First Name: _____ Middle Name: _____ Last Name: _____

Nick Name: _____ Date of Birth: Gender: O Male O Female

Ethnicity: _____ Town / City: _____

Who lives with the child? Select all that apply

O Biological Mom O Biological Dad O Adoptive Mom O Adoptive Dad

O Grandparent(s) O Foster Mom O Foster Dad O Uncle/ Aunt _____

O Sibling(s) _____ O Other, please specify:_____

I. Historian

I.1 What is your relationship to the child?

O Biological Parent O Adoptive Parent O Grandparent O Foster parent

O Uncle/ Aunt O Sibling O Other, please specify: _____

I.2. Your gender (please circle): O Male O Female

II. Pregnancy and Gestation History

II.1 Pregnancy history, including miscarriages and terminations

Total number of pregnancies:	
Total number of live births:	
Total number of miscarriages:	
Total number of premature births:	
Total number of terminations:	

II.2 Individual Pregnancies (Please check the row of the child scheduled for clinic)

	Age of Mom	Age of Dad	Result: Full Term, Preterm, Miscarriage, Termination	How many fetuses (single / twin/ triplet)	Abnormalities of Fetuses Y / N if yes please explain	Complications Y / N if yes please explain
☐						
☐						
☐						
☐						
☐						
☐						

II.3 Prenatal History of Affected Child

How many weeks pregnant was the mother when she found out she was pregnant? _____

Was the mother taking prenatal vitamins before she found out she was pregnant? _____

How much folate was the mother taking when she found out she was pregnant? _____

When did the mother start prenatal care? _____

Did the mother require fertility treatment for this pregnancy? _____

Was this in vitro fertilization? _____ or Other _____

What was the mother's occupation when she became pregnant? _____

Did the mother have any of the following medical conditions when she became pregnant? (Check)

☐ High-blood pressure ☐ Depression ☐ Anxiety

☐ Diabetes ☐ Bipolar Disorder ☐ Attention Deficit with or without hyperactivity

II.4 Pregnancy Environment

II.4.1 Vaccinations during pregnancy

Vaccination	Brand or serial number, if known	Age of Gestation in Weeks	Side Effects
Tetanus toxoid			
MMR			
Hepatitis A			
Hepatitis B			
Influenza			
Other:_____			

II.4.2 Supplements, Special Diets and/or Medications during pregnancy

Name	Reason for Taking	Gestation in Weeks when started	Were they taken until full term

II.4.3 Medications

Was Tylenol/Acetaminophen used during the pregnancy? ○ **Y** ○ **N**

When was it used? _____

How often was it used? _____

Where there any adverse effects? _____

Other medications taken within 6 months of conception

Name	Reason for Taking	How long taken	Did you continue taking during pregnancy

II.4.4 Other Drug Use / Exposure

Did the mother drink alcohol during the pregnancy? ○**Y** ○**N** How much? _____

Did the mother regularly use tobacco during the pregnancy? ○**Y** ○**N**

How much? _____ Type of Tobacco? _____

Did the father regularly use tobacco during the pregnancy? ○**Y** ○**N**

How much? _____ Type of Tobacco? _____

Did the mother drink caffeine during the pregnancy? ○**Y** ○**N** How much? _____

Did the mother use any recreational drugs during the pregnancy? ○**Y** ○**N**

What drug(s)? ☐Marijuana, ☐ cocaine, ☐ ecstasy, ☐ methamphetamine, ☐ crack, ☐ other: _____ How much? _____

Did the father use any recreational drugs during the pregnancy? ○**Y** ○**N**

What drug(s)? ☐Marijuana, ☐ cocaine, ☐ ecstasy, ☐ methamphetamine, ☐ crack, ☐ other: _____ How much? _____

II.4.5 Diet during pregnancy

II.4.5.1 Fish consumed during pregnancy.

