www.healthyheart.in

Dr. SAXENA
Integrative Medicine Pvt. Ltd.

Personal Information			
Date questionnaire Received:		**Date of initial Consultation:**	
Child's Name First Name:		**Last:**	
Child's D.O.B:		**Sex:**	
Parents Names:			
Address: Street:		**City:**	
State:		**Phone Number:( )**	
		Cell Phone:( )	
Siblings:	**Name:**	**Sex:**	**D.O.B**
		Male/Female	
		Male/Female	
		Male/Female	
		Male/Female	
Parent's Occupation(s): Mother			
Father			
Referred by:			
Primary Care Physician:			
Street Address:		**City:**	**State**
		Phone Number: ( )	
Please list diagnoses and explanations including dates) for child's condition:			
Other Problems to be addressed:			

Please bring several pictures of your child,that we may keep,Specifically portraying the change he or she has experienced i.e., if your child has regressed,bring in pictures that clearly show them before regression,and after regression.we would also appreciate a video of before regression and after regression.You Should keep avideo as he/she undergoes treatment.
PERSONAL INFORMATION(Continued)

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Describe your child to me,including his or her history.Please be as detailed as possible.

Circle the appropriate value

No Problem	Is a problem Mild	Mod	Severe	Symptoms
0	1	2	3	Aggression……..
0	1	2	3	Agitation/Irritability…….
0	1	2	3	Awkward body movements..
0	1	2	3	Constipation…….
0	1	2	3	Diarrhea…….
0	1	2	3	Eating/feeding problems……
0	1	2	3	Inappropriate use of toys……
0	1	2	3	Irritational fears……..
0	1	2	3	Lack of awareness……..
0	1	2	3	Lacks eye contact…….
0	1	2	3	Lacks speech……
0	1	2	3	Obessive/ OCD behaviors……
0	1	2	3	Poor attention……..
0	1	2	3	Poor fingers/hand skills……..
0	1	2	3	Repetitive,self-stim behaviors…..
0	1	2	3	Seizures……..
0	1	2	3	Self-injury……..
0	1	2	3	Sleep disturbances……
0	1	2	3	Social deficits/withdrawal……..
0	1	2	3	Sound sensitivity…….
0	1	2	3	Speech/language deficits…….
0	1	2	3	Temper tantrums…….

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When did you notice your child's problem?

What did you 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 note of any other event, action, etc.that you think may have some bearing/relationship to your child's condition.Again,be 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 problems:

PRENATAL HISTORY

Maternal age of delivery: #of pregnancies/births prior_____after this child

Illness during pregnancy

Medication during pregnancy:
Heavy metal Exposure during pregnancy (increased/tuna/swordfish/sea Bass consumption; dental work: root canal, amalgams; flu VAX; Rhogam injection, contact lens, tattoos, painting work
Other complications during pregnancy:
Complications during labor and delivery:
Mode of delivery: C-section/vaginal? If a C - section, explain why?
Vaginal delivery, did you have forceps/vacuum?
Medication(s)during labor and delivery?
Full term/premature?
Complications after delivery?

Medications given to child during the hospital stay?(including immunizations)

DIETARY/NUTRITIONAL HISTORY

Breast-fed? If yes, how long? _____ months

Bottle-fed? If yes, brand of formula? Began at what age? How long?

Foods? Began at what age? First foods?

Known allergies to food? (Please list)

Suspected sensitivities to foods? (Please list)

Food cravings:

FOODS MY CHILD EATS: (Place an X in appropriate column)

FOOD	Daily	3-5 times per week	1-3 times per 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					
Salt foods					
Meat					
Pasta: White					
Wheat					
Other					

DIETARY/NUTRITIONAL HISTORY(Continued)

Place an X in the most appropriate description below of your child's diet:

_____Mostly baby food
_____Mostly carbohydrates (bread, pasta, etc..)
_____Mostly dairy (milk, cheese, etc.)
_____Mostly meat
_____Mostly vegetarian
_____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
Lunch
Afternoon snacks
Dinner
Other
DAY 2
Breakfast
Morning Snack
Lunch
Afternoon Snacks
Dinner
Other
DAY 3
Breakfast

Morning Snack
Lunch
Afternoon snack
Dinner
Other
FAMILY HISTORY
List any allergies, major illness, genetic diseases, neurologic, bipolar, obessive, compulsive, or other problems for child's family members.
Mother:
Father:
Sibblings:
Maternal Grandparents:
Paternal Grandparents:
Others
SOCIAL HISTORY
Who lives in the home with your child?
Any adopted children in your family?
Pets in the house?
Care givers 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 responce 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?
DEVELOPMENT HISTORY
Please list the age when the following skills were mastered and any problems associated with these skills:
1.) First words:
2.) Phrases or sentences:
3.)Sitting up:
4.)Crawling:
5.) Pulling to a stand:

6.) Walking:
7.) Running:
8.) Walking up and down steps without help:
9.) Jumping:
10.) Put on clothing:
11.) Learned to pedal:
12.) Rode 2-wheel bicycle:

MEDICAL HISTORY (continued)

Please list the approximate dates and any reactions to any medications taken by your child IN THE PAST. If the dates are too numerous, just the number of times the medication was given per year.

