www.DRFunctionalNeurology.com

972.322.2280 * 972.695.6306 Fax

PEDIATRIC DETAILED INTAKE FORM

PREPARING FOR THE FIRST VISIT

1. Both parents (or legal guardians) should be at the first visit with the child.
2. Total time for the first visit will be about an hour. Make sure the child is well fed, rested and hydrated.
3. Please bring the completed ***DETAILED PEDIATRIC INTAKE FORM*** with you. Dr. Rosenthal will review the records before he sees you and your child.
4. Please bring any medical records, DVD's, films or copies of therapy notes with you. Dr. Rosenthal needs to review these to get a complete picture of your child's health.
5. If needed please bring diapers, binky's, bottles, wet wipes, books or snacks so the child will be comfortable.
6. Please explain to the child why they are coming to the office. Re-assure them there will be no needles or shots during their visit.
7. The first visit should last about an hour. More time may be necessary depending on the complexity.

FINANCIAL POLICY

We are committed to the successful completion of your child's treatment program. Please understand the payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any evaluation and/or treatment.

Full payment is expected at the time of service. We accept cash, checks, Visa, MasterCard, and American Express. We do accept assignment of SOME insurance. Please check with the office to see which plans we are providers for. We also file for out of network providers. We do provide you with the necessary paperwork so that you may be re-imbursed by your insurance company.

REGARDING INSURANCE

Our policy is to recommend what is best for each patient. What an insurance company may or may not re-imburse is between the patient and the patient's insurance company. This office will not and cannot set its recommendations by what an insurance company's policy may be. This office will not enter into dispute with an insurance company regarding reimbursement. This is the patient's responsibility.

We do not know if your policy covers chiropractic care or not, and make no representations that yours does. Some insurance policies now cover chiropractic care and they range from a large deductible and a percentage of the bill to a no deductible and 100% of the bill.

DR FUNCTIONAL NEUROLOGY DOCTOR OF CHIROPRACTIC

WWW.DRFUNCTIONALNEUROLOGY.COM

972.322.2280 * 972.695.6306 FAX

SCHEDULING OF APPOINTMENTS

One of the most precious gifts is our time. It is important that you keep your appointments as scheduled by your doctor. Schedule ahead as this will assure you of getting the appointment time you want and. **Unless canceled at least 24 hours in advance**, our policy is to **charge for missed appointments** at the rate of a normal office visit. Please help us serve you better by keeping your scheduled appointments.

The goal of chiropractic care in this office is to improve your child's ability to achieve his or her optimal developmental potential. We will do everything possible to make your care affordable so that you can follow through on your treatment schedule.

I have read the financial policy. I understand and will abide to the terms of the agreement here within.

Name of **Patient**: _____ (Please print)

Name of Parent or Guardian: _____

Signature of Parent or Guardian: _____

Date: _____

DR FUNCTIONAL NEUROLOGY DOCTOR OF CHIROPRACTIC

WWW.DRFUNCTIONALNEUROLOGY.COM

972.322.2280 * 972.695.6306 FAX

Note: In this questionnaire "you" is used as if the child were answering questions, avoiding repetition of him/her.
Please bring this form and any medical records with you to the first visit so that the Dr. Rosenthal will have a complete picture of the child's background. Thank you in advance for taking the time and effort giving us this valuable information.

First Name:_____Middle:_____Last Name:_____

Birthdate: _____ / _____ / _____ Birth Order: _____Age : _____

☐Male ☐Female Eye Color: _____ Hair Color: _____

Blood Type: ☐Not known ☐A ☐B ☐AB ☐O ☐Rh+ ☐Rh-

Height: _____ Weight: _____SS#:_____

Home address: _____

City:_____State_____Zip_____

Parent(s) Email Address: _____Name:_____

Parent(s) Email Address: _____Name:_____

Home Telephone: (_____)_____ Cell or Other Number: _____

Referred By: _____

Mother or Primary Provider's Name: _____Occupation_____Work #_____

Father or Secondary Provider's Name: _____Occupation_____Work #_____

Person(s) filling out this questionnaire: _____ Date:_____

Why are you consulting us today?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

What things would you like to see change or improve?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

What is your relationship to the child?

☐Natural Mother ☐Natural Father ☐Stepmother ☐Stepfather
☐Adoptive Mother ☐Adoptive Father ☐Foster Mother ☐Foster Father
☐Grandmother ☐Grandfather ☐Older Sister ☐Older Brother
☐Social Worker ☐Caseworker ☐Other _____

What is the child's race?

☐White ☐Black ☐Oriental ☐Hispanic
☐Asian ☐Native Am ☐Other _____

Who is responsible for the child's care at this time?

☐Natural Parents ☐Natural Mother ☐Natural Father ☐Adoptive Parents
☐Natural Mother and Stepfather ☐Natural Father and Stepmother
☐Grandparents ☐Grandmother ☐Grandfather ☐Foster Parents
☐Orphanage ☐Agency ☐Other: _____

Who referred the child here, or recommended that the child come here?

☐No one, decided yourself to bring the child
☐Occupational Therapist
☐Friend of the Family
☐Therapeutic optometrist
☐Family Doctor
☐A Community Agency
☐Other:_____
☐Speech therapist
☐Physical Therapist
☐Pediatrician
☐Nurse
☐School
☐The police

What is the main problem that led to the child being brought here?

☐Balance the brain
☐Suicidal Thoughts
☐Arguments with Parents
☐Academic Problems
☐Refusal to go to School
☐Health Problems
☐Neglect by Parents
☐Fears
☐Child has no problems
☐Suicidal Actions
☐Anxiety
☐Speech delay
☐Motor delay
☐Physical Abuse
☐Bed-Wetting
☐Other: _____
☐Depression
☐Problems thinking clearly
☐Adjustment to Parents Divorce
☐Behavior Problems in School
☐Behavior Problems at Home
☐Sexual Abuse
☐Stealing

How severe is this problem?

☐Does not apply ☐Mild☐Moderate ☐Severe

How long has the child had this problem?

☐Does not apply
☐For past several months
☐For the past several years
☐For the past several years
☐For the past year
☐Other: _____
☐For the past several days
☐For the past two years

Which of the following has this problem affected?

☐Does not apply ☐None ☐The child's academia performance
☐The child's relationship with peers ☐The child's relationships with family members
☐The child's physical health ☐The child's emotional health
☐The child's behavior ☐Other: _____

Has the child been treated for this problem?

☐Does not apply ☐No ☐Yes, but with only partial success
☐Yes, but without success ☐Yes, with success:_____

What other problems is the child having?

☐None ☐Depression ☐Anxiety
☐Suicidal Thoughts ☐Suicidal Actions ☐Problems thinking clearly
☐Arguments with Parents ☐Adjustment to Parents Divorce
☐Academic Problems ☐Behavior Problems in School
☐Refusal to go to School ☐Behavior Problems at Home
☐Health Problems ☐Physical Abuse ☐Sexual Abuse
☐Neglect by Parents ☐Bed-Wetting ☐Stealing
☐Fears ☐Other: _____

What is the child's status in school?

☐Has not started school ☐Home schooled
☐Full-time, regular classes ☐Full-time, special education classes
☐Part-time, regular classes ☐Part-time, special education classes
☐Suspended from school ☐Expelled from school
☐Being Tutored at Home ☐Other: _____

What grade is the child in now (or when school starts again in the Fall)?

