INTEGRATED HEALTHCARE OF GEORGIA

John C. Thomas, DC, DAAIM, CNS, CFMP

Improving Lives through Neurological & Nutritional Therapies

Thank you for choosing our office and allowing us to help you in this time of need. We help sick people get healthy and healthy people stay that way. Our purpose is to help as many people as possible and it is an honor each time we are asked to improve a person's health and we take our role as your healthcare provider very seriously. Our patients' confidence in us drives our commitment to provide the highest quality care possible to them and their families.

We have helped many types of patients with many different symptoms and levels of health. We help our patients to find answers to their health problems and if you are accepted as a patient, we hope to do the same for you. The process of identifying the exact, correct underlying CAUSE of your problems requires a great deal of information and testing.

That process begins with filling out our New Patient Application. **Please take your time and fill this form out completely and thoughtfully**. The doctor will meet with you to discuss your condition and do an examination. Based on what the doctor learns, special advanced neurological and metabolic tests may be ordered. If directed by the doctor your visit may end with some therapy to help provide you some temporary relief and determine if you are a candidate for care. The doctor will review the information learned from the consultation, examination and prior testing to determine if you are accepted into our office. Everything will be explained to you on at your visit.

We do not accept all cases. If we feel we can help you, we will explain your treatment options. If we feel we cannot, we will help you find someone who can. Again, we look forward to serving you. If you have any questions, please do not hesitate to ask.

IMPORTANT!

Please have the New Patient Application Form completed <u>BEFORE</u> your initial visit. If possible, please submit all paperwork and previous lab testing (past 6-12 months) prior to your initial visit. This allows the doctor to familiarize themselves with your case and do any needed research before your visit. Please submit via:

1) Fax: (678) 456-9125
2) Email: info@ihcog.com
3) Mail (if there is sufficient time):

Integrated Healthcare of Georgia
2230 Towne Lake Parkway, Building 1000-120, Woodstock, Georgia 30189

Confiming Your Appointment

We will call you to confirm your appointment one business day prior to the appointment. If we fail to reach you, please leave a message at (678) 324-6963 or email us confirming the appointment at **info@ihcog.com.** Your initial visit will take about an hour. Please arrive a little early, as our schedule often won't allow us to start an appointment late.

If you would like your appointment to be moved to an earlier date, let us know and we will call you if there is an opening.

A Note from Dr. Thomas.

We understand the cause of ADHD at the cellular level. The prefrontal lobe of the brain, right behind the forehead is the part of the brain that controls higher, more sophisticated thought processes. This is the part of the brain that makes man such a unique species. Relating the past and the future, planning, making choices, and controlling emotions are some of the functions of the frontal lobe. Weak neuronal transmissions in this critical part of the brain are the cause of ADHD and ADD. Impulsivity, difficulty with planning, poor working memory, inadequate problem solving skills, and hyperactivity can now be positively and dramatically influenced by brain exercises. Every day experiences and challenges can be turned into mental exercises by parents who have acquired the skills to implement a training program for their children; teaching these exercises in one of our main focuses. ADHD is a conduction deficit at the neuronal synapse (a synapse is a microscopic space between two neurons critical to nerve conduction and transmission of information). If the conduction of an inhibitory impulse is weak, when the child has an urge to dart into the street, wander away from mother, or to hit someone, he/she will do so without ever going through the inhibitory steps of considering the consequences. If the conduction is a stimulatory impulse and it is weak, the child (or adult) will show signs of inattention, forgetfulness, and an inability to focus. All mental activities need either neural stimulation or inhibition.[1]

Left Brain Skills	**Right Brain Skills**
Think of the Left Brain as a Gas Pedal	*Think of the Right Brain as a Brake Pedal*
Starts Things	Stops Things
Starts Movement	Stops Movement
Starts Thoughts	Stops Thoughts
Small Movements	Big Movements
Small Details	Big Picture
Early Academics	Social Learning
Rote Memorization	Reading and Math Comprehension
Verbal Communication	Non-Verbal Communication
Generates Approach Response	Generates Withdrawal Response
Likes Routine	Stimulated by Something New
Stimulated by High Frequency (Video Games/TV/Computers)	Stimulated by Low Frequency (Nature Sounds)

Children suffering from AD-HD, hyperactivity, and Autism Spectrum Disorders show a decreased frequency of firing of the right brain. This decreased FOF is called a "Functional Disconnection Syndrome (FDC)". For example, if a child has FDS of the right brain, the child will lose his "brake pedal" and have an inability to: stop thought processes and movement, to have proper social etiquette, to comprehend math and reading, and to have and interpret non-verbal communication accurately. Conversely, a FDS of the right brain also means the child's left brain is over-stimulated. This means his "gas pedal" is pushed to the floor. This leads to an uncontrolled ability to start things such as movement and thought processes. They have fine motor skills and rote memorization. They like routine, and do not like change. They are stimulated by high frequency activities such as watching TV, playing video games, and flashing lights.

Brain-Based Therapy for children suffering from ADHD, ASD, and hyperactivity is typically geared towards increasing the frequency of firing of the right brain's function through multiple modalities such as nutritional counseling, nutraceutical support, olfactory stimulation, visual stimulation, gross motor and postural correction, and Neurofeedback therapy.

What is Neurofeedback Therapy?

Think of your brain as a race car, capable of incredible performance. Now imagine a driver behind the wheel who does not know how to properly shift gears. It is for this reason that people find their brain encumbered by problems. Brainwave training teaches the brain to work at its fullest capacity, to switch gears as needed for the tasks at hand. Neurofeedback, aka Neurotherapy, provides a unique drugless approach to treating Neurological Dysregulation Syndrome (NDS) that may be associated with the symptoms of many neurological based conditions including ADD/ADHD, Headaches, Migraines, Learning Disorders, Memory Loss Associated with Aging, Overeating or Binge Eating, Fibromyalgia, Chronic Fatigue Syndrome, Panic/Anxiety Disorders, and Insomnia, just to name a few. NDS is a condition that results from tension on the nervous system caused by subluxation, poor nutrition, stress, drugs or trauma. Neurofeedback is a painless brain retraining process that uses sophisticated technology to achieve significant, measurable results and provide relief of conditions associated with NSD. Neurofeedback permanently alters the active landscape of the brain, enabling children with developmental disorders to think, feel and respond differently because they are using their brain in a more effective manner.

Services We May Recommend

Neurofeedback Therapy
Audio / Visual Entrainment
Hyperbaric Oxygen Therapy
Exercise with Oxygen Therapy
Brain Based Therapies
Olfactory Stimulation
Visual Stimulation
Auditory Stimulation
Cerebellum / Balancing Exercises
Vestibular Stimulation
Gross Motor and Postural Exercises
Interactive Metronome
Nutritional Counseling
Food Sensitivity Testing
Advanced Metabolic Testing
Nutraceutical / Supplement Support
Amino Acid Therapy

We look forward to meeting with you and answering any questions you may have regarding the health of your child.

Yours in health,

Dr. John C. Thomas
Doctor of Chiropractic
Doctor of Pastoral Medicine
Diplomate, Board Certified Integrative Medicine
Certified Nutrition Specialist
Certified Functional Medicine Practitioner
Gluten Practitioner

Integrated Healthcare of Georgia
John C. Thomas, DC, DPSc, DAAIM, CNS, CFMP

Before Receiving Consultation or Treatment In Our Office
Please Review These Principles Outlined Below

1. Dr. John C. Thomas' goal is to provide you with adjunctive and supportive care for your health condition. We do not claim to treat or cure any disease or medical diagnosis.

2. Our office offers some services that are not covered by insurance. These services are considered experimental and may not be billed to your insurance. Dr. John C. Thomas will review all services that are considered covered services and those that are not.

3. Nutritional support may be offered for your case. Nutritional supplements are not FDA regulated and have not been proven to cure or treat any disease or illness. If Dr. John C. Thomas recommends supplementation in your case you may use the products we have in our office or you may purchase your supplementation elsewhere.

4. Our services are not a replacement for your medical treatment. We choose to work alongside your medical provider as this serves you in the most effective manner possible.

5. Dr. John C. Thomas will never give advice on the use of your medications. Medications must be managed by your medical doctor. You must work with a medical doctor for the management of any medications you take now or in the future.