TYPES OF MEDICATIONS	DATE(S)	REACTION(S)	NAME OF DRUG
Antibiotic:			
Seizures medications:			

Antihistamines:			
Steroids:			
Anti fungal i.e. Nystatin, Diflucan,			
Others			
NAME	**DOSAGE**	**PURPOSE**	**RESULTS**

MEDICAL HISTORY

Previous diagnostic studies – Please list dates and results:

PREVIOUS STUDY	DATE(S)	RESULTS
X-rays		
Hearing tests		
EEG		
CT Scan (brain)		
CT scan (Other)		

MRI		
Other		
Other		
Other		

Illness – Please list appropriate dates and any complications

ILLNESS	DATE(S)	COMPLICATIONS
Ear Infections		
Sinus Infections		
Bronchitis		
Pneumonia		
Thrush		
Chicken pox		
Seizures		
Mono		
Other:		
Other:		

SIGNS AND SYMPTOMS

Please an (X) next to any signs/symptoms your child may demonstrate and note duration and details is appropriate.

Description	Mild	Moderate	Severe	Duration	Unique Details
Stimming (repetitive Actions)					
Rocking					
Head banging					
Self-multilation					
Nail biting					
Hand/arm biting					
Nail/Skin picking					
Aggressiveness Hitting,kicking,					
Biting others					
Mood Swings					
Irritablity/tantrums					

Fears/anxieties					
Hyperactivity					
Inability to concentrate/focus					
Fidgrty in seat					
Impulsive					
Dizziness					
Seizures					
Poor co-ordination					
Problems with buttons,ties,snaps,or zippers					
Processing problems-visual,motor,language, sensory,etc					
Problems with social interactions					
Sensitive to crowds					
Trouble remembering					
Low self-esteem					
Fatigue					
Cold hands/feet					
Cold intolerance					
Re-current /chronic fever					
Flushing					
Excessive Sweating					
Difficulty Falling asleep					
Night waking					
Nightmares					
Difficulty walking					
Bed wetting/soiling					
Daytime wetting/soiling					
Numbness tingling					

hands and feet					
Headache					
Blinking					
Staring					

MEDICAL HISTORY(CONTINUED)		
Major surgeries - Please describe and give dates:		
SURGERY	DATE(S)	RESULTS

Major injuries – Please describe and give dates:

INJURY	DATE(S)	RESULT(S)

IMPORTANT – Please provide copies of most recent results of the following: BLOOD WORK URINE TESTS STOOL TESTS		
IMMUNIZATIONS: Please list dates and any complications:		
DESCRIPTION		
DTP/DTap		
HIB(hemophilus)		
Hepatitis B		
OPV/IPV(polio)		
Varivax(Chicken Pox)		
MMR(measles)		
Rotavirus vaccine		
Prevanar:		
Other:		

SIGNS AND SYMPTOMS

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:

Description	Mild	Moderate	Severe	Duration	Unique Detail's
Dark Circles/puffines under eyes					
Eye Discharge					
Night-blindness in child/family					
Congestion					

Dripping nose					
Sensitivity to bright lights					
Ear aches					
Ringing in ears					
Sensitive to sounds/noise					
Bad breathe					
Nose Bleeds					
Acute sense of smell					
Hoarseness					
Sore throats					
Cough					
Wheezing					
Geographic tongue					
Swollen gums					
Canker sores					
Dry lips/mouth					
Diarrhea					
Constipation					
Foul-smelling stools					
Bloating					
Passing gas					
Belching					
Stomachache					
Refusal to eat					
Sensitive to texture of food					
Difficulty swallowing					
Food cravings					
Mucous/blood in stools					
Anal itching					
Muscle cramps					
Tremors					
Weakness					
Stiffness					
Eczema					
Psoriasis					
Hives					
Acne					
Seborrhea(Cradle cap)					

