CONFIDENTIAL PATIENT DATA

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION Today's Date:_____ Date of Birth_____

Name: _____ ☐Male ☐Female

Address_____ City_____ State_____Zip_____

Home Phone: _____ Work Phone _____ Cell /Pager: _____ Age

Mother's Name if minor_____Father's Name if minor_____

Name of Individual to contact in case of emergency: _____Phone : _____

Referred to this office by: ☐ TV ☐ Newspaper Ad ☐ Health Journal Ad ☐ In-Office Seminar

☐Friend – Name? _____ ☐MD – Name? _____

☐Other_____

Please list Doctors treated for any health condition in the last year:

1. Name: _____ When: _____
   Reason for visit: _____
2. Name: _____ When: _____
   Reason for visit: _____
3. Name: _____ When: _____
   Reason for visit: _____
4. Name: _____ When: _____
   Reason for visit: _____

Please List Current Medications and Nutritional Supplements:

_____

_____

_____

_____

List your child's developmental disorder according to severity	Date parent 1st saw symptoms	Date Diagnosed	Is disorder getting better or worse?
1._____			
2._____			
3._____			
4._____			

What type of care are you looking for? ☐ Temporary Relief ☐ Maximum Recovery

Specific Goals you as a parent want to see:

Improve: _____

_____

Behaviors you do not want to see any more:_____

_____

Have any other family members been diagnosed with ADD, ADHD, Dyslexia or Autism Spectrum Disorders?

Yes____ No____ If yes, please list relationship _____

Have any other family members been diagnosed with AutoImmune Disease, Crohn's Disease, Rheumatoid Arthritis, Lupus, Scleroderma, MS, ALS, Thyroid Disease, Diabetes, other?

Yes____ No____ If yes, please list and explain relationship _____

_____

Symptoms are WORSE in the: ☐ Morning ☐ Afternoon ☐ Evening

Mom's health During Pregnancy:

Was Mom overweight? Yes___ No___ If yes, weight _____
Was Mom sick? Yes___ No___ Name Illness _____
How many births has Mom had? _____
How many miscarriages?_____
Did Mom use fertility drugs? Yes___ No___
Health of siblings _____
Mental stress during pregnancy, such as divorce, job loss, death in family, car accident, trauma, etc? Yes___ No___
Please explain:_____
Mom's exposure to toxins, such as mold, poisons, pesticides, etc? Yes___ No___
Please explain:_____
Infections Mom had during pregnancy: Yeast_____ Bacterial_____ Viral_____
Did Mom drink alcohol during pregnancy? Yes___ No___ Smoke? Yes___ No___ Coffee? Yes___ No___
Excessive bleeding? Yes___ No___ Vomiting? Yes___ No___

Birthing Process:

What type of delivery? _____
Any birth trauma? _____
Was delivery induced? Yes___ No___ Natural? Yes___ No___ Epidural? Yes___ No___
APGAR score _____ at 1 minute _____ at 5 minutes

Infant Toxic Exposure:

Mold in house? Yes___ No___ Pesticides? Yes___ No___ Other? _____

Infections:

Name al infections first two years of child's life:
_____ Age of onset_____ Medications Given:_____
_____ Age of onset_____ Medications Given:_____
_____ Age of onset_____ Medications Given:_____
_____ Age of onset_____ Medications Given:_____
_____ Age of onset_____ Medications Given:_____
Is child on antibiotics now? Yes___ No___

Please list all surgeries and child's age at time of surgery:

_____
_____

Motor Development:

Child's age when first: held head up_____ rolled over_____ sat up_____
Crawled _____ walked_____
Did child display any "cute" or out of ordinary behavior when learning to crawl or walk? Yes____ No____
If Yes, explain:_____
_____
Age potty trained:_____ Age stopped wetting bed:_____ Age of first words:_____
Age child spoke 2 or 3 words together:_____
Has child lost language? Yes____ No____ If Yes, what age and how far did they regress? _____
_____
How many words was your child using in a sentence before regression? _____
Has your child lost eye contact? Yes____ No____ If Yes, at what age? _____
How long did Mom breast feed? _____
Age child started bottle-feeding? _____ Formula? _____ Soy or Dairy based?_____
Age cow's milk was introduced:_____ Age wheat & grains introduced:_____

Vaccine Response:

Seizures? Yes____ No____ When did seizures start?_____ How long did they last?_____
Bowel symptoms? Yes____ No____ If Yes, please explain:_____

Swelling at injection site? Yes____ No____ Fever? Yes____ No____

Current Diet:

What is your child eating now? Please list foods and beverages consumed within the last few days:

_____

_____

_____

_____

Does your child refuse to eat certain foods? Yes____ No____ If Yes, please explain:

_____

_____

How many glasses of milk does your child drink per day? _____

How much cheese per day?_____ How much bread per day?_____

How many of these does your child drink per day? Sodas____ Juice box____ Sweet Teas____ Water____

Other drinks:_____

Does your child eat salty food or crave salty food? Yes____ No____

Fast food meals per day: _____ Meat intake per day: _____ ounces What type of meat:_____

How many fruits per day?_____ Veggies?_____

G.I. Tract:

How many bowel movements per day? _____ Is your child constipated? Yes____ No____

Bloating? Yes____ No____ Dark circles under eyes? Yes____ No____

Is your child's behavioral symptoms worse during: Damp____ Hot____ Misty____ Moldy____ Other_____

Does your child wake up at night laughing or giggling? Yes____ No____

Does your child put pressure on stomach? Yes____ No____

Please check the following activities that AGGRAVATE your child's condition:

READING STUDYING WORKING IN GROUPS MATH PLAYING VIDEO GAMES

TURNING HEAD WATCHING TV SOCIALIZING OTHER _____

Please check the following activities that RELIEVE your child's condition: PLAYING VIDEO GAMES

MEDICATION RELAXING EXERCISE LAYING DOWN OTHER _____

Please check any additional symptoms your child may be experiencing:

BLURRED VISION	BUZZING IN EARS	COLD FEET	COLD HANDS	DAY DREAM
CONCENTRATION LOSS	CONFUSION	CONSTIPATION	DEPRESSION	DIARRHEA
DIZZINESS	FACE FLUSHED	FAINTING	FATIGUE	FIDGETY
SHORT ATTENTION SPAN	HEADACHES	INSOMNIA	LIGHT BOTHERS EYES	
LOSS OF BALANCE	LOSS OF SMELL	LOSS OF TASTE	EASILY COLD	STIFF NECK
SHORT TEMPER	RINGING IN EARS	SHORTNESS OF BREATH	STOMACH UPSET	

AUTHORIZATION TO TREAT

I, the undersigned patient, hereby authorize Dr. Graf and/or Dr. Richardet (and appointed staff) to administer such treatment as is necessary, and to perform services and or procedures as are considered necessary on the basis of findings during the course of said treatment.

I hereby certify that I have read and fully understand the above AUTHORIZATION TO TREAT, the reasons why the treatment is necessary, its advantages and possible complications, if any, as well as possible alternative mode of treatment which were explained to me.

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Patient Signature _____ Date _____

Guardian Signature _____ Relationship _____

Witness Signature _____ Date _____