



Child's Name: _____ Age: _____ Gender: _____
Date of Birth: _____
Mother's & Father's Name: _____

HISTORY

- 1. Formal Diagnosis?

- 2. Chief complaints in order of importance (1-5)
1) _____
2) _____
3) _____
4) _____
5) _____

- 3. Pregnancy and Delivery Complications?

- 4. Breast feeding in hospital was formula supplemented?
Any issues early on sucking illness eczema other? _____

- 5. Development at home, breast fed? When was food supplemented? Any dairy based products introduced? And problems with feeding, reflux etc.?

- 6. Any immune issues, first or now? Eczema asthma allergies infections?

- 7. Any sleeping issues first or now? _____

- 8. Parents relationship, married, live together? _____

- 9. Developmental milestones? When did they walk alone? When did they talk?
How many words do they speak now?



10. Verbal vs. Non-verbal communication? Eye contact, joint attention?
Do they look in a mirror? Recognize or know body parts? Do they care about their appearance, clothes etc.?

11. Do they have friends, do they play with other kids? _____
Where are they in school, what grade? _____
12. Do they know letters numbers colors shapes? _____
13. Do they read at all? Can they do Math? Do they write color or draw?

14. Is there any learning disability in school? What are the most difficult subjects?

15. What are the best subjects for the child? _____
16. Any emotional issues, tantrums etc.? _____
17. Any major sensory issues, hyper, hyposensitivities? _____
18. Do they feel pain? _____
19. Are they a picky eater? Any food preferences? What do they drink?
Gluten Free Dairy Free Soy Free Other _____

20. Do they have a sense of smell or taste? _____
21. What does muscle tone and motor activity look like? What is hand, foot dominance?
When? _____

22. Any obvious balance issues, motion sickness, afraid of high places? Does she spin herself,
get dizzy? _____

23. Any stims or tics? Any OCD behaviors? _____
24. Any unusually strong skills? Early reading memorizing songs memory for details or
locations other? _____



25. Bowel movements, toileting issues Before and Now? _____

26. Parents jobs, personalities extrovert Introvert creative logical linear
other _____
Parents' health and development? Parents' dominance profile?

27. Any family or genetic history of Physical or mental health issues, learning challenges
What does the child like to do during the day for playtime? How much computer screen
time? _____

28. Do they prefer to be outdoor or indoors? _____

29. What treatments or tests?

Blood Tests MRI Genetic Metabolic EEG IQ Allergy?

30. Has any treatments helped? What has been the most effective?

31. How did they come aware of my work? Have they read Disconnected Kids? Have they
tried any of the treatments or therapies and if so, describe?

