lives in the primary home?

Mother

Grandmother

Father

Grandfather

Stepmother

Others List: _____

Stepfather

Girlfriend

Boyfriend

Brothers Ages: _____

Sisters Ages: _____

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

6. What county is the school in? _____

Family history: (Please check all that apply)

Allergies

Multiple Sclerosis

- Alzheimer's
- Asthma
- Autism
- Celiac disease
- Chronic Fatigue syndrome
- Crohn's disease
- Eczema Yeast problems
- Fibromyalgia
- Genetic disorders
- Irritable Bowel Syndrome
- Lupus

- Obsessive Compulsive disorder
- Parkinson's
- Seizures
- Tic disorders
- Thyroid disorders
- Tourette disorder
- Ulcerative colitis
- Wheat (gluten) sensitivity

Medication Log

Date: _____

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

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