Please indicate the approximate total number of times the mother ate the following groups of fish. You may check the specific fish she ate

Fish Group	Fish	Number of Total Times for all Fish
A	☐ King Mackerel, ☐ Marlin, ☐ Orange Roughy, ☐ Shark, ☐ Swordfish, ☐ Tilefish, ☐ Bigeye, and/or ☐ Ahi Tuna	
B	☐ Bluefish, ☐ Grouper, ☐ Spanish or Gulf Mackerel, ☐ Chilean Sea Bass, ☐ Canned Albacore, and/or ☐ Yellow fin Tuna	
C	☐ Striped Bass, ☐ Carp, ☐ Alaskan Cod, ☐ Halibut, ☐ Lobster, ☐ Mahi Mahi, ☐ Monkfish, ☐ Sablefish, ☐ Snapper, ☐ Canned, chunk light or Skipjack Tuna and/or ☐ Sea Trout	

II.4.5.2 Food Elimination

List all foods that were eliminated from the diet, the reason why they were eliminated, the gestation weeks at which they were eliminated and any positive or negative response to the elimination

Food	Reason Eliminated	Weeks Eliminated	Effect Observed

II.4.5.3 Special Diet

Please indicate if the mother was on any special diet during pregnancy

Diet	Reason for Starting	Weeks Diet Used	Effect Observed
☐ Gluten Free			
☐ Casein Free Diet			
☐ Feingold/Elimination Diet			
☐ Soy Free Diet			
☐ Atkins/Modified Atkins/ Ketogenic			
☐ Specific Carbohydrate Diet			
☐ Elemental Diet			
☐ Yeast Free Diet			
☐ Low Oxalate Diet			
☐ Other: _____			

II.4.5.4 Dairy

Please indicate what types of Milk products were consumed during pregnancy

Dairy Type (milk, yogurt, ice cream, etc.)	How often	Effect Observed

II.4.6 Travel History during pregnancy

Place travelled	Medications/ vaccinations needed	Gestation in weeks at that time	Illness or Side effects of medication

II.5 Pregnancy Care

Did the mother have amniocentesis? ○**Y** ○**N**

Did the mother have Chorionic villus sampling? ○**Y** ○**N**

Did the mother have ultrasounds? ○**Y** ○**N**

II.6 Pregnancy course and complications

Did the mother continue to work during pregnancy? ○**Y** ○**N**

Approximately how much weight did the mother gain during the pregnancy? _____○**lb.** ○**kg**

Morning Sickness	Never	Once / Week	Several times / week	Daily	Hospitalization
First Trimester	○	○	○	○	☐
Second Trimester	○	○	○	○	☐
Third Trimester	○	○	○	○	☐

Did the mother develop **gestational diabetes**? ○**Y** ○**N**

When was it diagnosed? _____

Was it controlled with diet? ○**Y** ○**N** If yes, specify: _____

Did the mother require insulin? ○**Y** ○**N**

Did the mother develop any of the following during pregnancy? Check all that apply

☐ Hypertension	☐ Pre-eclampsia	☐ Eclampsia
☐ HELLP syndrome	☐ Kidney disease	☐ Seizures
☐ Migraines	☐ Depression	☐ Anxiety
☐ Respiratory illness	☐ Fever	☐ Chorioamnionitis
☐ Gastrointestinal illness (constipation or diarrhea)	☐ Kidney or bladder infection/UTI	☐ Pelvic Inflammatory disease

Did the mother have any physical trauma during pregnancy? ○**Y** ○**N**

If yes, explain: _____

Did the mother have any surgery that required anesthesia, general or local? ○**Y** ○**N**

Did the mother require bed rest? ○**Y** ○**N,** Hospitalization? ○**Y** ○**N,** Cerclage? ○**Y** ○**N**

Was any medication prescribed for the above conditions? ○**Y** ○**N**

If yes, specify: _____

Where there any adverse effects? _____

Did the mother have any of the following during pregnancy?