☐Not in school, will not be in school ☐Preschool
☐Kindergarten ☐First ☐Second ☐Third
☐Fourth ☐Fifth ☐Sixth ☐Seventh ☐Other: _____

Who does the child live with?

☐Natural parents ☐Natural Mother ☐Natural Father
☐Natural Mother and Stepfather ☐Natural Father and Stepmother
☐Shared living arrangements with both parents (divorce) ☐Relatives_____
☐Friends ☐Adoptive Parents ☐Foster parents
☐Lives in an orphanage ☐Lives in an agency ☐Other_____

Where does the child live?

☐House ☐Apartment ☐Trailer ☐Condo ☐Boarding School
☐Agency housing ☐Institution ☐Other _____
☐Lives at multiple residences (please explain):_____

How many children are in the child's family including the child?

☐Only child ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐More than 10

Of the other children in the family, how many are stepbrothers and stepsisters?

☐Does not apply ☐None ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐More than 8

What is the child's position in the family?

☐Does not apply, only child ☐The youngest child
☐A middle child ☐The oldest child ☐Other _____

How much education has the child's current male (or primary) caretaker completed?

☐Does not apply ☐Do not know ☐Less than Eighth Grade
☐Eighth Grade ☐Some High School ☐High School Graduate
☐Some College ☐College Graduate ☐Master's Degree
☐Medical Degree ☐Law Degree ☐Other: _____

What is the main type of work the child's current male (or primary) caretaker does?

☐Does not apply ☐Do not know ☐Has primarily been unemployed
☐Works in many different occupations ☐Unskilled worker (factory etc)
☐Skilled worker (welder, carpenter etc) ☐Clerical worker
☐Salesperson ☐Small business owner ☐Technical specialist
☐Business manager ☐Health professional ☐Social services professional
☐Business executive ☐Military service ☐Not employed outside the home
☐Other: _____

Which of the following is true about the child's current male (or primary) caretaker?

☐Does not apply ☐Do not know ☐He is not presently married
☐This is his first marriage ☐This is his 2nd marriage ☐He has been married >2 times

How many hours per day does the male (or primary) caretaker spend with the child?

☐ >8 hours ☐4-8 hours ☐2-4 hours ☐2 hours ☐<1 hour ☐Does not apply

How much education has the child's current female (or secondary) caretaker completed?

☐Does not apply ☐Do not know ☐Less than Eighth Grade
☐Eighth Grade ☐Some High School ☐High School Graduate
☐Some College ☐College Graduate ☐Master's Degree
☐Medical Degree ☐Law Degree ☐Other: _____

What is the main type of work the child's current female (or secondary) caretaker perform?

☐Does not apply ☐Do not know ☐Has primarily been unemployed
☐Works in many different occupations ☐Unskilled worker (factory etc)
☐Skilled worker (welder, carpenter etc) ☐Clerical worker
☐Salesperson ☐Small business owner ☐Technical specialist
☐Business manager ☐Health professional ☐Social services professional
☐Business executive ☐Not employed outside the home
☐Military service ☐Other: _____

Which of the following is true about the child's current female (or secondary) caretaker?

☐Does not apply ☐Do not know ☐She is not presently married
☐This is her first marriage ☐This is her 2nd marriage ☐She has been married >2 times

How many hours per day does the female (or secondary) caretaker spend with the child?

☐ >8 hours ☐4-8 hours ☐2-4 hours ☐2 hours ☐<1 hour ☐Does not apply

How many meals does the family have together in a week (all the family members)?

Breakfast	☐Never	☐Do not know	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Lunch	☐Never	☐Do not know	☐1	☐2	☐3	☐4	☐5	☐6	☐7
Dinner	☐Never	☐Do not know	☐1	☐2	☐3	☐4	☐5	☐6	☐7

What is the main source of income for the child's household family?

☐Does not apply	☐Do not know	☐Father's job
☐Mother's job	☐Both parents' jobs	☐Welfare
☐Alimony	☐Child support payments	☐Other _____

What is the economic status of the child's household family?

☐Medicaid	☐Medicare	☐Public assistance
☐Lower-lower	☐Lower-middle	☐Lower-upper
☐Middle-lower	☐Middle-middle	☐Middle-upper
☐Upper-lower	☐Upper-middle	☐Upper-upper

How old was the child's natural father at the time of the child's birth?

☐Do not know ☐15-19 ☐20-29 ☐30-39 ☐40-49 ☐50 or older

How old was the child's natural mother at the time of the child's birth?

☐Do not know ☐15-19 ☐20-29 ☐30-39 ☐40-49 ☐50 or older

Was the pregnancy planned?

☐Do not know ☐Yes ☐No

What was the mother's attitude while pregnant with the child?

☐Do not know ☐Accepting ☐Ambivalent ☐Happy
☐Angry ☐Depressed ☐Worried ☐Fearful
☐Moody ☐Other: _____

What was the child's physical condition immediately after birth?

☐Do not know ☐Normal, no unusual problems ☐Injured at birth
☐Difficult breathing ☐Problems with heart ☐Problems with bones
☐Low birth weight ☐Problems with digestion ☐Infection
☐Jaundice ☐Had blood transfusion ☐Had seizures
☐Fever ☐Place in intensive care ☐Placed in incubator
☐Other: _____

Approximately how much did the child weigh when born?

☐Do not know ☐1 pound ☐2 pounds ☐3 pounds ☐4 pounds ☐5 pounds
☐6 pounds ☐7 pounds ☐8 pounds ☐9 pounds ☐10 pounds ☐10 + pounds

How many days did the child spend in the hospital after birth?

☐Do not know ☐5 days or less ☐More than 5 days
☐More than 10 days ☐More than 20 days ☐More than 30 days

Who was the child's primary caretaker before age 2?

☐Natural Parents ☐Natural Mother ☐Natural Father ☐Adoptive Parents
☐Natural Mother and Stepfather ☐Natural Father and Stepmother
☐Grandparents ☐Grandmother ☐Grandfather ☐Foster Parents
☐Orphanage ☐Agency ☐Other: _____

Describe the child's temperament before age 2?

☐Do not know ☐Calm ☐Active ☐Sociable
☐Withdrawn ☐Happy ☐Unhappy ☐Alert
☐Sleepy ☐Affectionate ☐Crying ☐Difficult
☐Irritable ☐Hypersensitive ☐Angry ☐Regular
☐Irregular ☐Fearful ☐Cranky ☐Curious
☐Playful ☐Other: _____

How was the child fed before age 2?

☐Do not know ☐Bottle ☐Breast ☐Bottle and Breast

From birth to age 2, when did the child develop physical skills such as sitting and crawling?

☐Do not know ☐Earlier than most ☐At about the time as most children
☐Later than most children ☐Other _____

When did the child learn to walk?

☐Do not know ☐Before 1 year ☐1 to 1 ½ years ☐1 ½ to 2 years
☐ 2 to 3 years ☐ Does not apply ☐Other: _____

When did the child learn to talk?

☐Do not know ☐Before 1 year ☐1 to 1 ½ years ☐1 ½ to 2 years
☐2 to 3 years ☐ Does not apply ☐Other: _____

When did toilet training begin?

☐Does not apply ☐Before 1 year ☐1 year ☐1 ½ years
☐2 years ☐2 ½ years ☐3 years ☐3 ½ years
☐4 years ☐After 4 years ☐Other:_____

Where there problems in potty training?

☐Do not know ☐No ☐Severe problems ☐Moderate ☐Mild

What was the child's primary caretaker from ages 2-5?