6. I completely understand that there are no guarantees of help, correction, relief, or cure, written, spoken, or implied. I understand that this clinic does NOT treat any disease or any medical diagnosis.

7. I am making a sane and conscious decision to seek advice as per the above understood terms for either myself and/or my dependents. In doing so, I agree to the above terms and acknowledge this with my signature below.

Patient Signature: _____ Date: _____

Pediatric Patient Application

Today's Date: _____

Please Print Clearly. Please complete ALL information on this form.

PERSONAL INFORMATION

First Name:_____ **Middle Initial:** _____ **Last Name:** _____

Called (Nick) Name:_____ **Age:** _____ **Birth Date:**_____ **Gender:** ☐ **M** ☐ **F**

Home Address: _____ **City:** _____

State:_____ **Zip:**_____ **Email:**_____ **May we send you our online newsletters?** ☐ Y ☐ N

Home Phone:_____ **Cell Phone:**_____ **Work Phone:** _____

Parents or Legal Guardian's Name:_____

Marital Status: ☐ S ☐ M ☐ W ☐ D **# of Children:** _____ **Spouse's Name:** _____

Emergency Contact:_____**Phone:**_____

Primary Physician:_____ **Phone :**_____

How did you hear about us? ☐ Internet ☐ Insurance Plan ☐ Doctor ☐ Drove By ☐ Advertisement in _____

☐ Family _____ ☐ Friend _____ ☐ Co-Worker _____

HEALTH HISTORY

Please list your child's 5 major health concerns in order of importance:

Health Concern Description	Approx. Date Began	Complications or Comments	Getting Worse?

List any major illnesses, injuries, and/or surgeries with approximate dates:

Illness, Injury, Surgery Description	Approx. Date Began	Complications or Comments	Full Recovery?

Any Doctor Visits within: ☐ 12 Months; For:_____☐ *I deny any doctor visits*

Office Use Only

_____

_____

_____

_____

_____

List the main health complaints you have in order of their importance:

1. Description of your <u>MAIN or WORST</u> health problem: _____

_____

When did your complaint begin?_____ The condition is: ☐ New ☐ Recurring ☐ Exacerbation ☐ Chronic

Describe how your complaint began? _____

How often do you experience your complaint?

☐ Constant (76-100% of day) ☐ Frequent (51-75% of day) ☐ Occasional (24-50% of day) ☐ Intermittent (0-25% of day)

Is your complaint changing? ☐ Getting Better ☐ Getting Worse ☐ Not Changing

Complaint feels <u>better with</u>: ☐ Activity ☐ Bending ☐ Cold / Heat ☐ Massage ☐ Movement ☐ OTC Meds
☐ Rx Meds ☐ Rest ☐ Stretching ☐ Sitting ☐ Standing ☐ Twisting ☐ Walking ☐ Nothing Helps

Is your complaint worse in the: ☐ Morning ☐ Afternoon ☐ Night ☐ With Activity ☐ All the time ☐ Unpredictable

Complaint feels <u>worse with</u>: ☐ Standing ☐ Sitting ☐ Cold / Heat ☐ Lifting ☐ Movement ☐ Pushing
☐ Pulling ☐ Rest ☐ Stretching ☐ Lying ☐ Twisting ☐ Walking ☐ Bending

Does your complaint interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ No Other:_____

What activities do you enjoy, but do poorly or not at all due to your complaint? _____

Who have you seen for your current complaint? ☐ Nobody ☐ Medical Doctor ☐ Osteopath ☐ Physical Therapist

☐ Other Chiropractor ☐ Other _____ ☐ Treatment: _____

What have you done to control your symptoms:_____

Have you had a similar complaint in the past? ☐ No ☐Yes (How many times?) _____

What are your expectations/goals from care in our office?_____

Please rate the intensity of your symptoms on a scale of 0-10 (0 being no symptoms, 10 being extreme) _____ Current ____ Avg

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2. Description of your <u>SECOND WORST</u> health problem: _____

_____

When did your complaint begin?_____ The condition is: ☐ New ☐ Recurring ☐ Exacerbation ☐ Chronic

Describe how your complaint began? _____

How often do you experience your complaint?

☐ Constant (76-100% of day) ☐ Frequent (51-75% of day) ☐ Occasional (24-50% of day) ☐ Intermittent (0-25% of day)

Is your complaint changing? ☐ Getting Better ☐ Getting Worse ☐ Not Changing

Complaint feels <u>better with</u>: ☐ Activity ☐ Bending ☐ Cold / Heat ☐ Massage ☐ Movement ☐ OTC Meds
☐ Rx Meds ☐ Rest ☐ Stretching ☐ Sitting ☐ Standing ☐ Twisting ☐ Walking ☐ Nothing Helps

Is your complaint worse in the: ☐ Morning ☐ Afternoon ☐ Night ☐ With Activity ☐ All the time ☐ Unpredictable

Complaint feels <u>worse with</u>: ☐ Standing ☐ Sitting ☐ Cold / Heat ☐ Lifting ☐ Movement ☐ Pushing
☐ Pulling ☐ Rest ☐ Stretching ☐ Lying ☐ Twisting ☐ Walking ☐ Bending

Does your complaint interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ No Other:_____

What activities do you enjoy, but do poorly or not at all due to your complaint? _____

Who have you seen for your current complaint? ☐ Nobody ☐ Medical Doctor ☐ Osteopath ☐ Physical Therapist

☐ Other Chiropractor ☐ Other _____ ☐ Treatment: _____

What have you done to control your symptoms:_____

Have you had a similar complaint in the past? ☐ No ☐Yes (How many times?) _____

Please rate the intensity of your symptoms on a scale of 0-10 (0 being no symptoms, 10 being extreme) _____ Current ____ Avg

3. Description of your THIRD WORST health problem: _____

_____

When did your complaint begin?_____ **The condition is:** ☐ New ☐ Recurring ☐ Exacerbation ☐ Chronic

Describe how your complaint began? _____

How often do you experience your complaint?

☐ Constant (76-100% of day) ☐ Frequent (51-75% of day) ☐ Occasional (24-50% of day) ☐ Intermittent (0-25% of day)

Is your complaint changing? ☐ Getting Better ☐ Getting Worse ☐ Not Changing

Complaint feels better with: ☐ Activity ☐ Bending ☐ Cold / Heat ☐ Massage ☐ Movement ☐ OTC Meds
☐ Rx Meds ☐ Rest ☐ Stretching ☐ Sitting ☐ Standing ☐ Twisting ☐ Walking ☐ Nothing Helps

Is your complaint worse in the: ☐ Morning ☐ Afternoon ☐ Night ☐ With Activity ☐ All the time ☐ Unpredictable

Complaint feels worse with: ☐ Standing ☐ Sitting ☐ Cold / Heat ☐ Lifting ☐ Movement ☐ Pushing
☐ Pulling ☐ Rest ☐ Stretching ☐ Lying ☐ Twisting ☐ Walking ☐ Bending

Does your complaint interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ No Other:_____

What activities do you enjoy, but do poorly or not at all due to your complaint? _____

Who have you seen for your current complaint? ☐ Nobody ☐ Medical Doctor ☐ Osteopath ☐ Physical Therapist

☐ Other Chiropractor ☐ Other _____ ☐ Treatment: _____

What have you done to control your symptoms:_____

Have you had a similar complaint in the past? ☐ No ☐Yes (How many times?) _____

Please rate the intensity of your symptoms on a scale of 0-10 (0 being no symptoms, 10 being extreme) _____ Current ____ Avg

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4. Description of your FOURTH WORST health problem: _____

_____

When did your complaint begin?_____ **The condition is:** ☐ New ☐ Recurring ☐ Exacerbation ☐ Chronic

Describe how your complaint began? _____

How often do you experience your complaint?