☐ CT scan ☐ X-ray ☐ MRI

Please list all infections, including treatments and type of infection during pregnancy

Type of Infection	Medication	Dose	Duration	Symptoms

Was the fetus found to have any of the following?

☐ Oligohydramnios	☐ Brain malformation
☐ Polyhydramnios	☐ Atrial septal defect
☐ Ventriculomegally	☐ Ventricular septal defect

III. Birth History

III.1 Number of weeks gestation	
III.2 Birth Weight	
III.3 Birth Length	
III.4 Birth Head Circumference	
III.5 If Multiple, What was the order	
III.5 Days in Hospital	
III.6 What unit (NICU, stepdown, etc.)	

III.7 Delivery of the child

a. Preterm labor? ○**Y** ○**N**
b. Premature rupture of membranes? ○**Y** ○**N**
c. Delivered Vaginally? ○**Y** ○**N**
   - ○Spontaneously
   - ○Induced – Medication: _____
   - ○Assisted – Medication: _____
   - ○Rupture of membranes: _____
d. Planned Caesarian Section ○**Y** ○**N**
e. Emergency Caesarian Section ○**Y** ○**N**
f. Require Forceps ○**Y** ○**N**
g. Require Vacuum Extraction ○**Y** ○**N**
h. Cord around the child's neck: ○**Tight** ○**Loose**
i. Early Decelerations? ○**Y** ○**N**

III.8. Please check all of the following complications that apply to the delivery of the child:

☐ Drop in fetal heart rate	☐ Require Forceps
☐ Fetal Distress	☐ Require Vacuum Extraction
☐ Meconium	☐ Others, please specify:_____

III.9 Any of the below treatments needed?

	Treatment needed	How many days
☐	Required intubation (breathing tube)	
☐	Required oxygen without a breathing tube	
☐	Feeding tube needed	

III.10 Please check all of the following neonatal conditions the child had, if any, and list Duration, Age (DOL), and Treatment

Treatment	Duration, Age, Treatment		Duration, Age, Treatment
☐ Jaundice		☐ Pneumonia	
☐ Transient breathing difficulties /bronchopulmonary		☐ Chronic lung disease	
		☐ Feeding difficulties	
☐ Intraventricular hemorrhage		☐ Necrotizing enterocolitis	
☐ Periventricular leukomalacia		☐ Seizure(s)	
☐ Brain damage		☐ Patent ductusarteriosus	
☐ Congenital heart disease		☐ Other, please specify	

III.11 If your child is a male, is he circumcised? ○**Y** ○**N**
III.11.1 Were there any pain medications given? ○**Y** ○**N**
If Yes, what was given:_____
Where there any adverse effects? _____

IV. Early Life History (up to 1 year old)

IV.1 Feeding of the baby:

	Percentage of Feeds Per Day	Ages in months when fed in this manner	Brand of Bottle and/or Formula and solid food
Breast fed			
Breast Milk in Bottle			
Formula			
Solids			

IV.2 Food or Formula Allergies: _____

IV.3 Any special diet employed during infancy: _____

IV.4 Was Tylenol/Acetaminophen administered during infancy? ○**Y** ○**N**
What was it used for? _____
How often was it used? _____
Where there any adverse effects? _____

IV.5 Pacifier used? ○**Y** ○**N**
How much used during the Daytime: _____ Nighttime: _____
At what age did he/she stop using: _____

IV.6 Please indicate all places of residence with approximately when the residence was built

Type of Residence (e.g., apartment or private home)	Year Built	Zip code	Ages in months

IV.7 Mattress Brand used for child: _____

V. Developmental History

V.1 Speech Milestone:

Communication Milestones	Age at which first occurred (months)
☐ First speech like sounds	
☐ First time said "mama" or "dada"	
☐ First word besides from "mama" or "dada"	
☐ First time words used to specifically refer to something	
☐ First time put words together in a phrase	
☐ First time pointed to something he/she wanted	
☐ First time pointed to something to show interested	

V.2 Motor Milestone:

Motor Milestones	Age at which first occurred (months)
☐ Rolling over	
☐ Sitting without support	
☐ Crawling	
☐ Creeping / Cruising	
☐ Standing Independently	
☐ Walking Independently	

V.3 If your child lost skills (regressed) please fill out table below:

Skill	Age when regression occurred	Duration of Regression (how fast did it occur)	Age at which skill was regained
☐ Speech			
☐ Fine Motor Skills			
☐ Coordination			
☐ Social Interactions			
☐ Pointing			
☐ Eye Contact			

V.4 Was regression associated with any of the following factors?