☐Natural Parents ☐Natural Mother ☐Natural Father ☐Adoptive Parents
☐Natural Mother and Stepfather ☐Natural Father and Stepmother
☐Grandparents ☐Grandmother ☐Grandfather ☐Foster Parents
☐Orphanage ☐Agency ☐Other: _____

Describe the child's motor development (running, jumping, throwing, etc) from ages 2-5:

☐Does not apply ☐Advanced in comparison to other children
☐Average in comparison to other children ☐Slow in comparison to other children
☐Other: _____

Describe the child's language development (talking in sentences, vocabulary, etc) from ages 2-5.

☐Do not know ☐Advanced in comparison to other children
☐Average in comparison to other children ☐Slow in comparison to other children
☐Other: _____

Describe the child's social development (development of friendships, relationships with peers, relationships with adults, etc.) from ages 2 – 5.

☐Do not know ☐Advanced in comparison to other children
☐Average in comparison to other children ☐Slow in comparison to other children
☐Other: _____

Describe the child's mental development (counting, knowledge of alphabet, doing puzzles, understanding concepts, etc.) from ages 2 – 5.

☐Do not know ☐Advanced in comparison to other children
☐Average in comparison to other children ☐Slow in comparison to other children
☐Other: _____

Describe the child's temperament from ages 2 – 5.

☐Do not know ☐Calm ☐Active ☐Sociable
☐Withdrawn ☐Happy ☐Unhappy ☐Alert
☐Sleepy ☐Affectionate ☐Crying ☐Difficult
☐Irritable ☐Hypersensitive ☐Angry ☐Regular
☐Irregular ☐Fearful ☐Cranky ☐Curious
☐Playful ☐Other: _____

Which of the following school has the child attended?

☐None ☐Infant day care ☐Preschool ☐Kindergarten

At what age did the child start kindergarten?

☐Has not attended ☐4 ☐5 ☐6 ☐7 ☐Older than 7 years old

Did the child have any problems when starting kindergarten?

☐Does not apply ☐No ☐Was afraid
☐Complained of being ill to avoid going to school
☐Had to be punished to go to school
☐Other: _____

Which of the following describes the child's experience in kindergarten?

☐Does not apply ☐Enjoyed school ☐Felt neutral about school ☐Disliked school

Which of the following describe the child's behavior in kindergarten?

☐Does not apply ☐None ☐Fearful ☐Withdrawn
☐Aggressive ☐Disobedient ☐Distractive ☐Active
☐Other: _____

Describe the child's academic performance in kindergarten?

☐Does not apply ☐Slow ☐Average ☐Advanced

At what age did the child start the first grade?

☐Has not attended ☐5 ☐6 ☐7 ☐8 ☐More than 8 years old

Which of the following describes the child's experience in the first grade?

☐Does not apply ☐Enjoyed school ☐Felt neutral about school ☐Disliked school

Describe the child's academic performance in first grade?

☐Does not apply ☐Excellent grades ☐Good grades
☐Average grades ☐Poor grades ☐Other _____

Describe the child's experiences in the first grade:

☐Does not apply ☐None ☐Suspended ☐Expelled
☐Frequently Absent ☐Placed in Full-time special education
☐Placed in Part-time special education ☐Placed in accelerated academic program
☐Counseled ☐Evaluated by psychologist
☐Other: _____

Describe the child's academic performance since the first grade?

☐Does not apply ☐Excellent grades ☐Good grades
☐Average grades ☐Poor grades ☐Other _____

Describe the child's experiences since the first grade.

☐Does not apply ☐None ☐Suspended ☐Expelled
☐Frequently Absent ☐Placed in Full-time special education
☐Placed in Part-time special education ☐Placed in accelerated academic program
☐Counseled ☐Evaluated by psychologist
☐Other: _____

Describe the child's current subject strengths in school.

☐Does not apply ☐None ☐Art ☐Music ☐Reading
☐Math ☐Spelling ☐English ☐Science ☐History
☐Social Studies ☐Other: _____

Describe the child's current subject weaknesses in school.

☐Does not apply ☐None ☐Art ☐Music ☐Reading
☐Math ☐Spelling ☐English ☐Science ☐History
☐Social Studies ☐Other: _____

Describe the child's current skill strengths in school.

☐Does not apply ☐None
☐Test preparation ☐Paper and Reports
☐Playing attention in class
☐Being careful and checking work
☐Understanding concepts
☐Behaving correctly
☐Reading comprehension
☐Intelligence
☐Concentration ☐Organization
☐Handwriting ☐Memorizing
☐Getting assignments done on time
☐Vocabulary and expression
☐Pleasing the teacher
☐Taking tests ☐Reading speed
☐Spelling ☐Working hard
☐Other: _____

Describe the child's current skill weaknesses in school.

☐Does not apply ☐None
☐Test preparation ☐Paper and Reports
☐Playing attention in class
☐Being careful and checking work
☐Understanding concepts
☐Behaving correctly
☐Reading comprehension
☐Intelligence
☐Concentration ☐Organization
☐Handwriting ☐Memorizing
☐Getting assignments done on time
☐Vocabulary and expression
☐Pleasing the teacher
☐Taking tests ☐Reading speed
☐Spelling ☐Working hard
☐Other: _____

Does the child currently have behavior problems in the classroom?

☐Does not apply ☐No
☐Required to sit in an isolated area
☐Often reprimanded
☐Can't wait until turn
☐Required to sit near teacher
☐Has been sent to the principal's office
☐Talks out of turn
☐Other _____

Does the child currently have problems with attention and concentration in the classroom?

☐Does not apply ☐No
☐Not getting assignments done
☐Forgets teacher's instructions
☐Difficulty sitting still
☐Other: _____
☐Daydreaming
☐Material disorganized or messy
☐Acts without deliberation
☐Difficulty being quiet

How is the child described by current teacher(s)?

- ☐Does not apply
- ☐Fidgety
- ☐Distractible
- ☐Answers questions before completed
- ☐Has problem maintaining attention
- ☐Has problem playing quietly
- ☐Interrupts
- ☐Frequently loses objects
- ☐None of the following
- ☐Has problem remaining seated
- ☐Doesn't wait turn in games
- ☐Fails to finish assignments
- ☐Switches from one unfinished task to another
- ☐Talks excessively
- ☐Doesn't listen
- ☐Fails to consider safety
- ☐Other _____

Which of the following are true?

- ☐Do not know
- ☐None
- ☐Child has had regular medical checkups
- ☐Child has had regular hearing tests
- ☐Child has had regular vision tests
- ☐Child has had regular dental checkups
- ☐Child's symptoms improve with a fever

Which of the following are true?

- ☐None
- ☐Child wears glasses
- ☐Child wears a hearing aid
- ☐Child wears an orthopedic brace
- ☐Child wears orthopedic/corrective shoes
- ☐Child uses crutches for walking
- ☐Other: _____

What problems does the child have with sleep?

- ☐None
- ☐Trouble getting to sleep
- ☐Waking up a lot at night
- ☐Not getting enough sleep
- ☐Sleeping too much
- ☐Restlessness in bed
- ☐Waking up too early in the morning
- ☐Sleeping enough, but still tired
- ☐Falling asleep in school
- ☐Refusing to go to bed at night
- ☐Refusing to get up in the morning
- ☐Sleepwalking
- ☐Nightmares or Night Tremors
- ☐Other: _____

What problems does the child have with eating?

- ☐None
- ☐Refuses to eat balanced diet
- ☐Eating too many snacks
- ☐Finicky about food
- ☐Has a poor appetite
- ☐Overeats
- ☐Other _____

Does the child have problems with wetting or soiling?