☐ Constant (76-100% of day) ☐ Frequent (51-75% of day) ☐ Occasional (24-50% of day) ☐ Intermittent (0-25% of day)

Is your complaint changing? ☐ Getting Better ☐ Getting Worse ☐ Not Changing

Complaint feels better with: ☐ Activity ☐ Bending ☐ Cold / Heat ☐ Massage ☐ Movement ☐ OTC Meds
☐ Rx Meds ☐ Rest ☐ Stretching ☐ Sitting ☐ Standing ☐ Twisting ☐ Walking ☐ Nothing Helps

Is your complaint worse in the: ☐ Morning ☐ Afternoon ☐ Night ☐ With Activity ☐ All the time ☐ Unpredictable

Complaint feels worse with: ☐ Standing ☐ Sitting ☐ Cold / Heat ☐ Lifting ☐ Movement ☐ Pushing
☐ Pulling ☐ Rest ☐ Stretching ☐ Lying ☐ Twisting ☐ Walking ☐ Bending

Does your complaint interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ No Other:_____

What activities do you enjoy, but do poorly or not at all due to your complaint? _____

Who have you seen for your current complaint? ☐ Nobody ☐ Medical Doctor ☐ Osteopath ☐ Physical Therapist

☐ Other Chiropractor ☐ Other _____ ☐ Treatment: _____

What have you done to control your symptoms:_____

Have you had a similar complaint in the past? ☐ No ☐Yes (How many times?) _____

Please rate the intensity of your symptoms on a scale of 0-10 (0 being no symptoms, 10 being extreme) _____ Current ____ Avg

Office Use Only

_____

_____

SPECIFIC GOALS DESIRED

Improve: _____

Behaviors you do not want to see anymore: _____

_____

GENERAL HEALTH QUESTIONS (*Please answer the following questions?)*

What is your child's present weight? _____ What is your child's ideal weight? _____

Does your child have problems with recurring headaches? ☐ No ☐Yes

Does your child experience pain or stiffness? ☐ Neck ☐Upper back ☐ Low back ☐ Shoulders ☐ Hips ☐ Other _____

Does your child experience fatigue and loss of energy? ☐ No ☐Yes What time(s) of the day are they most tired? _____

Does your child have trouble getting to sleep? ☐ No ☐Yes Does your child feel groggy and not rested in the morning? ☐ No ☐Yes

Does your child wake in the night and have trouble getting back to sleep? ☐ No ☐Yes

How many times do you wake up in the night?_____ Does your child wake up at night laughing or gigging? ☐ No ☐Yes

What time does your child usually go to sleep? _____ Number of hours of sleep per night? _____

Does pain (ie stomach) wake your child up at night? ☐ No ☐Yes Does your child have irritability or mood swings? ☐ No ☐Yes

Does your child experience: ☐ Depression ☐ Worry ☐ Lack of Concentration ☐ Memory Problems
☐ Anxiety ☐ Panic Attacks ☐ Other _____

Does your child have or experience? ☐ digestive gas ☐ bloating ☐ constipation ☐ diarrhea ☐ reflux ☐ heartburn

Has your child had a change in bowel or bladder habits? ☐ No ☐ Yes Does your child have loose stools? ☐ No ☐Yes

Number of bowel movements: ☐ More than 1/day ☐ 1/day ☐ Every 2 days ☐ 3/week ☐ 2/ week ☐ 1/ week ☐ Other _____

Does your child apply pressure to their stomach? ☐ No ☐Yes Does your child have dark circles under their eyes? ☐ No ☐Yes

Are your child's behavioral symptoms worse during weather changes: ☐ Damp ☐Hot ☐ Misty ☐Moldy ☐ Other _____

Does your child have allergy or sinus problems? ☐ No ☐Yes List any food / substances you are sensitive or allergic to: _____

_____

Has your child had a sore that does not heal? ☐ No ☐Yes Do you have a nagging cough or hoarseness? ☐ No ☐Yes

STRESS or MAJOR LIFE CHANGES: (divorce, losses, trauma, school, relocation, major life problems, etc.)

_____

_____

Blood Sugar Levels (if checked)

The HIGHEST your blood sugar gets: WITH medication _____ WITHOUT medication _____

The LOWEST your blood sugar gets: WITH medication _____ WITHOUT medication _____

FAMILY HISTORY

Father: Age:_____ or Age at Death:_____ Cause of Death:_____ Significant Illness:_____

Mother: Age:_____ or Age at Death:_____ Cause of Death:_____ Significant Illness:_____

Are there any diseases or conditions common among your family members? ☐ No ☐ Yes, which relative and what type of condition?

☐ Cancer ☐ Diabetes ☐ Heart ☐ Auto-immune ☐ Other _____

Have any other family members been diagnosed with Autism Spectrum Disorders, ADHD, ADD, or Dyslexia? ☐ No ☐ Yes

Which relative and what type of condition? _____

Any household pets or other animals family members are in close contact with? _____

Do pets have health conditions of any kind? ☐ No ☐ Yes What kind? _____ How many? _____

MOTHER'S HEALTH DURING PREGNANCY

Was mother overweight? ☐ No ☐ Yes If Yes, weight: _____

Was mother sick? ☐ No ☐ Yes If Yes, name of illness: _____

How many births has the mother had? _____ How many miscarriages? _____

Did mother use fertility drugs? ☐ No ☐ Yes

What is the general health of the siblings? _____

What maternal stressors were present during the pregnancy? Divorce? ☐ No ☐ Yes Job Loss? ☐ No ☐ Yes

Car Accident? ☐ No ☐ Yes Physical Trauma? ☐ No ☐ Yes Death in the Family? ☐ No ☐ Yes

If yes to any of the above, please explain: _____

_____

Known infections mother had during pregnancy? ☐ Yeast ☐ Bacterial ☐ Viral ☐ Other _____

Did mother drink alcohol during pregnancy? ☐ No ☐ Yes Smoke? ☐ No ☐ Yes Vomitting? ☐ No ☐ Yes

Drink Coffee? ☐ No ☐ Yes Have excessive bleeding? ☐ No ☐ Yes Take Medication? ☐ No ☐ Yes

BIRTHING PROCESS

What type of delivery? ☐ Natural/Vaginal ☐ C-section Was delivery induced? ☐ No ☐ Yes Epidural? ☐ No ☐ Yes

Any birth trauma? ☐ No ☐ Yes If yes, please explain: _____

APGAR Score: At one minute: _____ At five minutes: _____

INFANT TOXIC EXPOSURE

To your knowledge, have you ever had long-term exposure to chemicals, pesticides, herbicides, radiation, or heavy metals?

☐ No ☐Yes, explain _____

Mold in house? ☐ No ☐ Yes Other? ☐ No ☐ Yes _____

INFECTIONS

Name all infections in the first two years of the child's life?

_____ Age of Onset? _____ / _____ Age of Onset? _____

_____ Age of Onset? _____ / _____ Age of Onset? _____

_____ Age of Onset? _____ / _____ Age of Onset? _____

Antibiotics: # of antibiotic prescribed or taken in past year: _____ Avg. # prescribed or taken per year for past 5 years: _____

Is your child on antibiotics now? ☐ No ☐ Yes At what age did your child first start antibiotics? _____ , for what? _____

VACCINES

Did your child receive the full vaccination schedule? ☐ No ☐ Yes If no, please list those that were received? _____

_____

In response to vaccinations:

Did your child have Seizures? ☐ No ☐ Yes When did the seizures start? _____ How long did they last? _____

Did your child have Bowel Symptoms? ☐ No ☐ Yes If yes, explain: _____

Was there swelling at the injection site? ☐ No ☐ Yes Was there a Fever? ☐ No ☐

HEALTH HISTORY (*Please check the correct box for each item below. Check at least one box for each sign or symptom listed)*

Childhood Illness: ☐ ADD ☐ Bed Wetting ☐ Diabetes ☐ Food Allergies ☐ Measles ☐ Seizure Disorder
☐ *I deny any childhood illnesses* ☐ Allergies ☐ Hay fever ☐ Cerebral Palsy ☐ Ear Infections ☐ Headaches ☐ Mumps
☐ Sickle Cell ☐ Asthma ☐ Chicken Pox ☐ Fetal Drug Exposure ☐ Hepatitis ☐ Rash
☐ Spina Bifida ☐ Eczema ☐ Depression ☐ HIV ☐ Scoliosis ☐ Other

Any Injuries: ☐ Broken Bones ☐ Head Injury ☐ Soft Tissue Injury ☐ Motor Vehicle Accident
☐ *I deny any injuries* ☐ Back Injury ☐ Disc Injury ☐ Joint Injury ☐ Severe Fall
☐ Severe Laceration _____

MOTOR DEVELOPMENT

Child's age when first held head up? _____ Rolled Over? _____ Sat Up? _____ Crawled? _____ Walked? _____

Did child display any "cute" or out of the ordinary behavior when learning to crawl of walk? ☐ No ☐ Yes

If yes, please explain: _____

Age potty trained: _____ Age stopped wetting bed: _____ Age of first words (ie "mamma", "dada") _____

Age child first spoke 2-3 word together: _____

Has your child lost language? ☐ No ☐ Yes If yes, at what age and how far did they regress? _____

How many words was your child using in a sentence before regression? _____

Has your child lose eye contact? ☐ No ☐ Yes If yes, at what age? _____

DRUGS, MEDICATIONS, SUPPLEMENTS (*Please list current medications and supplements being taken, include over the counter medication)*

Medications: ☐ None ☐ Allergies ☐ Anti-Depressants ☐ Blood Pressure ☐ Insulin ☐ Muscle Relaxers
☐ Nerve Pills ☐ Pain Killers ☐ Cholesterol ☐ Other: _____

Drug/Supplement Name	Taken for What or Condition?	Taken How Often?	Aprox. Start Date	Results/Side effects experiencing?

