

Questionnaire for Children with Autism & Related Developmental and/or Attention Problems

Note: In this questionnaire "you" is used as if the child were answering questions, avoiding repetition of him/her.

First Name: _____ Middle: _____ Last Name: _____		
Birthdate (mm/dd/yy): _____ / _____ / _____		Birth Order: _____ Place of Birth (city, state, country): _____
<input type="checkbox"/> Male <input type="checkbox"/> Female		Eye Color: _____ Hair Color: _____
Blood Type: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> AB <input type="checkbox"/> O Rh + <input type="checkbox"/> - <input type="checkbox"/>		Allergy to medication: _____ Hair Texture: _____
Height: _____		Weight: _____ (lbs) SS#: _____ / _____ / _____
Address E-mail Address: _____		
Street: _____		City/State: _____ Zip: _____ Country: _____
Referred by: _____		
Home Telephone: () _____		
Mother's Name: _____ Occupation: _____ Work Phone: _____		
Father's Name: _____ Occupation: _____ Work Phone: _____		
Person(s) filling out this questionnaire: _____ Date: _____		

This questionnaire is intended to give you a way of describing yourself as an individual. Many of the questions have to do with details that are not required to "make a diagnosis" but may be biochemical or immunologic clues that influence our thinking about treatment options. Whatever label has been given to you, keep in mind that it is just a label, not a cause. Symptoms and other findings described in this questionnaire are the body's way of speaking to us about causes. Our job is to listen and learn.

Please make suggestions for improving this questionnaire by emailing me at sidneymb@aol.com with "questionnaire suggestion" in the subject line.

Thank you, Sidney M. Baker, MD

This questionnaire can be obtained from Autism Research Institute 4182 Adams Avenue, San Diego, CA 92116:
Phone 619-281-7165, Fax: 619-563-6840. or Downloaded from the ARI website <http://www.autism.com/ari/>

Symptom score sheet for monitoring progress: Record the main problems in the Symptom column. Choose the most difficult problems as well as symptoms that may indicate progress.

# =rank, P= past, L= lab,		(symptom scores go in the columns below dates)									
↓	Symptom (0= Absent, 3= mild, 6= Moderate, 9=severe, 12= incapacitating.)	Date									
0	Example: Poor expressive language	9									
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
P											
P											
P											
L											
L											
L											

Laboratory data:

Evaluation/Test	Date	Done?	Abnormal?	Not sure?
24 hour urine amino acids		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amino acid screen		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood chemistry screen		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood count		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood test for fatty acids		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood test for food allergies		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CAT scan		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colonoscopy		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DMSA loading study		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EEG		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Folic acid		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fragile X chromosome study		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair elements		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immune profile		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Evaluation/Test	Date	Done?	Abnormal?	Not sure?
Intestinal permeability		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Detoxification profile		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MRI		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organic acids quantitative – fungal/bacterial metabolites		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organic acids quantitative – metabolism		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organic acids screen		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PET scan		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pinworm prep		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plasma amino acids		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plasma or serum zinc		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RBC elements		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Serum Ferritin (iron stores)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Serum methylmalonic acid		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Serum Vitamin A		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Small bowel biopsy		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stool culture		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stool parasites		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Profile		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uric acid test (blood or urine)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Peptides		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine elements		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine Kryptopyrrole		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Personal Descriptive Information

With whom do you live? And what do they do? (Include children, parents, relatives, friends...please include ages) {Example: Wendy, age 7, sister, George, Dad, age 40, Lawyer]

Who are the main people who care for you?

Please describe your strengths and/or unusual skills:

What pets live with you - indoor or outdoors only?

When and where have you lived or traveled outside of the United States?

Major life changes recent or soon for you or your family?

Have you experienced any major losses in life?

What is your religion and how important is religion/spirituality in you and your family's life?

Do you have a favorite toy or object?

Is there something else about you that I should know?

Past and present professionals:

Primary Care:		
Primary Care		
Specialist:		
Specialist:		
Therapist:		
Other		
Homeopathic:		
Chiropractor:		
Who made the initial diagnosis of autism/other disorder? When?		

Past Evaluations

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

Check if Yes	Check if Abnormal	Date	Evaluation/Test
<input type="checkbox"/>	<input type="checkbox"/>	_____	Psychological Evaluations
<input type="checkbox"/>	<input type="checkbox"/>	_____	Wechsler Preschool & Primary Scale of Intelligence
<input type="checkbox"/>	<input type="checkbox"/>	_____	Speech and Language Evaluations
<input type="checkbox"/>	<input type="checkbox"/>	_____	Genetic Evaluation
<input type="checkbox"/>	<input type="checkbox"/>	_____	Neurological Evaluations
<input type="checkbox"/>	<input type="checkbox"/>	_____	Gastroenterology Evaluations
<input type="checkbox"/>	<input type="checkbox"/>	_____	Celiac/Gluten testing
<input type="checkbox"/>	<input type="checkbox"/>	_____	Allergy Evaluation
<input type="checkbox"/>	<input type="checkbox"/>	_____	Nutritional Evaluation
<input type="checkbox"/>	<input type="checkbox"/>	_____	Auditory Evaluation
<input type="checkbox"/>	<input type="checkbox"/>	_____	Vision Evaluation
<input type="checkbox"/>	<input type="checkbox"/>	_____	Osteopathic
<input type="checkbox"/>	<input type="checkbox"/>	_____	Acupuncture
<input type="checkbox"/>	<input type="checkbox"/>	_____	Physical Therapy
<input type="checkbox"/>	<input type="checkbox"/>	_____	Occupational Therapy
<input type="checkbox"/>	<input type="checkbox"/>	_____	Sensory Integration Therapy
<input type="checkbox"/>	<input type="checkbox"/>	_____	Language Classes
<input type="checkbox"/>	<input type="checkbox"/>	_____	Sign Language
<input type="checkbox"/>	<input type="checkbox"/>	_____	Homeopathic
<input type="checkbox"/>	<input type="checkbox"/>	_____	Naturopathic
<input type="checkbox"/>	<input type="checkbox"/>	_____	Craniosacral
<input type="checkbox"/>	<input type="checkbox"/>	_____	Chiropractic