- ☐No
- ☐Occasionally wets bed
- ☐Frequently wets bed
- ☐Frequently soils bed
- ☐Occasionally wets pants
- ☐Frequently wets pants
- ☐Occasionally soils pants
- ☐Other: _____

What kinds of discipline do the child's parents (or caretakers) use?

☐Does not apply ☐Do not know ☐None
☐Yelling ☐Lectures ☐Physical Punishment
☐Grounding ☐Loss of allowance ☐Withdrawal of privileges

How strict are the child's parents (or caretakers)?

☐Does not apply ☐Do not know ☐Very strict
☐Strict ☐Average ☐Permissive ☐Very permissive

Has the child ever been abused by a current or previous member of the household?

☐Does not apply ☐Do not know ☐No ☐Yes, physically
☐Yes, emotionally ☐Yes, verbally ☐Yes, sexually ☐Yes, neglected

Which of the following describes the child now?

☐Has many close friends ☐Has several close friends
☐Has few close friends ☐Has no close friends

How does the child perceive his or her level of acceptance?

☐Great ☐Good ☐Mixed ☐Poor

Which problems does the child have with peers?

☐None ☐Being teased ☐Being physically attacked
☐Having frequent arguments ☐Being rejected by peer group
☐Being jealous of peers ☐Peers who have delinquent behavior
☐Having peers get poor grades ☐Other _____

How does the child participate in games with others?

☐Does not participate ☐Actively participates
☐Passively participates ☐Cheats occasionally
☐Cheats regularly ☐Has a strong drive to win
☐Has no interest in winning ☐Other _____

Does the child have imaginary playmates?

☐Never has had ☐Has had in the past, but not now ☐ Has currently

Does the child like to read?

☐Never has had ☐Has had in the past, but not now ☐ Does currently

Does the child's male caretaker have a many books in his home library?

☐Never has had ☐Has had in the past, but not now ☐ Has currently

Does the child's female caretaker have many books in her home library?

☐Never has had ☐Has had in the past, but not now ☐ Has currently

How many **hours a day** does the child spend in the activities below?

Nanny: ☐Never ☐< 30 min. ☐< 1 hour . ☐ 1-2 hours ☐>2 hour, if so how much:_____
Day care: ☐Never ☐< 30 min. ☐< 1 hour . ☐ 1-2 hours ☐>2 hour, if so how much:_____
Pre-school: ☐Never ☐< 30 min. ☐< 1 hour . ☐ 1-2 hours ☐>2 hour, if so how much:_____
Therapy: ☐Never ☐< 30 min. ☐< 1 hour . ☐ 1-2 hours ☐>2 hour, if so how much:_____
Travelling time: ☐Never ☐< 30 min. ☐< 1 hour . ☐ 1-2 hours ☐>2 hour, if so how much:_____

How much time "screen time" does the child have on a daily basis?

Television: ☐Never ☐< 10 min. ☐< 30 min. ☐< 1 hour ☐>1 hour, if so how much:_____
Internet: ☐Never ☐< 10 min. ☐< 30 min. ☐< 1 hour ☐>1 hour, if so how much:_____
Computer games: ☐Never ☐< 10 min. ☐< 30 min. ☐< 1 hour ☐>1 hour, if so how much:_____
Handheld games: ☐Never ☐< 10 min. ☐< 30 min. ☐< 1 hour ☐>1 hour, if so how much:_____
Texting: ☐Never ☐< 10 min. ☐< 30 min. ☐< 1 hour ☐>1 hour, if so how much:_____

Does the child have a cell phone?

☐No ☐Yes, If so is it: ☐Their's ☐Mom's ☐Dad's ☐Brother's ☐Sister's ☐Other's

If the child does have a cell phone, where go they generally keep it?

☐Does not apply ☐Front pocket ☐Right ☐Left
☐Back pocket ☐Right ☐Left ☐Chest pocket ☐Right ☐Left
☐Backpack/purse ☐Shoulder strap
☐Other (please specify)_____

Does the child wear a watch?

☐No ☐Yes
☐If so, which wrist is it worn on: ☐Right ☐Left
☐If so, is it: ☐Digital ☐Analog

What kind of portable gaming system does the child have?

☐Does not apply ☐Game Boy ☐Nintendo DS ☐iPhone
☐Play Station Portable ☐Leap Frog ☐VTech
☐Other (Please Specify):_____

Where does the child bring the Game Boy, Nintendo DS, PlayStation, Leap Frog etc. to?

☐Does not apply ☐To school ☐Some ☐Most places
☐Everywhere ☐Cannot go anywhere without it. ☐Other:_____

What kind of gaming system does the child have at the PRIMARY residence?

☐Does not apply ☐Abacus ☐Play Station ☐Wii
☐Nintendo Game Cube ☐Atari ☐Xbox/360
☐Other (Please Specify):_____

What kind of gaming system does the child have at his SECONDARY residence?

☐Does not apply ☐Game Boy ☐Nintendo DS
☐Play Station Portable ☐Leap Frog ☐Xbox
☐Other (Please Specify):_____

How many words does the child have in their vocabulary?

Spontaneous speech_____
Prompted speech_____

How many words does the child speak in a sentence?

Spontaneous speech_____(Low average to High average)
Prompted speech_____(Low average to High average)

Where does the primary caretaker of the child shop for food eaten at home?

☐Grows food at the home ☐Organic farmer ☐Natural food store
☐Whole Foods ☐Central Market ☐Supermarket
☐Wal Mart ☐Convenience store ☐Does not apply
☐Other (Please Specify):_____

What restaurants does the child typically eat at?

☐Does not apply ☐Casual dining ☐ Fast food
☐Other (Please Specify):_____

Please circle the letters/sounds the child is able to consistently verbally express:

A	B C D
E	F G H
I	J K L M N
O	P Q R S T
U	V W X
Y	Z

Past Evaluations

Please indicate if you have had any of the following evaluations, treatment, or consultations by placing a check mark in the appropriate columns. Please attach any copies of reports or provide the addresses where the evaluations took place. Add comments (to the back or attach sheet if needed).

Check If Yes	Check If ABNormal	Date	Evaluation / Test
☐	☐	_____	Chiropractic/Neurological
☐	☐	_____	Wechsler Preschool & Primary Scale of Intelligence
☐	☐	_____	Speech and Language Evaluations
☐	☐	_____	Genetic Evaluations
☐	☐	_____	Neurological Evaluations
☐	☐	_____	Gastroenterology Evaluations
☐	☐	_____	Celiac/Gluten Testing
☐	☐	_____	Allergy Evaluation
☐	☐	_____	Nutritional Evaluation
☐	☐	_____	Auditory Evaluation
☐	☐	_____	Vision Evaluation
☐	☐	_____	Osteopathic
☐	☐	_____	Acupuncture
☐	☐	_____	Physical Therapy
☐	☐	_____	Occupational Therapy
☐	☐	_____	Sensory Integration Therapy
☐	☐	_____	Language Classes
☐	☐	_____	American Sign Language (ASL)
☐	☐	_____	Homeopathic
☐	☐	_____	Naturopathic
☐	☐	_____	Craniosacral
☐	☐	_____	Psychological Evaluations
☐	☐	_____	WIAT testing
☐	☐	_____	Xray, MRI, CT, EEG, PET, SPEC
☐	☐	_____	Applied Behavioural Analysis (ABA)