SOCIAL HISTORY & DIET

Does your child have any food sensitivities or allergies? If yes , please list: _____

_____

List your child's 4 healthiest foods eaten during the average week.

_____ _____

_____ _____

List your child's 4 unhealthiest foods eaten during the average week.

_____ _____

_____ _____

List the top 4 foods your child craves regularly.

_____ _____

_____ _____

Does your child refuse to eat certain foods? ☐ No ☐Yes Which foods? _____

Does your child crave or eat salty foods? ☐ No ☐ Yes

How many meals does your child typically eat per day**?** **_____** if not 3 meals per day, which meals do you skip most often? _____

How often does your child eat out? ☐ None ☐ _____ times per: ☐ Day ☐ Week ☐ Month Where? _____

Do you find it difficult to have your child on a special diet? ☐ No ☐ Yes

How long did mother breastfeed? ☐ Never ☐ Months _____

Age child started bottle feeding: _____ Formula? ☐ No ☐ Yes -- ☐ Soy Based ☐ Casein (dairy) based? ☐ Rice based?

Age cow's milk was introduced: _____ Age wheat and grains were introduced: _____

Exercise: ☐ None ☐ Occasional ☐ Regular ☐ Frequent / Heavy What kind:_____

Substance Usage:

Caffeine: ☐ None ☐ Sodas (☐ regular ☐ diet) _____ glasses per: ☐ Day ☐ Week ☐ Month
☐ Coffee ____ cups per: ☐ Day ☐ Week ☐ Month (☐ Sugar ☐ milk ☐ non-dairy creamer)
☐ Tea (☐ sweet ☐ unsweet) _____ glasses per: ☐ Day ☐ Week ☐ Month
☐ Energy Drinks _____ per: ☐ Day ☐ Week ☐ Month

Sweets: ☐ None ☐ Chocolate / Candy _____ times per: ☐ Day ☐ Week ☐ Month

Fruit Juices: ☐ None ☐ _____ times per: ☐ Day ☐ Week ☐ Month

Milk / Dairy: ☐ None ☐ _____ times per: ☐ Day ☐ Week ☐ Month

Cheese: ☐ None ☐ _____ times per: ☐ Day ☐ Week ☐ Month ``

Wheat Products: ☐ None ☐ _____ times per: ☐ Day ☐ Week ☐ Month (include bread, bagels, pasta, etc.)

Other Grains: ☐ None ☐ _____ times per: ☐ Day ☐ Week ☐ Month (rice, oats, corn, quinoa, etc.)

Fast Food: ☐ None ☐ _____ times per: ☐ Day ☐ Week ☐ Month

Meat: ☐ None ☐ _____ times per: ☐ Day ☐ Week ☐ Month **What type?** _____

Vegetables: ☐ None ☐ _____ times per: ☐ Day ☐ Week ☐ Month **What type?** _____

How Much Water Does Your Child Drink (8 oz. glasses / day): ☐ None ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10-12 ☐ 13-15 ☐ 16+

Hobbies Your Child Enjoys: _____

_____

Hobbies / Activities that are limited or prevented by your childs current health condition? _____

_____

DIET (*Please fill out your diet for the 3 day, - food and beverage. Please be as detailed as possible.. Identify brands and how it was made. PLEASE BE HONEST.)*

DAY 1

BREAKFAST (Time eaten: _____) _____

_____

LUNCH (Time eaten: _____) _____

_____

DINNER (Time eaten: _____) _____

_____

SNACK (Time eaten: _____) _____

_____

SNACK (Time eaten: _____) _____

_____

DAY 2

BREAKFAST (Time eaten: _____) _____

_____

LUNCH (Time eaten: _____) _____

_____

DINNER (Time eaten: _____) _____

_____

SNACK (Time eaten: _____) _____

_____

SNACK (Time eaten: _____) _____

_____

DAY 3

BREAKFAST (Time eaten: _____) _____

_____

LUNCH (Time eaten: _____) _____

_____

DINNER (Time eaten: _____) _____

_____

SNACK (Time eaten: _____) _____

_____

SNACK (Time eaten: _____) _____

_____

Was the past 3 days of food your typical dietary intake? ☐ No ☐Yes if No explain _____

_____

DENTAL WORK *(Please indicate how many of the following your child has:)*

☐ Silver Fillings _____ ☐ Gold Crowns or inlays _____ ☐ Root Canals _____ ☐ Braces ☐ Bleeding Gums

☐ Composites (tooth-colored) _____ ☐ Stainless steel crowns or inlays _____ ☐ Root Canals with EndoCal _____

☐ Extractions _____ ☐ Porcelain crowns or inlays _____ ☐ Posts _____ ☐ Sensitive Teeth _____

☐ Bridgework _____ ☐ DeGussa Porcelain crowns or inlays _____ ☐ Implants _____ ☐ Bad Bite _____

☐ Partial or Full Dentures _____ ☐ Veneers _____ ☐ Temporaries _____ ☐ New Cavities _____

Has your child had any teeth extracted? (wisdom teeth, four bicuspid extraction, etc?) ☐ No ☐Yes _____

Has your child had dental surgery? (gum surgery, jaw surgery, etc?) ☐ No ☐Yes_____

Does your child need further dental work? ☐ No ☐Yes, if so what?_____

REVIEW OF SYSTEMS *(Please mark ALL boxes that apply.)*

Constitutional: ☐ Chills ☐ Night Sweats ☐ Weight Gain ☐ Weight Loss ☐ Fatigue ☐ Fever ☐ Daytime Drowsiness
☐ *I deny any constitutional issues*

Eye/Vision: ☐ Blindness ☐ Double Vision ☐ Eye Pain ☐ Photophobia ☐ Tearing ☐ Blurry Vision ☐ Cataracts
☐ *I deny any eye/vision issues* ☐ Change in Vision ☐ Glaucoma ☐ Field Cuts ☐ Itchy Eyes ☐ Wear Glasses / Contacts

Ears, Nose and Throat: ☐ Bleeding ☐ Fainting ☐ Nasal Congestion ☐ Ear Drainage ☐ Post Nasal Drip ☐ Runny Nose
☐ Discharge ☐ Headaches ☐ Sinus Infections ☐ Ear Infections ☐ Hoarseness ☐ TMJ Problems
☐ *I deny any E/N/T issues* ☐ Dizziness ☐ Smell Loss ☐ Dental Implants ☐ Hearing Loss ☐ Ear Pain ☐ Snoring
☐ Sore Throats (frequent) ☐ Tinnitus (ringing in ears) ☐ Difficulty Swallowing

Respiration: ☐ Asthma ☐ Coughing up blood ☐ Sputum production ☐ Cough ☐ Shortness of breath ☐ Wheezing
☐ *I deny any respiratory issues*

Cardiovascular: ☐ Angina (chest pain or discomfort) ☐ Heart Murmur ☐ Palpitations (irregular or forceful heart beats)
☐ *I deny any cardiovascular issues* ☐ Claudication (leg pain/achiness) ☐ Heart Problems ☐ Paroxysmal Nocturnal Breathing (waking at night with shortness of breath)
☐ Swelling of legs ☐ Ulcers
☐ Varicose Veins ☐ Orthopnea (difficulty breathing while lying down)