	Duration	Treatment	Other Details
☐ Viral Illness			
☐ Seizure			
☐ Fever			
☐ Rash			
☐ Vaccine			

V.5 Were there multiple regressions? ○**Y** ○**N**

How many regressions occur _____

Age of first regression (in months) _____

Age of last regression (in months) _____

Trigger to regression (if any, for example sickness): _____

V.6 Any change in behavior with Fever: ○ Improved ○ Regressed ○ No Change

Fever Maximum _____

Fever Cause _____

How many days after fever started did you notice the change _____

How many days after fever stopped did the effect go away_____

V.7 Any change in behavior with Antibiotic Use: ○ Improved ○ Regressed ○ No Change

Antibiotic prescribed _____

Reason for antibiotic _____

How many days after antibiotic started did you notice the change _____

How many days after antibiotic stopped did the effect go away_____

V.8 Social Developmental Disorders

	Age Diagnosed	Who Diagnosed	Treatments	Reports Enclosed?
☐ Autistic Disorder				
☐ Pervasive developmental disorder (PDD-NOS)				
☐ Asperger Syndrome				
☐ Social Communication Disorder				
☐ Hyperlexia				
☐ Other: _____				

V.9 Development Disorders (Please list any development disorders diagnosed)

	Age Diagnosed	Who Diagnosed	Treatments	Reports Enclosed?
☐ Speech delay				
☐ Fine Motor Delay				
☐ Gross motor delay				
☐ Global Delay				
☐ Intellectual Disability				
☐ Low I.Q.				
☐ Other: _____				

V.10 Learning Disorders (Please list any learning disorders diagnosed)

	Age Diagnosed	Who Diagnosed	Treatments	Reports Enclosed?
☐ Dyslexia				
☐ Dyscalculia				
☐ Dysgraphia				
☐ AD/HD				
☐ Auditory Processing Disorder				
☐ Other: _____				

VI. Immunizations

Immunizations	At what ages immunized	Lot Number	Complications	Premedication for Vaccine
☐ Hepatitis B				
☐ Inactivated polio vaccine				
☐ MMR				
☐ Influenza				
☐ Meningococcal				
☐ Rotavirus				
☐ Diphtheria, Tetanus, Pertussis (DPT)				
☐ Pneumococcus				
☐ Varicella				
☐ Hepatitis A				
☐ BCG Vaccine				
☐ Other: _____				

VI.1 Was Tylenol administered for immunizations? ○**Y** ○**N**
What was it used prior to or after immunization? _____
Where there any adverse effects? _____

VII. Medical Disorders

VII.1 Allergic disorders and treatment

VII.1.1. Specific Disorders

Allergic disorders	Age suspected	Diagnosed by doctor	Severity	Age resolved (Cont. if still an issue)
☐ Asthma				
☐ Allergies				
☐ Allergic rhinitis				
☐ Seasonal allergies				
☐ Eczema				
☐ Other: _____				

Please list all **previous** treatments for the above disorders – those your child is no longer taking

Medication	Dose	Duration of Treatment	Side effects

VII.1.2 Food Antibodies

List foods antibodies that your child has tested positive or negative, please specify whether these were IgG or IgE antibody tests

Food	Antibody Result	IgG / IgE	Age of Test

VII.1.3 Food Allergies

List foods which your child is allergic to and the age at which the allergic reaction occurred