Hospitalizations

Age	Reason for hospitalization

Medications

Type	Present	Past	Responses

Supplements

Type	Present	Past	Responses

Mothers Pregnancies:

Pregnancies_____ Live Births_____ Miscarriages_____

Mothers Pregnancy: Place a check mark if any of the following occurred during your mother's pregnancy:

Did your mother (child's):		Please describe if applicable
Difficulty getting pregnant (more than 6 months)	☐	
Infertility drug used	☐	Specify:_
In Vitro Fertilization	☐	
Forceps used in delivery	☐	
Drink Alcohol	☐	
Drink Coffee	☐	
Smoke Tobacco	☐	
Take Progesterone	☐	
Take prenatal vitamins	☐	
Take antibiotics	☐	
Take other drugs	☐	Specify:
Excessive vomiting, nausea (more than 3 weeks)	☐	
Have a viral infection	☐	
Have a yeast infection	☐	
Have amalgam filling put in teeth	☐	
Have amalgam fillings removed from teeth	☐	
How many filling in her teeth during?	☐	Number:
Have bleeding (which months?)	☐	
Have birth problems	☐	
Group B strep infection	☐	
Have c-section because of:	☐	
Use induction for labor (such as Pitocin)	☐	
Have anesthesia	☐	Specify:
Use Oxygen during labor	☐	
Have an x-ray	☐	
Have Rhogam, is so, how many shots?	☐	
Gestational Diabetes	☐	
High blood pressure (pre-eclampsia)	☐	
High blood pressure / toxemia	☐	
Have chemical exposure	☐	
Move to a newly built house	☐	
House painted indoors	☐	
House painted outdoors	☐	
House exterminated for insects	☐	

Perinatal

Place a check mark if applicable:

Very active before birth	☐Yes	☐No
Hospital / Birthing Center	☐Yes	☐No
Needed Newborn Special Care	☐Yes	☐No
Appeared Healthy	☐Yes	☐No
Easily consoled during first month	☐Yes	☐No
Antibiotics first month	☐Yes	☐No
Experienced no complication first month of life	☐Yes	☐No

Birth Weight and Apgar

Weight at birth: _____grams/lbs Apgar score at 1 minute _____ Apgar score at 5 minutes_____

Early Childhood Illnesses

Number of earaches in the first two years _____

Number of other infections in first two years _____

Number of times you had antibiotics in the first two years_____

Number of courses of prophylactic antibiotics in first two years_____

First antibiotic at _____months

First illness at _____months

Early Childhood Diseases

Please indicate the approximate age in months/years for the following diseases:

Mumps	_____mos./yrs	☐Never
Measles	_____mos./yrs	☐Never
Rubella (German measles)	_____mos./yrs	☐Never
Chicken pox	_____mos./yrs	☐Never
Whooping cough (pertussis)	_____mos./yrs	☐Never
Croup	_____mos./yrs	☐Never
Scarlet fever	_____mos./yrs	☐Never
Bronchiolitis	_____mos./yrs	☐Never
Asthma	_____mos./yrs	☐Never
Hand, foot and mouth disease	_____mos./yrs	☐Never
Pinkeye	_____mos./yrs	☐Never
Fifth disease ”slapped-cheek”	_____mos./yrs	☐Never
Rotavirus	_____mos./yrs	☐Never
Kawasaki disease	_____mos./yrs	☐Never
Meningitis	_____mos./yrs	☐Never
Strep throat	_____mos./yrs	☐Never
Reye’s syndrome	_____mos./yrs	☐Never
MRSA (staph infection)	_____mos./yrs	☐Never
Impetigo	_____mos./yrs	☐Never
Ringworm	_____mos./yrs	☐Never
Lyme disease	_____mos./yrs	☐Never
Flu	_____mos./yrs	☐Never
Seasonal allergies:	_____mos./yrs	☐Never

Developmental History

Please indicate the approximate age in months/years for the following milestones:

Lifted head up	_____mos./yrs	☐Never
Held head up without support	_____mos./yrs	☐Never
Rolled over belly to back	_____mos./yrs	☐Never
Rolled over back to belly	_____mos./yrs	☐Never
Sitting up	_____mos./yrs	☐Never
Sitting up without support	_____mos./yrs	☐Never

Crawl	_____mos./yrs	☐Never
Pulled to stand	_____mos./yrs	☐Never
Walked alone	_____mos./yrs	☐Never
Potty trained	_____mos./yrs	☐Never
Dry at night	_____mos./yrs	☐Never
First words	_____mos./yrs	☐Never
Spoke clearly	_____mos./yrs	☐Never
Lost non-verbal language	_____mos./yrs	☐Never
Lost verbal language	_____mos./yrs	☐Never
Lost eye contact	_____mos./yrs	☐Never
Began showing handedness	_____mos./yrs	☐Never
Dominant hand	Right Left	☐Never
Dominant foot	Right Left	☐Never
Dominant eye	Right Left	☐Never
Dominant ear	Right Left	☐Never

Developmental Disorders

Please indicate the approximate age in months/years for the following of diagnoses:

Erb's Palsy	_____mos./yrs	☐Never
Klumpke's palsy	_____mos./yrs	☐Never
Arnold Chiari Malformation	_____mos./yrs	☐Never
Patent foramen ovale	_____mos./yrs	☐Never
Cerebral palsy	_____mos./yrs	☐Never
Other	_____mos./yrs	☐Never
Autism	_____mos./yrs	☐Never
Asperger's	_____mos./yrs	☐Never
AD/HD	_____mos./yrs	☐Never
Others:		

Immunization	Please give approx. date if you don't have an exact one.	Did you have any of the following reactions: "Bowel" means any bowel symptom such as diarrhea, "Swelling" means swelling at the site of injection.

Diphtheria-Pertussis-Tetnus	Date	Bowel	Swelling	Crying	Seizure	Irritable	Fever	No Reaction
DTP 1		☐	☐	☐	☐	☐	☐	☐
DTP 2		☐	☐	☐	☐	☐	☐	☐
DTP 3		☐	☐	☐	☐	☐	☐	☐
DTP 4		☐	☐	☐	☐	☐	☐	☐
DTP 5		☐	☐	☐	☐	☐	☐	☐
Adult Diphtheria-Tetanus		☐	☐	☐	☐	☐	☐	☐
Pediatric Diphtheria-Tetanus		☐	☐	☐	☐	☐	☐	☐

H Influenza Type B	Date	Bowel	Swelling	Crying	Seizure	Irritable	Fever	No Reaction
Hib 1		☐	☐	☐	☐	☐	☐	☐
Hib 2		☐	☐	☐	☐	☐	☐	☐
Hib 3		☐	☐	☐	☐	☐	☐	☐
Hib 4		☐	☐	☐	☐	☐	☐	☐

Oral Polio Vaccine	Date	Bowel	Swelling	Crying	Seizure	Irritable	Fever	No Reaction
OPV 1		☐	☐	☐	☐	☐	☐	☐
OPV 2		☐	☐	☐	☐	☐	☐	☐
OPV 3		☐	☐	☐	☐	☐	☐	☐
OPV 4		☐	☐	☐	☐	☐	☐	☐
OPV 5		☐	☐	☐	☐	☐	☐	☐