Gastrointestinal: ☐ Abdominal Pain ☐ Belching ☐ Indigestion ☐ Difficulty Swallowing ☐ Vomiting Blood
☐ *I deny any gastrointestinal issues* ☐ Rectal Bleeding ☐ Diarrhea ☐ Jaundice ☐ Abnormal Stool Caliber (quality)
☐ Black/Tarry Stools ☐ Heartburn ☐ Nausea ☐ Abnormal Stool Color
☐ Constipation ☐ Hemorrhoids ☐ Vomiting ☐ Abnormal Stool Consistency

Female: ☐ Birth Control Therapy ☐ Cramps ☐ Irregular Menstruation ☐ Vaginal Discharge
☐ *I deny any female issues* ☐ Breast Lump/Pain ☐ Frequent Urination ☐ Urine Retention
☐ Burning Urination ☐ Hormone Therapy ☐ Vaginal Bleeding

Male: ☐ Burning Urination ☐ Frequent Urination ☐ Erectile Dysfunction
☐ *I deny any male issues* ☐ Prostate Problems ☐ Urination Retention ☐ Hesitancy/Dribbling

Endocrine: ☐ Cold Intolerance ☐ Excessive Appetite ☐ Excessive Thirst ☐ Goiter ☐ Hair Loss
☐ *I deny any endocrine issues* ☐ Voice Change ☐ Excessive Hunger ☐ Frequent Urination ☐ Heat Intolerance ☐ Diabetes
☐ Unusual Hair Growth

Skin: ☐ Nail Texture Changes ☐ Hair Loss ☐ Itching ☐ Varicosities ☐ Skin Color Changes
☐ *I deny any skin issues* ☐ Hair Growth ☐ Hives ☐ Rash ☐ Skin Lesions/Ulcers ☐ History of Skin Disorders
☐ Paresthesia (numbing/prickling/tingling)

Nervous System: ☐ Dizziness ☐ Limb Weakness ☐ Numbness ☐ Sleep Disturbance ☐ Tremors
☐ *I deny any nervous system issues* ☐ Facial Weakness ☐ Loss of Consciousness ☐ Seizures ☐ Strokes
☐ Headaches ☐ Loss of Memory ☐ Stress ☐ Unsteadiness of Gait

Psychological: ☐ Anxiety ☐ Depression ☐ Mood Changes ☐ Convulsions ☐ Appetite Changes
☐ *I deny any psychological issues* ☐ Insomnia ☐ Memory Loss ☐ Confusion ☐ Bipolar Disorder ☐ Other

Allergy: ☐ Anaphylaxis (history of sneezing) ☐ Food Intolerance ☐ Itching ☐ Sneezing ☐ Nasal Congestion
☐ *I deny any allergy issues*

Hematology: ☐ Anemia ☐ Blood Clotting ☐ Bleeding ☐ Fatigue ☐ Bruises Easily
☐ *I deny any hematology issues* ☐ Blood Transfusions ☐ Lymph Node Swelling

Office Use Only

Metabolic Assessment Form

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

Category I

- Feeling that bowels do not empty completely 0 1 2 3
- Lower abdominal pain relieved by passing stool or gas 0 1 2 3
- Alternating constipation and diarrhea 0 1 2 3
- Diarrhea 0 1 2 3
- Constipation 0 1 2 3
- Hard, dry, or small stool 0 1 2 3
- Coated tongue or "fuzzy" debris on tongue 0 1 2 3
- Pass large amount of foul-smelling gas 0 1 2 3
- More than 3 bowel movements daily 0 1 2 3
- Use laxatives frequently 0 1 2 3

Category II

- Increasing frequency of food reactions 0 1 2 3
- Unpredictable food reactions 0 1 2 3
- Aches, pain, and swelling throughout the body 0 1 2 3
- Unpredictable abdominal swelling 0 1 2 3
- Frequent bloating and distention after eating 0 1 2 3
- Abdominal intolerance to sugars and starches 0 1 2 3

Category III

- Intolerance to smells 0 1 2 3
- Intolerance to jewelry 0 1 2 3
- Intolerance to shampoo, lotion, detergents, etc. 0 1 2 3
- Multiple smell and chemical sensitivities 0 1 2 3
- Constant skin outbreaks 0 1 2 3

Category IV

- Excessive belching, burping, or bloating 0 1 2 3
- Gas immediately following a meal 0 1 2 3
- Offensive breath 0 1 2 3
- Difficult bowel movement 0 1 2 3
- Sense of fullness during and after meals 0 1 2 3
- Difficulty digesting fruits and vegetables; undigested foods found in stools 0 1 2 3

Category V

- Stomach pain, burning, or aching 1-4 hours after eating 0 1 2 3
- Use antacids 0 1 2 3
- Feel hungry an hour or two after eating 0 1 2 3
- Heartburn when lying down or bending forward 0 1 2 3
- Temporary relief by using antacids, food, milk, or carbonated beverages 0 1 2 3
- Digestive problems subside with rest and relaxation 0 1 2 3
- Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine 0 1 2 3

Category VI

- Roughage and fiber cause constipation 0 1 2 3
- Indigestion and fullness last 2-4 hours after eating 0 1 2 3
- Pain, tenderness, soreness on left side under rib cage 0 1 2 3
- Excessive passage of gas 0 1 2 3

Category VI (continued)

- Nausea and/or vomiting 0 1 2 3
- Stool undigested, foul smelling, mucous like, greasy, or poorly formed 0 1 2 3
- Frequent urination 0 1 2 3
- Increased thirst and appetite 0 1 2 3

Category VII

- Greasy or high-fat foods cause distress 0 1 2 3
- Lower bowel gas and/or bloating several hours after eating 0 1 2 3
- Bitter metallic taste in mouth, especially in the morning 0 1 2 3
- Burpy, fishy taste after consuming fish oils 0 1 2 3
- Difficulty losing weight 0 1 2 3
- Unexplained itchy skin 0 1 2 3
- Yellowish cast to eyes 0 1 2 3
- Stool color alternates from clay colored to normal brown 0 1 2 3
- Reddened skin, especially palms 0 1 2 3
- Dry or flaky skin and/or hair 0 1 2 3
- History of gallbladder attacks or stones 0 1 2 3
- Have you had your gallbladder removed? Yes No

Category VIII

- Acne and unhealthy skin 0 1 2 3
- Excessive hair loss 0 1 2 3
- Overall sense of bloating 0 1 2 3
- Bodily swelling for no reason 0 1 2 3
- Hormone imbalances 0 1 2 3
- Weight gain 0 1 2 3
- Poor bowel function 0 1 2 3
- Excessively foul-smelling sweat 0 1 2 3

Category IX

- Crave sweets during the day 0 1 2 3
- Irritable if meals are missed 0 1 2 3
- Depend on coffee to keep going/get started 0 1 2 3
- Get light-headed if meals are missed 0 1 2 3
- Eating relieves fatigue 0 1 2 3
- Feel shaky, jittery, or have tremors 0 1 2 3
- Agitated, easily upset, nervous 0 1 2 3
- Poor memory/forgetful 0 1 2 3
- Blurred vision 0 1 2 3

Category X

- Fatigue after meals 0 1 2 3
- Crave sweets during the day 0 1 2 3
- Eating sweets does not relieve cravings for sugar 0 1 2 3
- Must have sweets after meals 0 1 2 3
- Waist girth is equal or larger than hip girth 0 1 2 3
- Frequent urination 0 1 2 3
- Increased thirst and appetite 0 1 2 3
- Difficulty losing weight 0 1 2 3

Metabolic Assessment Form (continued)

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

Category XI

- Cannot stay asleep 0 1 2 3
- Crave salt 0 1 2 3
- Slow starter in the morning 0 1 2 3
- Afternoon fatigue 0 1 2 3
- Dizziness when standing up quickly 0 1 2 3
- Afternoon headaches 0 1 2 3
- Headaches with exertion or stress 0 1 2 3
- Weak nails 0 1 2 3

Category XII

- Cannot fall asleep 0 1 2 3
- Perspire easily 0 1 2 3
- Under high amount of stress 0 1 2 3
- Weight gain when under stress 0 1 2 3
- Wake up tired even after 6 or more hours of sleep 0 1 2 3
- Excessive perspiration or perspiration with little or no activity 0 1 2 3