Food	Reaction	Age of Reaction

VII.1.4 Food Elimination

List all foods that have been ever eliminated from the diet, the reason why they were eliminated, the ages at which they were eliminated and any positive or negative response to the elimination

Food	Reason Eliminated	Ages Eliminated	Effect Observed

VII.1.5 Special Diet

Please indicate if your child has been on any special diet

Diet	Reason for Starting	Ages Diet Used	Age Diet Stopped	Effect Observed
☐ Gluten Free diet				
☐ Casein Free diet				
☐ Feingold/Elimination Diet				
☐ Soy Free Diet				
☐ Atkins/Modified Atkins/ Ketogenic				
☐ Specific Carbohydrate Diet				
☐ Elemental Diet				
☐ Yeast Free Diet				
☐ Low Oxalate Diet				
☐ Other: _____				

Would you like to have a nutritional consultation? ○**Y** ○**N**

VII.2 Neurological

VII.2.1 Neurological disorders and treatment

	Age suspected	Diagnosed by doctor	Severity	Age resolved (Cont. if still an issue)
☐ Hypotonia				
☐ Cerebral Palsy				
☐ Tremor				
☐ Ataxia / Unsteadiness				
☐ Apraxia / Poor Coordination				
☐ Hearing Problems				
☐ Vision problems				
☐ Ophthalmoplegia (Lack of eye movement)				
☐ Amblyopia				
☐ Strabismus (Crossed eyed)				
☐ Muscle Disorder / Myopathy				
☐ Chronic headaches				
☐ Epilepsy / Seizures				
☐ Migraine headaches				
☐ Tic disorders				
☐ Tourette syndrome				
☐ Other: _____				

Please list all **previous** treatments for the above disorders – those your child is no longer taking

Medication	Dose	Duration of Treatment	Side effects

VII.3 Seizures/epilepsy

Did your child have febrile seizures? ○**Y** ○**N**

At what age did seizures start? _____

What is the average duration of a seizure in the last three months? _____

Was it diagnosed as a simple febrile seizure or complex febrile seizure? _____

Did your child have non-febrile seizures? ○**Y** ○**N**

At what age did seizures start? _____

Was there as specific trigger to the first seizure? _____

What is the number of seizures per day in the last three months? _____

What is the average duration of a seizure in the last three months? _____

What is the number of seizures per day in the worst three month period? _____

What is the average duration of a seizure in the worst three months? _____

What type of seizure is typical for the child (if more than one estimate the percentage, such as 50% Grand mal and 50% Absence)?

___ Grand mal / Generalized seizures (loss of consciousness and both arms and legs synchronously repetitively jerk and/or become stiff.)

___ Partial seizures (abnormal rhythmic movements are limited to one side or one portion of the body. These seizures may or may not be associated with a change in consciousness)

___ Absence seizures (These seizures are typically associated with staring episodes in which you cannot get a person's attention by calling their name or touching them)

___ Lennox-Gastaut

___ Infantile Spasms

Have you ever been told that your child has any of the following type of subclinical seizure activity? (These are special types of epilepsy that occur in sleep and are associated with language regression).

- ☐ Landau-Kleffner syndrome
- ☐ Continuous spike and wave during slow-wave sleep
- ☐ Landau-Kleffner variant or atypical Landau-Kleffner syndrome
- ☐ Subclinical discharges on EEG

Please provide copies of reports for all EEGs and if able disc/flash drive with testing

Date of EEG	Type: Routine, Sleep deprived, prolonged	Results (normal/abnormal) EEG?	Have you sent the report?

VII.4 Infections:

	Date of First Infection	Date of most recent	How many total (approx)	Duration of medication
☐ Sore throat				
☐ Strep throat				
☐ Sinusitis / Sinus Infections				
☐ Ear infections				
☐ Other:_____				

Please list all treatments for the above diseases, including treatments for each and every infection.