Polio Vaccine Injection	Date	Bowel	Swelling	Crying	Seizure	Irritable	Fever	No Reaction
Polio Vaccine Injection 1		☐	☐	☐	☐	☐	☐	☐
Polio Vaccine Injection 2		☐	☐	☐	☐	☐	☐	☐
Polio Vaccine Injection 3		☐	☐	☐	☐	☐	☐	☐
Polio Vaccine Injection 4		☐	☐	☐	☐	☐	☐	☐
Polio Vaccine Injection 5		☐	☐	☐	☐	☐	☐	☐

Measles-Mumps-Rubella	Date	Bowel	Swelling	Crying	Seizure	Irritable	Fever	No Reaction
MMR 1		☐	☐	☐	☐	☐	☐	☐
MMR 2		☐	☐	☐	☐	☐	☐	☐

Hepatitis-B Vaccine	Date	Bowel	Swelling	Crying	Seizure	Irritable	Fever	No Reaction
HBV 1		☐	☐	☐	☐	☐	☐	☐
HBV 2		☐	☐	☐	☐	☐	☐	☐
HBV 3		☐	☐	☐	☐	☐	☐	☐
HBV 4		☐	☐	☐	☐	☐	☐	☐

Miscellaneous	Date	Bowel	Swelling	Crying	Seizure	Irritable	Fever	No Reaction
Varivax (Chicken Pox)		☐	☐	☐	☐	☐	☐	☐
Tine Test		☐	☐	☐	☐	☐	☐	☐
Other:		☐	☐	☐	☐	☐	☐	☐

Please indicate approximate age when the child had an operation for:	AGE	Please describe any injuries	AGE
Appendix		Head Injury	

Circumcision		Broken Bone	
Hernia		Broken Bone	
Tonsils		Eye Injury	
Adenoids		Neck Injury	
P.E. Tubes in Ears		Abdominal Injury	
Other Surgery: _____ _____ _____		Other Injuries: _____ _____ _____	

Environmental History

Please indicate past and present exposures

Exposure:	Past	Present
Mold in bathroom	☐	☐
Damp cellar	☐	☐
Pest extermination – inside	☐	☐
Pest extermination – outside	☐	☐
Forced hot air head	☐	☐
Had water in basement	☐	☐
Mold visible on exterior of house	☐	☐
Heavily wooded or damp surroundings	☐	☐
Mold in cellar, crawl space or basement	☐	☐
Moldy, musty school / daycare	☐	☐
Tobacco smoke	☐	☐
Carpet in bedroom	☐	☐
Carpet in most parts of house	☐	☐
Feather or down bedding	☐	☐

Laboratory data (Please attach ALL AVAILABLE tests for Dr. Rosenthal to review):

Evaluation	Test	Done	Abnormal	Not Sure?
24 hour urine amino acids		☐	☐	☐
Amino acid screening		☐	☐	☐
Blood chemistry screen		☐	☐	☐
Blood count		☐	☐	☐
Blood test for fatty acids		☐	☐	☐
Blood test for food allergies		☐	☐	☐
CAT scan		☐	☐	☐
Colonoscopy		☐	☐	☐
DMSA loading study		☐	☐	☐
EEG		☐	☐	☐
Folic acid		☐	☐	☐
Fragile X chromosome study		☐	☐	☐
Hair elements		☐	☐	☐
Immune profile		☐	☐	☐
Intestinal permeability		☐	☐	☐
Liver detoxification profile		☐	☐	☐
MRI		☐	☐	☐
Organic acids quantitative – Fungal / bacterial metabolites		☐	☐	☐
Organic acids quantitative – Metabolism		☐	☐	☐
Organic acids screen		☐	☐	☐
PET scan		☐	☐	☐
Pinworm prep		☐	☐	☐
Plasma amino acids		☐	☐	☐
Plasma or serum zinc		☐	☐	☐
RBC elements		☐	☐	☐
Serum Ferritin (iron stores)		☐	☐	☐
Serum methylmalonic acid		☐	☐	☐
Serum Vitamin A		☐	☐	☐
Small bowl biopsy		☐	☐	☐
Stool culture		☐	☐	☐
Stool parasites		☐	☐	☐
Thyroid Profile		☐	☐	☐
Uric acid test (blood or urine)		☐	☐	☐
Urinary Peptides		☐	☐	☐
Urine elements		☐	☐	☐
Urine Kryuptopyrrole		☐	☐	☐

Childhood History

Please check if you have any of the following symptoms currently, if your symptoms are mild, moderate or severe and if they are occasional, frequent or always or if you have only had these symptoms in the past only.

PHYSICAL	Mild	Moderate	Severe	Occasional	Frequent	Always	Past
Double Jointed							
Lymph Nodes Enlarged							
Lymph Nodes Tender							
Overweight							
Pupils Uneven							
Pupils Unusually Large							
Pupils Unusually Small							
Shiners, Circles under eyes							
Underweight							
Webbed Toes							
STRENGTHS	**Mild**	**Moderate**	**Severe**	**Occasional**	**Frequent**	**Always**	**Past**
Cuddly							
Draws Accurate Pictures							
Likes to be held							
Ok if parents leave							
Exceptional music ability							
Good at Drawing Pictures							
Good at Puzzles							
Perfect Musical Pitch							
Physically coordinated							
Sensitive/Affectionate							
Pleasant/Easy to Care for							
Skill: doing fine work							
Skill: playing/small object							
Skill: throw/catch ball							
Strong desire to do things							
Unusual memory							
Wants to be more liked							

SENSORY	Mild	Moderate	Severe	Occasional	Frequent	Always	Past
Fearful of harmless objects							
Fearful of unusual events							
Unaware of danger							
Unaware of people's feelings							
Unaware of self as a person							
Very sensitive to pain							
Bothered by certain sounds							
Ear pain							
Ear Ringing							
Hearing acute							
Hearing loss							

SENSORY	Mild	Moderate	Severe	Occasional	Frequent	Always	Past
Likes certain sounds							
Sensitive to loud noise							
Covers ears with sounds							
Likes head burrowed							
Likes to be upside down							
Likes to be swung in air							
Intensely aware of odors							
Acute sense of smell							
Hates wearing shoes							
Insensitive to pain							
Bothered by bright lights							
Distorted vision							
Examines by sight							
Fails to blink at bright light							
Likes fans							
Likes flickering lights							
Poor vision							
Puts eye to bright light/sun							
Strabismus (crossed eye)							
Adopts complicated rituals							
Collects particular things							
Corrects imperfections							
Draws only certain things							
Fixated on one topic							
Lines objects precisely							
Lines things in neat rows							
Repeats old phrases							
Repetitive play/objects							
Tidy							
Upset if things change							
Upset if things aren't right							
Hypersensitive to touch							
Craves being touched							
Motion sickness							
Fear of heights							
Craves spinning activities							
Falls frequently							
VISUAL PROCESSING	Mild	Moderate	Severe	Occasional	Frequent	Always	Past
Eye pain while reading							
Head pain while reading							
Neck pain while reading							
Lazy eye							
Does not like to read							
Poor reading comprehension							
Sensitivity to light							
Does not recognize colors Consistently							
Difficulty following written Instructions							

VISUAL PROCESSING	Mild	Moderate	Severe	Occasional	Frequent	Always	Past
When reading, seems to Skip or miss words							
Auditory processing							
Doesn't seem to listen							
Plays loudly							
Extremely sensitive to Sound							
Doesn't like loud noise							
Needs to be told things repetitively							
Difficulty following verbal instructions							
Seems to not hear all words							
Prone to ear infections or In the ears							