Category XIII

- Edema and swelling in ankles and wrists 0 1 2 3
- Muscle cramping 0 1 2 3
- Poor muscle endurance 0 1 2 3
- Frequent urination 0 1 2 3
- Frequent thirst 0 1 2 3
- Crave salt 0 1 2 3
- Abnormal sweating from minimal activity 0 1 2 3
- Alteration in bowel regularity 0 1 2 3
- Inability to hold breath for long periods 0 1 2 3
- Shallow, rapid breathing 0 1 2 3

Category XIV

- Tired/sluggish 0 1 2 3
- Feel cold - hands, feet, all over 0 1 2 3
- Require excessive amounts of sleep to function properly 0 1 2 3
- Increase in weight even with low-calorie diet 0 1 2 3
- Gain weight easily 0 1 2 3
- Difficult, infrequent bowel movements 0 1 2 3
- Depression/lack of motivation 0 1 2 3
- Morning headaches that wear off as the day progresses 0 1 2 3
- Outer third of eyebrow thins 0 1 2 3
- Thinning of hair on scalp, face, or genitals, or excessive hair loss 0 1 2 3
- Dryness of skin and/or scalp 0 1 2 3
- Mental sluggishness 0 1 2 3

Category XV

- Heart palpitations 0 1 2 3
- Inward trembling 0 1 2 3
- Increased pulse even at rest 0 1 2 3
- Nervous and emotional 0 1 2 3
- Insomnia 0 1 2 3
- Night sweats 0 1 2 3
- Difficulty gaining weight 0 1 2 3

Category XVI

- Increased ability to eat sugars without symptoms 0 1 2 3

Category XVII

- Tolerance to sugars reduced 0 1 2 3
- "Splitting" – type headaches 0 1 2 3

Category XVIII (*Males Only*)

- Urination difficulty or dribbling 0 1 2 3
- Frequent urination 0 1 2 3
- Pain inside of legs or heels 0 1 2 3
- Feeling of incomplete bowel emptying 0 1 2 3
- Leg twitching at night 0 1 2 3

Category XIX (*Males Only*)

- Spells of mental fatigue 0 1 2 3
- Inability to concentrate 0 1 2 3
- Episodes of depression 0 1 2 3
- Muscle soreness 0 1 2 3
- Decreased physical stamina 0 1 2 3
- Unexplained weight gain 0 1 2 3
- Increase in fat distribution around chest and hips 0 1 2 3
- Sweating attacks 0 1 2 3
- More emotional than in the past 0 1 2 3

Category XX (*Menstruating Females Only*)

- Alternating menstrual cycle length Yes No
- Extended menstrual cycle (greater than 32 days) Yes No
- Shortened menstrual cycle (less than 24 days) Yes No
- Pain and cramping during periods 0 1 2 3
- Scanty blood flow 0 1 2 3
- Heavy blood flow 0 1 2 3
- Breast pain and swelling during menses 0 1 2 3
- Pelvic pain during menses 0 1 2 3
- Irritable and depressed during menses 0 1 2 3
- Acne 0 1 2 3
- Facial hair growth 0 1 2 3
- Hair loss/thinning 0 1 2 3

Child Neurotransmitter & Nutritional Questionnaire™ (CNNQ)

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

SECTION A

- Does your child eat pasta, breads, and breaded foods? 0 1 2 3
- Does your child have symptoms (fatigue, hyperactivity,etc.) after eating foods containing wheat/gluten? 0 1 2 3
- Does your child consume dairy products? 0 1 2 3
- Does your child have symptoms (fatigue, hyperactivity,etc.) after consuming dairy products? 0 1 2 3

SECTION B

- Does your child eat fried fish? 0 1 2 3
- Does your child eat roasted nuts or seeds? 0 1 2 3
- Is your child missing essential fatty acid-rich foods in his/her diet? (ie avocados, flax seeds, olives) (circle "0" if present, "3" if missing) 0 1 2 3
- Does your child eat fried foods? 0 1 2 3

SECTION C

- Is your child's mental speed slow? 0 1 2 3
- Does your child have difficulty with learning or memory? 0 1 2 3
- Does your child have difficulty with balance and coordination? 0 1 2 3

SECTION D

- Does your child have stress? 0 1 2 3
- Does your child not have enough sleep or rest? (circle "0" if regular enough, "3" if not enough) 0 1 2 3
- Does your child not have regular exercise? (circle "0" if regular exercise, "3" if no exercise) 0 1 2 3
- Does your child feel overly worried and scared? 0 1 2 3

SECTION E

- Does your child have temper tantrums? 0 1 2 3
- Does your child exhibit wild behavior 0 1 2 3
- Does your child frequently yell or scream for unnecessary reasons? 0 1 2 3
- Does your child have an inability to nap or sleep when physically exhausted? (circle "0" if able, "3" if unable) 0 1 2 3
- Is your child overly talkative? 0 1 2 3
- Does your child fidget and squirm when seated? 0 1 2 3
- Does your child run and climb excessively? 0 1 2 3
- Does your child have difficulty playing quietly or engaging in leisure activities? 0 1 2 3

SECTION F

- Does your child get excited easily? 0 1 2 3
- Does your child have anxiety and panic for minor reasons? 0 1 2 3
- Does your child feel overwhelmed for minor reasons? 0 1 2 3
- Does your child find it difficult to relax when he/she is awake? 0 1 2 3
- Does your child have disorganized attention? 0 1 2 3

SECTION G

- Does your child seem depressed? 0 1 2 3
- Does your child have mood changes with overcast weather? 0 1 2 3
- Does your child have symptoms of inner rage? 0 1 2 3
- Does your child seem uninterested in games or hobbies? 0 1 2 3
- Does your child have difficulty falling into deep, restful sleep? 0 1 2 3
- Does your child seem uninterested in friendships? 0 1 2 3
- Does your child have unprovoked anger? 0 1 2 3
- Does your child seem uninterested in eating? 0 1 2 3

SECTION H

- Does your child have difficulty handling stress? 0 1 2 3
- Does your child have anger and aggression while being challenged? 0 1 2 3
- Does your child feel tired even after many hours of sleep? 0 1 2 3
- Does your child tend to isolate himself/herself from others? 0 1 2 3
- Does your child get distracted easily? 0 1 2 3
- Does your child have a constant need and desire for candy and sugar? 0 1 2 3
- Does your child have disorganized attention? 0 1 2 3

SECTION I

- Does your child have difficulty with visual memory (shapes and images)? 0 1 2 3
- Does your child have difficulty remembering locations? 0 1 2 3
- Does your child have fatigue or low endurance for learning activities? 0 1 2 3
- Does your child have difficulty with attention or a short attention span? 0 1 2 3
- Does your child have slow or difficult speech? 0 1 2 3

Does your child have uncoordinated or slow movements? 0 1 2 3

FUNCTIONAL CHILDHOOD DEVELOPMENTAL DISORDER CHECKLIST

Please check items that apply to your child.

