



### New Pediatric Patient Information

Patient Name: \_\_\_\_\_ Gender: M or F DOB: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mother's Cell: \_\_\_\_\_ Father's Cell: \_\_\_\_\_

Mother's Work Phone: \_\_\_\_\_ Father's Work Phone: \_\_\_\_\_

Patient's Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician's Address: \_\_\_\_\_

If known, name of preferred local compounding pharmacy? \_\_\_\_\_

Any known allergies to medications? If yes, please list and describe adverse reaction: \_\_\_\_\_

\_\_\_\_\_

Privacy Constraints: \_\_\_\_\_

No Constraints – Ok to send mail and/or leave messages on answering machine or voice mail? \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number(s): \_\_\_\_\_

### Insurance Information:

While we do not participate with insurance and fees are due in full at the time of your visit, we will provide a duplicate copy for your encounter form ready to send to your insurance.

Policy Holder's Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

*In the sections that follow, we are trying to familiarize ourselves with your child.  
Please be as descriptive as possible.*

**Pregnancy and Delivery:**

Anything unusual about the pregnancy? (Illnesses, medications, antibiotics, difficulty): \_\_\_\_\_

Mother's Blood Type: \_\_\_\_\_ Child's Blood Type (if known): \_\_\_\_\_

**Labor and Delivery Duration:**

Delivery Method: \_\_\_\_\_ Anything unusual about the delivery? \_\_\_\_\_

Group B Strep: Yes or No      Antibiotics at Delivery: Yes or No      APGAR Score if remembered: \_\_\_\_\_

Anything unusual about the baby's hospital stay or initial newborn period? \_\_\_\_\_

Miscarriages: \_\_\_\_\_

**Infancy:**

Breast feeding (describe the length and character of feeding effort): \_\_\_\_\_

Colic or milk intolerance (describe symptoms, if present): \_\_\_\_\_

Formula used: \_\_\_\_\_ When was food introduced? \_\_\_\_\_

**Medical History**

Frequency of and age at first ear infections: \_\_\_\_\_

Asthma or allergies? If yes, please describe: \_\_\_\_\_

Accidents or trauma? If yes, please describe: \_\_\_\_\_

Hospitalizations/Surgeries? If yes, list dates as well as illness/procedures: \_\_\_\_\_

Diagnostic tests that have been performed on your child: \_\_\_\_\_

Specialists your child has seen and their impressions: \_\_\_\_\_

Right or left handed: \_\_\_\_\_

**Development**

Age at which you suspected something was unusual? Please describe what you felt was different: \_\_\_\_\_

Age at which your child: Rolled over: \_\_\_\_\_ Sat up: \_\_\_\_\_ Walked: \_\_\_\_\_

Words your child said at the time of his/her first birthday: \_\_\_\_\_

Did your child ever lose spoken words? If so, please describe the speech regression: \_\_\_\_\_

Did your child lose social and/or motor skills? If so, please describe: \_\_\_\_\_

Did you associate any regression with a vaccine? Yes or No. If so, please describe: \_\_\_\_\_

### **Current Status**

Major food cravings: \_\_\_\_\_

List all foods your child consumes: \_\_\_\_\_

Does your child eat or mouth non food items? If so, please describe: \_\_\_\_\_

Potty trained? If yes, at what age? \_\_\_\_\_

Describe your child's stools—color, smell, consistency (liquid, mashed potatoes, rocks, etc.); shape (balls, snakes, etc.), frequency, blood or mucus or whole food present, sink/float: \_\_\_\_\_

Does your child have bloating, pass excessive gas, unusual belching, stomach ache, unusual behaviors associated with bowel movements? \_\_\_\_\_

Does your child cover his/her ears or show auditory defensive behavior? \_\_\_\_\_

How does your child handle crowded places? \_\_\_\_\_

Does your child like certain kinds of touch and/or dislike others? Describe: \_\_\_\_\_

Does your child have sensitivity to food textures or difficulty swallowing? \_\_\_\_\_

Is cutting hair, nail cutting or brushing teeth difficult? \_\_\_\_\_

Does your child have sensitivity to texture of certain clothing or tags? \_\_\_\_\_