BEHAVIOR	Mild	Moderate	Severe	Occasional	Frequent	Always	Past
Aloof, indifferent, remote							
Behavior purposeless							
Bites or chews fingers							
Constant movement							
Curious/get into things							
Destructive							
Does opposite/asked							
Extremely cautious							
Falls/gets hurt easily							
Head banging							
Hold hands in strange place							
Hyperactive							
Imitates others							
Lost in thought, unreachable							
Melt downs							
Poor focus, attention							
Poor sharing							
Silly							
Tantrums							
Toe Walking							

BEHAVIOR	Mild	Moderate	Severe	Occasional	Frequent	Always	Past
Unusual play							
Uses adults hand for activity							
Watches TV for long Periods of time							
Doesn't do for self							
Teases others							
Unable to predict actions							
Won't attempt/ can't do							
Eye contact is poor							
Finger flicking							
Flap hands							
Jumps when pleased							
Licking							
Likes to flick finger in eye							
Likes to spin things							
Rhythmic rocking							
Sits long time staring							
Whirls self like a top							
Lacks initiative							
Headaches							
Jaw pains							
Leg pains							
Muscle pains							
Arched back with bright lights							
Seems angry							
Seems depressed							
Disliked by other children							
Shows poor self-esteem							
Sleeps excessively							
Trouble staying seated for meals or homework							
Fidgets excessively							
Doesn't finish work or tasks							
Easily distracted							
Acts before thinking							
Interrupts, often calls out							
Makes careless mistakes							
Disorganized							
Poor math/science skills Poor language, vocabulary							

GENERAL	Mild	Moderate	Severe	Occasional	Frequent	Always	Past
Holds bizarre posture							
Perspiration – odd odor							
Physically awkward							
Seizures – focal							
Seizures – generalized							
Seizures – petit mal							
Seizures – grand mal							
Stiffens body when held							
Unusual physical pliability							
Unusual sound of cry							
Conjunctivitis							
Eye Crushing							
Heart murmur							
Mitral valve prolapse							
Unusual fast heart beat							
Cheek/ear – pink/cold							
Cold all over							
Cold hands and feet							
Cold intolerance							
Hands/feet – very sweaty							
COMMUNICATION	Mild	Moderate	Severe	Occasional	Frequent	Always	Past Only
Answers by repeating question							
Asks using "you" not "I"							
Babbling							
Does not asks questions							
Expressive language poor							
Points to objects / can't name							
Receptive language poor							
Talks to self							
Uses one word for another							
Always frightened							
Anxiety							
Inconsolable crying							
Negative							
Phobias							
Severe mood swings							
Vocal Tics							
Does not recognize tone of others voice							

COMMUNICATION	Mild	Moderate	Severe	Occasional	Frequent	Always	Past
Speaks monotone							
Speaks very little							
Speaks excessively							
Does not read faces well							
Does not read body postures							
Does not respect others personal space							
Can tell when parents are angry by facial expression by tone of voice							
Can tell when they bother other children							
Other children think they are weird							
Very little expression							
Can pick up on jokes							
Recognizes metaphor							
Relies on slapstick comedy							

Class clowns							
Sometimes hurts others feelings							
SLEEP	Mild	Moderate	Severe	Occasional	Frequent	Always	Past
Awakes at night							
Daytime sleepiness							
Difficulty falling asleep							
Early waking							
Nightmares							
Sleeps less than normal							
Sleeps more than normal							
Abnormal food cravings							
Pica (eating non-edible things)							
Always thirsty							
Behavior worse with food							
Bread craving							
Carbohydrate of intolerance							

SLEEP	Mild	Moderate	Severe	Occasional	Frequent	Always	Past Only
Chew or swallow nonfood							
Craving for carbohydrates							
Craving for juice							
Craving for salt							
Diet soda craving							
Poor appetite							
Sweets before food							
Unusual/extreme water drinking							
DIGESTION & FOOD	Mild	Moderate	Severe	Occasional	Frequent	Always	Past Only
Abdominal bloating							
Abdominal pain							
Burping							
Colic							
Constipation							
Cracking lip corners							
Diarrhea							
Farting-regular							
Farting-stinky							
Fissures							
Intestinal parasites							
Lower abdominal bloating							
Mouth cold sores							
Little white bumps on face							
White bumps on back of arms							
Mouth thrush (yeast infxn)							
Nausea							
Pinworms							
Red ring around anus							
Reflux							
Sore throat							
Spitting up							
Stools bulky							
Stools light color							
Stools very stinky							
Stools with blood							
Stools with mucous							
Stools with undigested food							
Teeth grinding							
Upper abdominal pain							

SLEEP	Mild	Moderate	Severe	Occasional	Frequent	Always	Past
Vomiting							
Smells everything before tasting							
SKIN	Mild	Moderate	Severe	Occasional	Frequent	Always	Past
Blotchy skin							
Dark birth mark(s)							
Dark circle under eye(s)							
Diaper rash							
Ears get red							
Easy bruising							
Eczema							
Flushing							
Light birth mark(s)							
Odd body odor							
Pale skin							
Vitiligo							
HAIR,SKIN,NAILS	Mild	Moderate	Severe	Occasional	Frequent	Always	Past
Dry skin in general							
Feet cracking							
Feet peeling							
Hands cracking							
Hands peeling							
Fungus on or Fingernails or Toenails							
Upper abdominal pain Vomiting Smells everything before tasting							
Nails brittle							
Nails pitted							
Nail soft							
White spots or lines							
Calf cramps							
Foot cramps							
Muscle pain							
Muscle tone tense							
Muscle twitches							
Poor muscle tone/limp							
Poor posture							
Poor handwriting							
Scoliosis							
Knock kneed							
Feet turn in or out							
Slurred speech or lisp							

SLEEP	Mild	Moderate	Severe	Occasional	Frequent	Always	Past
Generally appears clumsy or awkward							
Rolled over in crib							
Sit up easily							
Active when first came home							
Did not move much when first got home							
Strong startle response							
Jumps when picked up or rocked back							
Needs to always lean on something							
Hooks feet on chair while sitting							
Slouches in chair							
Poor balance							
Crawled before walking							
Unusual crawl							
Did not crawl							
Walked late							
Walked early							
Head tilt							
Torticollis							
Stiff neck							
Birth trauma							
Forceps/Vacuum delivery							
Head bruised							
Head coned							
Unusually long labor							

URINARY	Mild	Moderate	Severe	Occasional	Frequent	Always	Past
Bed wetting after age 4							
Odd urinary odor							
Urinary hesitancy							
Urinary tract infections							

Review of Systems©

Please circle any of these that apply

Constitutional:	Growth problems	Fatigue	Fevers
	Weight loss	Weight gain	Poor appetite
	Chills	Obesity	Muscle wasting
Eyes	Blurred vision	Double vision	Drainage
	Glaucoma	Diabetes	Near sighted
	Far sighted	Use glasses	Color blindness
	Floaters	Cataracts	Use contacts
Nose/Throat	Loss of smell	Ringing in ears	Current/chronic Infections
	Dryness eyes/nose	Swelling nose/throat	Dizziness
	Drooling	Adenoids	Recent/chronic yeast infection
	Lip tie at birth		
	Ulcers		Tongue tie at birth
Cardiovascular	Blue lips	Blue fingers	Swelling feet
	Hypertension	Tobacco use	Regurgitation
	Swelling hands	Cold feet	Cold hands
	Red hands	White hands	Murmurs
	Chest pain with rest	Chest pain with exertion	Congestive heart failure
Respiratory	Persistent cough	Shortness of breath at rest	Shortness of breath with exertion
	Asthma	Bronchitis	
Gastro-intestinal	Belly pain	Constipation	Diarrhea
	Reflux	Vomitting	Nausea
	Gas/Bloating	Belching	Loss of control
Gastro-urinary	Difficulty urinating	Bed-wetting	Blood
	Late night urination	Loss of control	Urinary incontinence
	Bowel incontinence		
Musculoskeletal	Pain	Problems walking	Weakness
	Arthritis	Joint pain	Problems moving
Skin and hair	Itching	Rashes	Lesions
	Eczema	Allergies	White lines on nails
	Ingrown hair	Dryness	Excessive sweating