Motor Characteristics of a Left Brain Delay

- ☐ Fine motor problems (poor or slow handwriting)
- ☐ Difficulty with fine motor skills, such as buttoning a shirt
- ☐ Tends to write very large for age or grade level
- ☐ Stumbles over words when fatigued
- ☐ Exhibited delay in crawling, standing, and/or walking
- ☐ Loves sports and is good at them
- ☐ Good muscle tone
- ☐ Poor drawing skills
- ☐ Difficulty learning to play music
- ☐ Likes to fix things with the hands and is interested in anything musical
- ☐ Difficulty planning and coordinating body movements

Total _____

Sensory Characteristics of a Left Brain Delay

- ☐ Doesn't seem to have many sensory issues or problems, such as a sensitivity to sound
- ☐ Has good spatial awareness
- ☐ Has good sense of balance
- ☐ Eats just about anything
- ☐ Has a normal to above-average sense of taste and smell
- ☐ Likes to be hugged and held
- ☐ Does not have any oddities concerning clothing
- ☐ Has auditory processing problems
- ☐ Seems not to hear well, although hearing tests are normal
- ☐ Delay in speaking was attributed to ear infections
- ☐ Gets motion sickness and has other motion sickness issues
- ☐ In not under sensitive or over sensitive to pain

Total _____

Emotional Characteristics of a Left Brain Delay

- ☐ Overly happy and affectionate: loves to hug and kiss
- ☐ Frequently moody and irritable
- ☐ Loves doing new or different things but gets bored easily
- ☐ Lacks motivation
- ☐ Withdrawn and shy
- ☐ Excessively cautious, pessimistic, or negative
- ☐ Doesn't seem to get any pleasure out of life
- ☐ Socially withdrawn
- ☐ Cries easily; feelings get hurt easily
- ☐ Seems to be in touch with own feelings
- ☐ Empathetic to other people's feelings; reads people's emotions well
- ☐ Gets embarrassed easily
- ☐ Very sensitive to what others think about him or her

Total _____

Motor Characteristics of a Right Brain Delay

- ☐ Clumsiness and an odd posture
- ☐ Poor coordination
- ☐ Not athletically inclined and has no interest in popular childhood participation sports
- ☐ Low muscle tone – muscles seem kind of floppy
- ☐ Poor gross motor skills, such as difficulty learning to ride a bike and/or run and/or walks oddly
- ☐ Repetitive/stereotyped motor mannerisms (spins in circles, flaps arms)
- ☐ Fidgets excessively
- ☐ Poor eye contact
- ☐ Walks or walked on toes when younger

Total _____

Sensory Characteristics of a Right Brain Delay

- ☐ Poor spatial orientation – bumps into things often
- ☐ Sensitivity to sound
- ☐ Confusion when asked to point to different body parts
- ☐ Poor sense of balance
- ☐ High threshold for pain – doesn't cry when gets a cut
- ☐ Likes to spin, go on rides, swing, etc. – anything with motion
- ☐ Touches things compulsively
- ☐ A girl uninterested in makeup or jewelry
- ☐ Does not like the feel of clothing on arms or legs; pulls off clothes
- ☐ Doesn't like being touched and doesn't like to touch things
- ☐ Incessantly smells everything
- ☐ Prefers bland foods
- ☐ Does not notice strong smells, such as burning wood, popcorn, or cookies baking in the oven
- ☐ Avoids food because of the way it looks
- ☐ Hates having to eat and is not even interested in sweets
- ☐ Extremely picky eater
- ☐ Sensory Characteristics

Total _____

Emotional Characteristics of a Right Brain Delay

- ☐ Spontaneously cries and/or laughs
- ☐ Has sudden outbursts of anger or fear
- ☐ Worries a lot and has several phobias
- ☐ Holds on to past "hurts"
- ☐ Has sudden emotional outbursts that appear over-reactive and inappropriate to the situation
- ☐ Experiences panic and/or anxiety attacks
- ☐ Sometimes displays dark or violent thoughts
- ☐ Face lacks expression; doesn't exhibit much body language
- ☐ Too uptight; cannot seem to loosen up
- ☐ Lacks empathy and feelings for others
- ☐ Lacks emotional reciprocity
- ☐ Often seems fearless and is a risk taker

Total _____

FUNCTIONAL CHILDHOOD DEVELOPMENTAL DISORDER CHECKLIST (continued)

Please check items that apply to your child.

Behavioral Characteristics of a Left Brain Delay

- ☐ Procrastinates
- ☐ Is extremely shy, especially around strangers
- ☐ Is very good at nonverbal communication
- ☐ Is well likes by other children and teachers
- ☐ Does not have any behavioral problems in school
- ☐ Understands social rules
- ☐ Has poor self esteem
- ☐ Hates doing homework
- ☐ Is very good at social interaction
- ☐ Makes good eye contact
- ☐ Likes to be around people and enjoys social activities, such as going to parties
- ☐ Doesn't like to go to sleepovers
- ☐ Is not good at following routines
- ☐ Can't follow multiple-step directions
- ☐ Is in touch with own feelings
- ☐ Jumps to conclusions

Total _____

Behavioral Characteristics of a Right Brain Delay

- ☐ Logical thinker
- ☐ Often misses the gist of a story
- ☐ Always the last to get a joke
- ☐ Gets stuck in set behavior; can't let it go
- ☐ Lacks social tact and/or is antisocial and/or socially isolated
- ☐ Poor time management; is always late
- ☐ Disorganized
- ☐ Has a problem paying attention
- ☐ Is hyperactive and/or impulsive
- ☐ Has obsessive thoughts or behaviors
- ☐ Argues all the time and is generally uncooperative
- ☐ Exhibits signs of an eating disorder
- ☐ Failed to thrive as an infant
- ☐ Mimics sounds or words repeatedly with really understanding the meaning
- ☐ Appears bored, aloof, and abrupt
- ☐ Considered strange by other children
- ☐ Inability to form relationships
- ☐ Has difficulty sharing enjoyment, interests, or achievements with other people
- ☐ Inappropriately giddy or silly
- ☐ Acts inappropriately in social situations
- ☐ Talks incessantly and asks the same question repetitively
- ☐ Has no or little joint attention, such as the need to point to an object to get your attention
- ☐ Didn't look at self in mirror as a toddler

Total _____

Common Immune Characteristics of a Left Brain Delay

- ☐ Gets chronic ear infections
- ☐ Prone to benign tumors or cysts
- ☐ Has taken antibiotics more than 10 to 15 times before the age of ten
- ☐ Has had tubes put in the ears
- ☐ Catches colds frequently
- ☐ No allergies

Total _____

Common Immune Characteristics of a Right Brain Delay

- ☐ Has lots of allergies
- ☐ Rarely gets colds and infections
- ☐ Has had or has eczema or asthma
- ☐ Skin has little white bumps, especially on the backs of the arms
- ☐ Displays erratic behavior – good one day, bad the next
- ☐ Craves certain foods, especially dairy and wheat products

Total _____

Autonomic Characteristics of a Left Brain Delay

- ☐ Has bedwetting problem
- ☐ Has or had an irregular heartbeat, such as an arrhythmia or a heart murmur

Total _____

Autonomic Characteristics of a Right Brain Delay

- ☐ Problem with bowels, such as constipation and diarrhea
- ☐ Has a rapid heart rate and/or high blood pressure for age
- ☐ Appears bloated, especially after meals, and often complains of stomach pains
- ☐ Has body odor
- ☐ Sweats a lot
- ☐ Hands are always moist and clammy

Total _____

FUNCTIONAL CHILDHOOD DEVELOPMENTAL DISORDER CHECKLIST (continued)

Please check items that apply to your child.

Academic Characteristics of a Left Brain Delay

- ☐ Very good at big picture skills
- ☐ In an intuitive thinker and is led by feelings
- ☐ Good at abstract "free" association
- ☐ Poor analytical skills
- ☐ Very visual; loves images and patterns
- ☐ Constantly questions why you're doing something or why rules exist
- ☐ Has poor sense of time
- ☐ Enjoys touching and feeling actual objects
- ☐ Has trouble prioritizing
- ☐ Is unlikely to read instructions before trying something new
- ☐ In naturally creative, but needs to work hard to develop full potential
- ☐ Would rather do things instead of observe
- ☐ Uses good voice inflection when speaking
- ☐ Misreads or omits common small words
- ☐ Has difficulty saying long words
- ☐ Reads very slowly and laboriously
- ☐ Had difficulty naming colors, objects, and letters as a toddler
- ☐ Needs to hear or see concepts many times to learn them
- ☐ Has shown a downward trend in achievement test scores or school performance
- ☐ School work is inconsistent
- ☐ Was a late talker
- ☐ Has difficulty pronouncing words (poor with phonics)
- ☐ Had difficulty learning the alphabet, nursery rhymes, or songs when young
- ☐ Has difficulty finishing homework or finishing a conversation
- ☐ Acts before thinking and makes careless mistakes
- ☐ Daydreams a lot
- ☐ Has difficulty sequencing events in the proper order
- ☐ Often writes letters backwards
- ☐ Is poor at basic math skills
- ☐ Has poor memorization skills
- ☐ Has poor academic ability
- ☐ Has an IQ lower than expected and verbal scores are lower than nonverbal scores
- ☐ Performs poorly on verbal tests
- ☐ Needs to be told to do something several times before acting on it
- ☐ Stutters or stuttered when younger
- ☐ Is a poor speller
- ☐ Doesn't read directions well