Medication	Type of Infection	Dose	Duration of Treatment	Side effects

VII.5 Has your child been tested for any of the following:

Test	Abnormal Yes / No	Test results	Report enclosed?
☐ Immune deficiency			
☐ ANA (Antinuclear Antibody)			
☐ Thyroid Autoantibodies			
☐ Endothelial Autoantibodies (Connolly test)			
☐ PANDAS/PANS (Cunningham Test)			
☐ Folate Transporter Autoantibodies			
☐ Other: _____			

VII.6 Gastrointestinal symptoms

	Select the most appropriate answer for your child
Constipation	○ 5 or more stools per week ○ 3-4 stools per week ○ 0-2 stools per week
Diarrhea	○ 0-1 loose stools per day ○ 2-3 loose stools per day ○ 4 or more loose stools per day
Average Stool Consistency	○ Formed ○ Loose/unformed 3 or more days per week ○ Watery 3 or more days per week
Stool Smell	○ Normal ○ Abnormal 3 or more days per week ○ Unusually foul 3 or more days per week
Flatulence	○ Normal ○ Frequent 3 or more days per week ○ Daily
Stomach / Abdominal pain	○ None ○ Mild discomfort 3 or more times per week ○ Moderate to severe discomfort 3 or more times per week

VII.6.1 Gastrointestinal disorders:

	Age suspected	Diagnosed by doctor	Severity	Age resolved (Cont. if still an issue)
☐ Feeding problem				
☐ Vomiting				
☐ Chronic constipation				
☐ Chronic diarrhea				
☐ Gastroesophageal reflux disease				
☐ Food intolerance				
☐ Eosinophilic esophagitis				
☐ Dysbiosis / Bacterial Overgrowth				
☐ Lymphoid Nodular Hyperplasia				
☐ Celiac Disease				
☐ Enterocolitis / Inflammation				
☐ Crohn's Disease				
☐ Other: _____				

Please list all **previous** treatments for the above disorders – those your child is no longer taking

Medication	Dose	Duration of Treatment	Side effects

VII.7 Psychiatric symptoms

	Start of Symptoms	Severity	Age resolved (Cont. if still an issue)
☐ Aggressiveness towards others			
☐ Depression			
☐ Attention problems			
☐ Self-injurious behavior			
☐ Other: _____			

VII.7.1 Psychiatric disorders

	Age suspected	Diagnosed by doctor	Severity	Age resolved (Cont. if still an issue)
☐ Mood disorder (e.g. bipolar)				
☐ Depression				
☐ Obsessive compulsive disorder				
☐ Anxiety disorder				
☐ Schizophrenia				
☐ Other: _____				

Please list all **Previous** treatments for the above disorders – those your child is no longer taking

Medication	Dose	Duration of Treatment	Side effects

VII.8 Sleep disorders:

	Age suspected	Diagnosed by doctor	Severity	Age resolved (Cont. if still an issue)
☐ Insomnia				
☐ Difficulty staying asleep				
☐ Sleep apnea				
☐ Restless leg syndrome				
☐ Periodic limb movements				
☐ Narcolepsy				
☐ Sleep disordered breathing				
☐ Other: _____				

Please list all **previous** treatments for the above disorders – those your child is no longer taking

Medication	Dose	Duration of Treatment	Side effects

VII.9 Surgical procedures; Please write date (approximately):

Tonsillectomy:	Adenoidectomy:	Lumbar puncture:
Ear tube placement, how many times, L/R or both ears:		
Endoscopy, how many times:		
Upper:	Lower:	
Other, please specify:		

Please list all treatments for the above procedures

Name of anesthesia during surgery	Type and dose	Surgical Procedure	Side effects

VII.10 Genetic disorders:

Disorders	Age suspected	Diagnosed by doctor	Severity	Age resolved (Cont. if still an issue)
☐ Genetic disorder				
☐ Sickle-cell anemia				
☐ Other: _____				

VII.10.1 Genetic Testing:

Test	Age tested	Test Results
☐ SNP Microarray		
☐ Fragile X		
☐ Whole Exome Sequencing		
☐ Karyotype		
☐ Mitochondrial DNA		
☐ Mitochondrial Nuclear DNA		
☐ Other: _____		

VII.11 Other symptoms

	Start of Symptoms	Severity	Age resolved (Cont. if still an issue)
☐ Dilated pupils			
☐ Constricted pupils			
☐ Flushing or turning pale			
☐ Rapid heart rate			
☐ Easy Fatigability			
☐ Exercise Intolerance			
☐ High Pain Tolerance			
☐ Low Pain Tolerance			
☐ Heat/Cold Intolerance			
☐ Lack of sweating			
☐ Other: _____			

VII.12 Other disorders:

Disorders	Age suspected	Diagnosed by doctor	Severity	Age resolved (Cont. if still an issue)
☐ Microcephaly (Small head)				
☐ Macrocephaly (Large head)				
☐ Growth Failure / Failure to thrive				
☐ Short stature				
☐ Growth hormone deficiency				
☐ Accelerated Growth / Overgrowth				
☐ Tall stature				
☐ Overweight / Obese				
☐ Cardiovascular disease				
☐ High Blood Pressure				
☐ Congenital Heart Disease				
☐ Heart Failure				
☐ Renal / Kidney Disorder				
☐ Bladder Problems				
☐ Genital Problems				
☐ Blood or anemia problems				
☐ Mitochondrial Disorder				
☐ Metabolic Disorder				
☐ Immunological Disorder				
☐ Cerebral Folate Deficiency				
☐ Bone or joint problems				
☐ Skin conditions				
☐ Thyroid problems				
☐ Heat/Cold Intolerance				
☐ Syncope / Fainting episodes				
☐ Lack of sweating				
☐ Cancer				
☐ Diabetes				
☐ Genetic disorder				
☐ Sickle-cell anemia				
☐ Other: _____				

Please list all **previous** treatments for the above disorders – those your child is no longer taking

Medication	Dose	Duration of Treatment	Side effects

VII.13 Current Behavioral Therapies

Classroom settings/ Therapies	Start of treatment	End of Treatment	Times/days per week	Minutes per week
☐ Mainstream Classroom				
☐ Special education Classroom				
☐ Behavioral Classroom				
☐ Inclusion Classroom				
☐ Resource Classroom				
☐ Aide or paraprofessional				
☐ Accommodations				
☐ Reading or writing Assistance				
☐ Assistance in study skills				
☐ Assistance in mathematics				
☐ Assistance in social skills				

Treatment/Therapies	Start of treatment	End of Treatment	Times/days per week	Minutes per week
☐ Speech therapy				
☐ Physical therapy				
☐ Occupational therapy				
☐ Applied Behavioral Analysis (ABA)				

Other Treatments/Therapies	Start of treatment	End of Treatment	Times/days per week	Minutes per week
☐ Developmental therapy				
☐ Hippotherapy				
☐ Vision therapy				
☐ Auditory listening therapy				
☐ Sensory integration therapy				
☐ Art therapy				
☐ Other: _____				
☐ Other: _____				
☐ Other: _____				

VIII. Travel History

Travel History			
Place travelled	Medications/ vaccinations needed	Age at that time	Illness or Side effects of medication

IX. Family History

IX.1 Check all the **sleep disorders** in the child's biological family:

	Mom	Dad	Sibling	Mom's parents	Dad's parents	Mom's siblings	Dad's siblings	Maternal cousin	Paternal cousin
Insomnia	☐	☐	☐	☐	☐	☐	☐	☐	☐
Snoring	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sleep apnea	☐	☐	☐	☐	☐	☐	☐	☐	☐
Restless legs syndrome	☐	☐	☐	☐	☐	☐	☐	☐	☐
Periodic limb movement	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sleep walking / terrors / talking	☐	☐	☐	☐	☐	☐	☐	☐	☐
Narcolepsy	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐

IX.2 Check all the **developmental disorders** in the child's biological family:

	Mom	Dad	Sibling	Mom's parents	Dad's parents	Mom's siblings	Dad's siblings	Maternal cousin	Paternal cousin
Speech delay	☐	☐	☐	☐	☐	☐	☐	☐	☐
Gross motor delay	☐	☐	☐	☐	☐	☐	☐	☐	☐
Fine motor delay	☐	☐	☐	☐	☐	☐	☐	☐	☐
Global developmental delay	☐	☐	☐	☐	☐	☐	☐	☐	☐
Intellectual disability	☐	☐	☐	☐	☐	☐	☐	☐	☐
Low IQ	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐

IX.3 Check all the **social developmental disorders** in the child's biological family:

	Mom	Dad	Sibling	Mom's parents	Dad's parents	Mom's siblings	Dad's siblings	Maternal cousin	Paternal cousin
Autism	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asperger syndrome	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pervasive Developmental Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐

IX.4 Check all the **neurological disorders** in the child's biological family:

	Mom	Dad	Sibling	Mom's parents	Dad's parents	Mom's siblings	Dad's siblings	Maternal cousin	Paternal cousin
Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seizures with fever	☐	☐	☐	☐	☐	☐	☐	☐	☐
Migraine headaches	☐	☐	☐	☐	☐	☐	☐	☐	☐
Chronic headaches	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tic disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tourette syndrome	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐

IX.5 Check all the **infectious disorders** in the child's biological family:

	Mom	Dad	Sibling	Mom's parents	Dad's parents	Mom's siblings	Dad's siblings	Maternal cousin	Paternal cousin
Recurrent sore throats	☐	☐	☐	☐	☐	☐	☐	☐	☐
Recurrent strep throats	☐	☐	☐	☐	☐	☐	☐	☐	☐
Recurrent ear infections	☐	☐	☐	☐	☐	☐	☐	☐	☐
Recurrent yeast infections	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐

IX.6 Check all the **learning and attention disorders** in the child's biological family:

	Mom	Dad	Sibling	Mom's parents	Dad's parents	Mom's siblings	Dad's siblings	Maternal cousin	Paternal cousin
Learning disability	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dyslexia	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dysgraphia	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dyscalculia	☐	☐	☐	☐	☐	☐	☐	☐	☐
ADHD	☐	☐	☐	☐	☐	☐	☐	☐	☐
ADD (without hyperactivity)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐	☐	☐	☐	☐	☐

IX.7 Check all the **gastro-intestinal disorders** in the child's biological family:

	Mom	Dad	Sibling	Mom's parents	Dad's parents	Mom's siblings	Dad's siblings	Maternal cousin	Paternal cousin
Chronic diarrhea	☐	☐	☐	☐	☐	☐	☐	☐	☐
Chronic constipation	☐	☐	☐	☐	☐	☐	☐	☐	☐
Gastro-esophageal reflux (GERD)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Food intolerance	☐	☐	☐	☐	☐	☐	☐	☐	☐
Irritable bowel syndrome	☐	☐	☐	☐	☐	☐	☐	☐	☐
Inflammatory bowel disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Celiac disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Crohn's disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ulcerative colitis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐

IX.8 Check all the **psychiatric disorders** in the child's biological family:

	Mom	Dad	Sibling	Mom's parents	Dad's parents	Mom's siblings	Dad's siblings	Maternal cousin	Paternal cousin
Mood disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bipolar disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐
Aggressive / self-injurious behavior	☐	☐	☐	☐	☐	☐	☐	☐	☐
Obsessive compulsive disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐
Suicides/Attempts	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐

IX.9 Check all the **other** disorders in the child's biological family:

	Mom	Dad	Sibling	Mom's parents	Dad's parents	Mom's siblings	Dad's siblings	Maternal cousin	Paternal cousin
Chronic abdominal pain	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐
Genetic disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sickle-cell anemia	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding or blood disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