	Absent sweating	Nevus	
Neurological/ developmental	Seizures	Floppy tone	Cerebal palsy
	Fainting	Headaches	Epilepsy
	Multiple sclerosis	Incoordination	Stroke
	Autism	ADD	ADHD
	Parkinson's	Traumatic brain injury	Concussion
	Erb's palsy	Klumpke's palsy	Arnold chiari malformation
	Patent foramen ovale		
	Aspergers	Visual midline shift	Muscular dystrophy
Blood/Lymph	Bleeding	Bruising easily	Swelling
	Diabetes	Poor wound healing	Recent transfusion
Endocrine	Hair loss	Hormone replacement	Hyperthyroidism
	Hypothyroidism	Hashimoto's	
Allergic/Immunologic	Environmental	Seasonal	Auto-immune
	Latex	Anaesthesia problems	Drug allergies
Psychiatric	Behavioural changes	Personality changes	Sadness
	Mania	Agitation	Visual hallucinations
	Anxiety	Obsessive	Auditory hallucinations
	Bipolar	Psychosis	Self injuring
	Sadistic	Depression	OCD
	Suicial thoughts		
Sleep	Problems getting to sleep	Problems staying asleep	Sleep walking
	Well rested after sleep	Enjoy naps	
Genetic	Ehlers-Danlos Syndrome	Cystic fibrosis	
	MECP2	CDKL5	Downs Syndrome
Corrective and/or supportive devices	AFO	Shoes	Leg brace
	Spinal brace	Arm brace	Helmet
	Wheelchair	Crutches	Cane
Hand dominance	Right	Left	Don't know
Foot dominance	Right	Left	Don't know
Eye dominance	Right	Left	Don't know
Ear dominance	Right	Left	Don't know

Family Health History©

Please mark any of these that apply

Family History	Heart disease	Vascular	Cancer	Thyroid	Obesity	Diabetes	Genetics	Other
Father								
Mother								
Brother 1								
Brother 2								
Brother 3								
Sister 1								
Sister 2								
Sister 3								
Grandfather (Father's side)								
Grandmother (Father's side)								
Uncle 1 (Father's side)								
Uncle 2 (Father's side)								
Aunt 1 (Father's side)								
Aunt 2 (Father's side)								
Grandfather (Mother's side)								
Grandfather (Mother's side)								
Uncle 1 (Mother's side)								
Uncle 2 (Mother's side)								
Aunt 1 (Mother's side)								
Aunt 2 (Mother's side)								
© Dr. David Rosenthal								

www.DRFunctionalNeurology.com

AUTHORIZATION FOR EVALUATION, MANAGEMENT AND SUPPORT

I clearly understand and agree that all services rendered to me will be charged directly to me and that I am personally responsible for all payments. There are inherent risks in every health care delivery system. Chiropractic health care is no exception. We want you to be informed of potential events associated with chiropractic health care before consenting to evaluation, management and support.

I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable. I hereby authorize Dr. David Rosenthal to examine and manage my condition as he deems appropriate through the use of Chiropractic health care, and I give authority for these procedures to be performed. Chiropractic manipulation/adjustment is the introduction of energy with the use of the Doctor's hands or with calibrated instruments. Frequently the maneuvers are associated with a "pop" or "click" sound or sensation in the area being evaluated, managed or supported.

Dr. Rosenthal will not be held responsible for any pre-existing medically diagnosed conditions nor any medical diagnosis. I understand that management and recommendations involve the use of chiropractic care and may or may not incorporate various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, hydrotherapy, dietary modification, exercise recommendations, brain-based rehabilitation, and nutritional supplementation.

I am fully aware and agree to the statements below with my initials:

1.	_____Initials	I am fully aware and agree that Dr. David Rosenthal is licensed in the state of Texas as a Doctor of Chiropractic (DC) and not a medical doctor (md).
2.	_____Initials	I am fully aware and agree that Dr. Rosenthal is not licensed as a primary care physician in the state of Texas and that if I do have a diagnosable medical condition will seek care from a medical physician licensed to treat my specific diagnosis, condition, or disease process. I will not hold Dr. Rosenthal liable for being a primary care physician in the state of Texas.
3.	_____Initials	I am fully aware and agree that Dr. Rosenthal may make recommendations to manage my case that may include: diet, brain-based exercises, nutritional advice, and nutritional supplementation. I understand that nutrition is not an exact science. I acknowledge that no claims or guarantees have been made to me regarding me or my child's (ward's) as a result of Dr. Rosenthal's chiropractic care.
4.	_____Initials	**POSSIBLE RISKS:** As with any health care procedure, complications are possible following chiropractic intervention. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications. The risks of stroke complications due to chiropractic treatment are so rare that no statistical literature is available to calculate possibility. The risk of cerebrovascular injury, or stroke, has been estimated between one in one million and one in twenty million manipulations/adjustments. The probability of adverse reactions due to ancillary procedures are also so rare that no statistical literature is available to calculate.

5.	_____Initials	I agree to accept full responsibility for applying the advice I receive and for any risk that may be involved in applying these chiropractic procedures and/or principles.
6.	_____Initials	I am fully aware and agree that Dr. Rosenthal does not prescribe any allopathic medical treatments or pharmaceutical medications.
7.	_____Initials	I am fully aware and agree that nutritional recommendations including vitamins, minerals, herbals and homeopathics are used for support and educational purposes only and not intended to render medical advice or serve as any treatment protocol for any pathology, disease or disorder. The nutritional protocols are used to support various body systems. The products recommended are only intended as support for natural metabolic processes that are under temporary stress or to address an additional demand for nutrients. These recommendations have not been evaluated by the Food and Drug Administration and should not be construed as claims to treat, cure or prevent disease, as they are not intended to act as drugs nor to replace any drug prescribe by a physician. We believe that such an act may be detrimental to the health and well being of an individual and that dietary supplements should only be used in a supportive role in such conditions.
8.	_____Initials	I am fully aware and agree that there are **POSSIBLE RISKS OF REMAINING UNMANAGED OR SUPPORTED:** Delay of management and support allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of management and support will complicate the condition and make future rehabilitation more difficult. We will always provide you with our best care; and, if results are suboptimal or finding indicate, we will refer you to another provider who will assist you with your condition.
9.	_____Initials	I agree that no pictures and or videos in analog or digital form will be allowed without the express written permission of Dr. Rosenthal.
10.	_____Initials	I affirm and agree that I am indeed the patient or guardian/ward listed in this paperwork and do affirm that I/we have the listed health complaints and I/we are not part of an investigatory body including local, state or federal commissions involved with health care, legal bodies, insurance investigators, chiropractic and/or medical boards and investigations.
11.	_____Initials	I affirm and agree that I have received a dated copy of this authorization for care form.

Patient Name: _____Date:_____ (Please Print)

Patient Signature: _____Date:_____

Signature of Parent or

Legal Guardian/Ward: _____Date:_____