Total _____

Total Left Brain Delays _____

Academic Characteristics of a Right Brain Delay

- ☐ Poor math reasoning (word problems, geometry, algebra)
- ☐ Poor reading comprehension and pragmatic skills
- ☐ Misses the big picture
- ☐ Very analytical
- ☐ Likes "slapstick" or obvious physical humor
- ☐ Is very good at finding mistakes (spelling)
- ☐ Takes everything literally
- ☐ Doesn't always reach a conclusion when speaking
- ☐ Started speaking early
- ☐ Has tested for a high IQ, but scores run the whole spectrum
- ☐ IQ is above normal in verbal ability and below average in performance abilities
- ☐ Was an early word reader
- ☐ Is interested in unusual topics
- ☐ Learns in a rote (memorizing) manner
- ☐ Learns extraordinary amounts of specific facts about a subject
- ☐ Is impatient
- ☐ Speaks in a monotone, has little voice inflection
- ☐ Is a poor nonverbal communicator
- ☐ Doesn't like loud noises (like fireworks)
- ☐ Speaks out loud regarding what he or she is thinking
- ☐ Talks "in your face" – is a space invader
- ☐ Good reader but does not enjoy reading
- ☐ Analytical; led by logic
- ☐ Follows rules without questioning them
- ☐ Good at keeping track of time
- ☐ Easily memorizes spelling and mathematical formulas
- ☐ Enjoys observing rather than participating
- ☐ Would rather read an instructions manual before trying something new
- ☐ Math was often the first academic subject that became a problem

Total _____

Total Left Brain Delays _____

Grand Total _____

The Neurodevelopmental Clan

(Please select the most appropriate character that describes your child, you may select more than one.)

□ Pooh

inattentive
head in the clouds

□ Tigger

hyperactive
bouncy

□ Eeyore

depressed

□ Piglet

anxious
easily startled

□ Rabbit

inflexible
rigid
wants his/her way

IMPORTANT QUESTIONS (*Please take several minutes to answer these questions so we can help you get better faster, circle as many that apply)*

1. How have you taken care of your child's health in the past?

   a. Medications
   b. Emergency Room
   c. Routine Medical
   d. Psychologist
   e. Nutrition/Diet
   f. Holistic Care
   g. Vitamins
   h. Chiropractic
   i. Other (please specify): _____

2. How did the previous method(s) work out for your child?

   a. Bad results
   b. Some results
   c. Great results
   d. Nothing changed
   e. Did not get worse
   f. Did not work very long
   g. Still trying
   h. Confused

3. How have others been affected by your child's health condition?

   a. No one is affected
   b. Haven't noticed any problem
   c. They tell me to do something
   d. People avoid me

4. What are you afraid this might be (or beginning) to affect (or will affect)?

   a. Job
   b. Kids
   c. Future ability
   d. Marriage
   e. Self-esteem
   f. Sleep
   g. Time
   h. Finances
   i. Freedom

5. Are there health conditions you are afraid this might turn into?

   a. Family health problems
   b. Heart disease
   c. Cancer
   d. Diabetes
   e. Arthritis
   f. Fibromyalgia
   g. Depression
   h. Chronic Fatigue
   i. Need surgery

6. How has your child's health condition affected your job, relationships, finances, family, or other activities? Please give examples:

_____

_____

7. What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.)

_____

_____

_____

8. What are you most concerned with regarding your child's health problem?

_____

_____

9. Where do you picture your child being in the next 1-3 years if this problem is not taken care of? Please be specific.

_____

_____

10. What would be different/better without this problem? Please be specific.

_____

_____

11. What do you desire most to get from working with us?

_____

_____

12. What is that worth to you?

_____

_____

13. Regarding cost of care, this specialized form of care will require out of pocket expenses. We will do our best to find a way to make this work within your financial means. Will this present a problem for you?

_____

14. Considering your history and current health problems, would you say... (**please check ONE**)

☐ I am "sick and tired of being sick and tired" and am willing to do whatever is necessary to end my child's current problems and recover their health.

☐ I would like to see improvement in my child's health and symptoms as long as treatment options fit into our schedule and finances.

☐ I would like improvements in my child's current health, but am more concerned about future health problems. I am looking for preventative health options.

☐ I would like rapid improvement in my child's problems without a long term commitment to lifestyle changes.

☐ I am unable to make changes to my child's diet or lifestyle and cannot afford any time or financial commitments at this time. I just am looking for more information.

Office Use Only

_____

_____

Additional information regarding your health you think we may need to know:

Financial Terms of Acceptance and Consent

1. I understand this care does not promote or practice medicine, any decisions about medication changes or alterations must be discussed with your medical doctor. Many of the treatments used to help support your condition including Neurofeedback therapy, hyperbaric oxygen therapy, brain-based therapies, spinal decompression therapy, rehabilitation therapy, infrared light therapy, metabolic evaluations, oxygen or vibration therapy may not be covered by insurance and may not be reimbursable.
2. All insurance assignment patients must pay their deductibles in full, and the co-payment at the time of service, unless other arrangements are made with the front desk.
3. Patients that receive insurance checks directly for reimbursement of services performed by Integrated Healthcare of Georgia agree to forward those checks directly to our office within 10 days of receipt.
4. The patient acknowledges and agrees to be responsible to Integrated Healthcare of Georgia for any costs incurred in collecting checks that are denied due to insufficient funds, stopped payments, or any other reason. A service charge of $30.00 will be charged for any check upon which payment is denied.
5. If the patient chooses to finance care through a 3rd party, the patient understands that the financing companies are separate and distinct entities and are not affiliated with Integrated Healthcare of Georgia or Dr. John C. Thomas. Therefore, we are not responsible for any dispute between the patient and the financing company.
6. It is impossible for the doctors to know exactly how many treatments the patient will need to reach maximum recovery. The treatment plan listed above is an approximation and may be adjusted according to patient presentation. Furthermore the treatments in this program do not include other services in the office including cervical pillows, lumbar supports, cervical traction units, heel lifts, nutritional supplements, orthotics, home equipment not indicated, or maintenance care.
7. In the event that the patient terminates the treatment prematurely, the patient is responsible for all care they have received at the time of termination minus any discounts offered, and will be refunded any pro-rated fees owed based on the current fee schedule. The fee schedule for each service is available at the front desk. We cannot legally refund any fees for service already performed, even if the patient is not satisfied with the results of the treatment. Refunds are issued within 30 days.

I hereby consent to the performance of examination, diagnosis, diagnostic X-rays, and any treatment listed above, on me (or the patient named above, for whom I am legally responsible) by Dr. John C. Thomas and/or other professionals working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backdrop for Dr. John C. Thomas and Integrated Healthcare of Georgia. I understand and I am informed that there is the unlikely possibility of adverse events from examination and treatment including, but not limited to, soreness, fractures, disc injuries, strokes, dislocations, sprains, increased symptoms and pain, or no improvement of symptoms or pain. I agree that if I suspect any adverse event that I will inform Dr. Thomas immediately. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. *I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatments. I understand that this clinic does not treat disease or any medical diagnosis.* I intend this consent form to cover the entire course of treatment of my present condition and for any future condition(s) for which I seek treatment. I understand that I may refuse treatment at any time and that I am responsible for my healthcare choices.

NOTE: Due to the cutting edge nature of our care, Insurance does not pay for Neurological Services, Functional Medicine/Nutrition, or most lab testing. You will have to pay for services in this office. Some major medical insurance may pay for standard lab testing, but more functional tests are falling outside their coverage and are as a result cash-basis. We have contracted with several discount labs which offer a discount off retail blood test prices as well. Most functional tests, including salivary tests, stool tests, food antibody tests and immune panels are non-covered and are therefore the responsibility of the patient.

By signing below, I acknowledge that I understand and agree to all terms of acceptance. I also acknowledge that any questions that I have regarding treatment, or my financial obligation, have been met to my satisfaction. I understand that this is a legal and binding document.

TO BE COMPLETED BY THE PATIENT

Printed Name:_____ Signature:_____ Date:_____

TO BE COMPLETED BY THE PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient's Name:_____ Patient's Signature:_____

Date Signed: _____ Signature of Representative:_____

Relationship or Authority of Patient's Representative:_____