Other rashes					
Easy bruising					
Itchy scalp					
Dry skin/oily skin					
Pale skin					
Sensitivity to insect bites					
Sensitive to texture clothes					
Cracking/peeling hands					
Cracking/peeling feet					
Strong body odor					
Soft nails					
Thickening of nails					
Ridges/pitting of nails					
Hite spots/lines on nails					
Brittle nails					
Tics					

By C.Keith Conners, ph.D

Conners parent Rating Scale – Revised(l)

Child's Name:_____Gender: M F
(Circle one)

Birthdate:_____/_____/_____Age:_____School Grade:_____

Parent's Name:_____Today's Date:_____/____/____
Month Day Year

Instructions: Below are a number of common problems that children have. Please rate each item according to your child's behaviour in the last month. For each item, ask yourself "How much of a problem has this been in the last month?" and circle the best answer for each one. If none, not at all, seldom ,or very infrequently, you would circle 0.If very much true, or it occurs very often or frequently, you would circle 3.You would circle 1 or 2 for ratings in between. Please respond to all the items.

1. Angry and resent……0 1 2 3
2. Difficulty doing or completing homework……...0 1 2 3
3. Is always "on the go" or acts as if driven by a motor car……...0 1 2 3
4. Timid, easily frightened……0 1 2 3
5. Everything must be just so……0 1 2 3

6. Has no friends…….0 1 2 3
7. Stomach aches……....0 1 2 3
8. Fights……...0 1 2 3
9. Avoids, expresses reluctance about, or has difficulties engaging in tasks that require sustained mental effort (such as schoolwork or homework)……0 1 2 3
10. Has difficulty sustaining attention in tasks or play activities…..0 1 2 3
11. Argues with adults……...0 1 2 3
12. Fails to complete assignments…….0 1 2 3
13.Hard to control in malls or while grocery shopping……..0 1 2 3
14. Afraid of people……0 1 2 3
15 Keeps checking things over again and again……...0 1 2 3
16. Loses friends quickly……...0 1 2 3
17. Aches and pains……...0 1 2 3
18. Restless or overactive……..0 1 2 3
19. Has trouble concentrating in class…….0 1 2 3
20. Does not seem to listen to what is being said to him/her……..0 1 2 3
21. Loses temper…….0 1 2 3
22. Needs close supervision to get through assignments……0 1 2 3
23. Runs about or climbs excessively in situations where it is Inappropriate……..0 1 2 3
24. Afraid of new situations…….0 1 2 3
25. Fussy about cleanliness……..0 1 2 3

26 Does not know how to make Friends…….. 0 1 2 3
27. Get aches and pains or stomachaches before school … 0 1 2 3
28. Excitable,impulsive ……... 0 1 2 3
29. Does not Follow ……... 0 1 2 3
30.Has dufficulty organizing tasks and activities
31. Irritable
32. Restless in the "squirmy area"
33. Afraid of being alone
34. Things must be done the same wayevery time
35.Does not get invited
36. Headaches
37. Fails to finish things he/she starts
38. Inattentive, easily distracted
39. Talks excessively
40. Actively defies or refuses to comply with adult's requests
41. Fails to give close attention to details or makes careless

mistakes in schoolwork, work or other activities
42. Has difficulty waiting in lines or awaiting turns in games or group situations
43. Has lot of tears
44. Has rituals that he/she must go through
45. Distractiblity or attention span a problem
46. Complains about being sick even when nothing is wrong
47. Temper outbursts
48. Gets distracted when given instruction to do something
49. Interrupts or intrudes on other (e. g .butts into others conversations or games)
50. Forgetful in daily activities
51. Cannot grasp arithmetic
52. Will run around between mouthfuls at meals
53. Afraid of the dark, animals, or bugs
54. Sets very high goals for self
55. Fidgets with hands or feet or Squirms in seat
56. Short attention span
57. Touchy or easily annoyed by others
58. Has sloppy handwriting
59. Has difficulty playing or engaging in leisure activities quietly
60. Shy,withdrawn
61.Blames others for his/her mistkes or misbehavior
62. Fidgeting
63. Messy or disorganized at home or school
64. Gets upset if someone rearranges his/her things
65. Clings to parents or other adults
66. Disturbs other children
67.Delibrately does things that annoy other people
68. Demands must be met immediately
69.Only attends if it is something he/she is very interested
70. Spiteful or vindictive
71. Losses things necessary for tasks or activities (e.g.,school)
72. Feels interior to others
73. Seems tired or slowed down all the time
74. Spelling is poor
75. Cries often and easily
76. Leaves seat in classroom or in other situations in which remaining seated is expected
77. Mood changes quickly and drastically
78. Easily frustrated in efforts
79. Easily distracted by extraneous stimuli

80. Blurts cut answers to questions before the questions have been completed