Does your child have any OCD (obsessive/compulsive) type behaviors (lining things up, rigid rituals, "stuck" on an object)? \_\_\_\_\_

Does your child have difficulty with transition from one activity or setting to another? Please describe: \_\_\_\_\_

Does your child have any stimming/repetitive behaviors (toe walking, hand flapping, spinning him/herself or objects, etc.)? \_\_\_\_\_

How does your child interact with children the same age as your child? \_\_\_\_\_

How does your child interact with children who are younger or older? \_\_\_\_\_

How does your child interact with adults? \_\_\_\_\_

Does your child head bang, nail bite, self-mutilate, bite his arms or hands, skin pick? If so, describe: \_\_\_\_\_

Is your child moody, irritable, have difficulty focusing, impulsive, overactive, anxious, fearful, aggressive? Please describe: \_\_\_\_\_

Does your child have processing problems (auditory, visual, motor, etc.) \_\_\_\_\_

Does your child have fine motor difficulties, difficulty with buttons or zippers; clumsiness, and/or gross motor skill troubles, etc.? \_\_\_\_\_

Does your child have language and/or signs? \_\_\_\_\_

Describe sleep from birth to present—briefly. Currently, how long to fall asleep; does she stay asleep, awakening time, naps: \_\_\_\_\_

With what daily activities do you have to help your child? (Dressing, bathing, brushing teeth, eating): \_\_\_\_\_

What therapies is your child involved with currently? \_\_\_\_\_

What therapies have you tried in the past? \_\_\_\_\_

What type of school/educational program is your child enrolled in currently? \_\_\_\_\_

What medications and nutritional supplements is your child taking currently? (List name, dose, and frequency): \_\_\_\_\_

What medications and nutritional supplements have helped the most? \_\_\_\_\_

What medications and supplements have a negative effect? \_\_\_\_\_

What aspects of your child's current status concern you the most? \_\_\_\_\_

What are your goals for your child's medical care? List them in order of importance: \_\_\_\_\_

Is there anything else we should know about your child or your family? \_\_\_\_\_

**Review of Systems—if present, please indicate if not described above:**

Breath holding, seizures, headache: \_\_\_\_\_

Fatigue, flushing, dark circles under eyes, weakness, stiffness: \_\_\_\_\_

Cold hands and feet, cold or heat intolerance, tingling of hands or feet, cracking or peeling of hands or feet: \_\_\_\_\_

Recurrent/chronic fever, recurrent illness/infection: \_\_\_\_\_

Blinking, tics, ringing in ears: \_\_\_\_\_

Bad breath, nose bleeds, swollen gums, dry lips or mouth: \_\_\_\_\_

Acute sense of smell or hearing: \_\_\_\_\_

Night blindness in child/family: \_\_\_\_\_

Geographic tongue: \_\_\_\_\_

Dermatographism (you can "write" on the skin with your fingernail and leave a transient red mark): \_\_\_\_\_

Hoarseness/sore throats: \_\_\_\_\_ Grinding teeth: \_\_\_\_\_

Anal itching or itchy skin or itchy scalp: \_\_\_\_\_

Eczema, psoriasis, hives, acne, seborrhea (cradle cap), sensitivity to bug bites, other rashes: \_\_\_\_\_

Easy bruising, dry skin, pale skin, oily skin: \_\_\_\_\_

Thickening of nails, ridging or splitting of nails, brittle or soft nails: \_\_\_\_\_

Strategies to put pressure on abdomen, reflux, colic: \_\_\_\_\_

Does your child lean on people or objects or lie down to play? \_\_\_\_\_

**In this next section, we are looking for genetic tendencies.**

If your child is adopted, please complete to the best of your knowledge the information about the biologic parents. Please consider, for each person, the following: Asthma, allergies, diabetes, blood pressure problems, strokes or

heart attacks when young (40's and 50's), blood clotting troubles (deep venous thromboses, pulmonary emboli, abnormal menstrual cycles), kidney disease, seizures, migraines, and other neurologic disorders, mental disorders (diagnosed and "Uncle Bob was a little nutty," especially schizophrenia, bipolar disease, depression, anxiety), substance use/abuse, hormone problems (most commonly thyroid troubles), autoimmune diseases (Lupus, rheumatoid arthritis, chronic fatigue, multiple sclerosis, etc.), night vision disturbance, gut troubles (Celiac, Crohn's, constipation, irritable bowel, etc), learning disabilities, ADHD, etc:

Mother's date of birth and medical history: \_\_\_\_\_

\_\_\_\_\_

Father's date of birth and medical history: \_\_\_\_\_

\_\_\_\_\_

Sibling—names, dates of birth, medical history: \_\_\_\_\_

\_\_\_\_\_

Maternal grandmother year of birth and medical history: \_\_\_\_\_

Maternal grandfather year of birth and medical history: \_\_\_\_\_

Paternal grandmother year of birth and medical history: \_\_\_\_\_

Paternal grandfather year of birth and medical history: \_\_\_\_\_

Any maternal siblings and significant medical history: \_\_\_\_\_

Any paternal siblings and significant medical history: \_\_\_\_\_

Any of your child's cousins with significant medical history: \_\_\_\_\_

### **Social history**

Mother's occupation: \_\_\_\_\_ Father's occupation: \_\_\_\_\_

Who lives in the house? \_\_\_\_\_

Who are your child's caregivers? \_\_\_\_\_

Do you have pets? If so, what kind and how does your child do with them? \_\_\_\_\_

Does anyone smoke at home? \_\_\_\_\_

### **Environmental History**

Location of home: City/suburban/wooded/farm/etc.) \_\_\_\_\_

Water source for home: (well/city/filtration system and type if present)\_\_\_\_\_

Heating/cooling system type: (electric/gas/oil/other)\_\_\_\_\_

Do you live near power lines, woods, industrial area, water:\_\_\_\_\_

If you live near water, please describe (swamp, river, ocean, retention pond, etc.):\_\_\_\_\_

Does your home, and especially your child's room, have a lot of dust, mold, feathers, or stuffed animals? Please describe.\_\_\_\_\_



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**Pediatric Patient Consent Form**

To Whom It May Concern:

We ask that both parents sign this document and return it to the Born Clinic. Your signatures will document your understanding and consent of the principles and practices of Born Preventive Health Care Clinic (Born Clinic).

In asking Born Clinic for help in optimizing the options for my child, \_\_\_\_\_ (*name*), I understand that my child’s symptoms may relate to other underlying medical issues. Evaluation and treatment of these medical issues may impact behavior and cognition. These symptoms are indicated on the questionnaire and other documents introduced at the initial visit. I am not seeking a cure for a disease/condition such as Autism, ADHD, Allergies, Asthma and other related problems, but rather an approach focusing on my child as an individual and his/her potential medical problems.

I understand that no environmental cause has proven to be linked to Autistic Spectrum Disorder (ASD) or Attention Deficit Hyperactivity Disorder (ADHD) or related problems in children or adults. However, due to the possible causative links, I desire to have the biochemical, immunological, and toxicological aspects of my child’s problems investigated and treated.

I desire that my child be evaluated with diagnostic steps aimed at some or all of the following factors:

- Necessary dietary changes
- Vitamin, mineral, amino acid supplementation
- Detoxification, immune, antimicrobial, and enzyme therapy
- Other necessary medications and adjunctive interventions

I understand that many elements of this approach may be described as unproven or off-label. I understand that many of the above factors may be considered unproven or experimental by third party payors.

My signature below confirms my consent to the diagnostic approach embodied in this document and acknowledges that I have had ample opportunity to voice concerns or ask questions. Any specific measures taken have been or will be carried out by me or under my supervision as a parent.

To the extent that some of the approaches embodied in this document have already been undertaken in my child’s care, I acknowledge that my understanding of the approaches at the time of first considering each of these steps was essentially no different than at the time of signing this document. At no time in the course of my child’s care did any of the practitioners at Born Clinic lack my complete informed consent.

\_\_\_\_\_  
(Parent)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Parent)

\_\_\_\_\_  
(Date)