Hospitalizations

Age	Reason for hospitalization	Discharge summary attached?
		<input type="checkbox"/>
		<input type="checkbox"/>

Operations

Please indicate approximate age when you had an operation for:	AGE
Appendix	
Circumcision	
Hernia	
Tonsils	
Adenoids	
P.E. Tubes in Ears	
Other surgery	

Injuries

Please describe any injuries	AGE
Head injury	
Broken bone	
Broken bone	
Eye injury	
Neck injury	
Abdominal injury	
Other injury	

Please use this space for comments or narrative.

You may wish to highlight those consultations, tests or treatments you found most, or least, helpful.

Mother's Past Pregnancies: number of:

Pregnancies _____ Live births _____ Miscarriages _____

Mother's Pregnancy: Place a check mark if any of the following occurred during your mother's pregnancy:**Did your mother:****(Please describe if applicable)**

Difficulty getting pregnant (more than 6 months)	<input type="checkbox"/>	
Infertility drugs used	<input type="checkbox"/>	Specify:
In vitro fertilization	<input type="checkbox"/>	
Drink alcohol	<input type="checkbox"/>	
Drink coffee	<input type="checkbox"/>	
Smoke tobacco	<input type="checkbox"/>	
Take Progesterone	<input type="checkbox"/>	
Take prenatal vitamins	<input type="checkbox"/>	
Take antibiotics	<input type="checkbox"/>	
Take other drugs	<input type="checkbox"/>	Specify:
Excessive vomiting, nausea (more than 3 weeks)	<input type="checkbox"/>	
Have a viral infection	<input type="checkbox"/>	
Have a yeast infection	<input type="checkbox"/>	
Have amalgam fillings put in teeth	<input type="checkbox"/>	
Have amalgam fillings removed from teeth	<input type="checkbox"/>	
Have how many fillings in her teeth during?	<input type="checkbox"/>	Number of fillings in your mom's teeth when pregnant?
Have bleeding (which months?)	<input type="checkbox"/>	
Have birth problems	<input type="checkbox"/>	
Group B strep infection	<input type="checkbox"/>	
Have c-section because of	<input type="checkbox"/>	
Use induction for labor (such as Pitocin)	<input type="checkbox"/>	
Have anesthesia -what was used?	<input type="checkbox"/>	
Use oxygen during labor	<input type="checkbox"/>	
Have an x-ray	<input type="checkbox"/>	
Have Rhogam, if so how many shots	<input type="checkbox"/>	How many when pregnant? _____
Gestational Diabetes	<input type="checkbox"/>	
High blood pressure (pre-eclampsia)	<input type="checkbox"/>	
High blood pressure/toxemia	<input type="checkbox"/>	
Have chemical exposure	<input type="checkbox"/>	
Father have chemical exposure	<input type="checkbox"/>	
Move to a newly built house	<input type="checkbox"/>	
House painted indoors	<input type="checkbox"/>	
House painted outdoors	<input type="checkbox"/>	
House exterminated for insects	<input type="checkbox"/>	

Pregnancy:

Total weight gain during pregnancy _____ lb	Dotal weight loss during pregnancy _____ lb
Please describe diet during pregnancy	Please describe labor
<hr/> <hr/> <hr/>	

Perinatal

Place a check mark if applicable:

Very active before birth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hospital/Birthing Center	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Needed Newborn Special Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Appeared healthy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Easily consoled during first month?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Antibiotics first month	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced no complications first month of life	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Birth Weight and Apgar

Weight at birth: _____ lbs	Apgar score at one minute _____	Apgar score at 5 mins _____
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Early Childhood Illnesses

Number of earaches in the first two years: _____
Number of other infections in the first two years: _____
Number of times you had antibiotics in the first two years of life: _____
Number of courses of prophylactic antibiotics in first 2 years of life: _____
First antibiotic at _____ months.
First illness at _____ months.

Description of Developmental Problems

At what age did developmental problems appear to begin? 0-1months

 2-6 months 6-15 months 16-24 months After 24 months

Is this impression shared among parents and others caring for the child?:

...Or does this impression as to the timing of onset differ among parents and others caring for the child?

Is the impression as to the timing of onset weak?

... or is the impression strong:

Developmental History

Please indicate the approximate age in months for the following milestones: (example: walking 14 months):

		Never
Sitting up	_____ months	<input type="checkbox"/>
Crawl	_____ months	<input type="checkbox"/>
Pulled to stand	_____ months	<input type="checkbox"/>
Potty trained	_____ months	<input type="checkbox"/>
Walked alone	_____ months	<input type="checkbox"/>
Dry at night	_____ months	<input type="checkbox"/>
First words ("mama, dada" etc.)	_____ months	<input type="checkbox"/>
Spoke clearly	_____ months	<input type="checkbox"/>
Lost language	_____ months	<input type="checkbox"/>
Lost eye contact	_____ months	<input type="checkbox"/>

Medications and Supplements Past and Present:

	Medication or Supplement <i>(please mark the response by checking in the appropriate columns)</i>	Taking now?	Comments.				
			NO RESPONSE	GOOD	VERY GOOD	BAD	NEGATIVE, THEN GOOD
aast	SUBSTANCES AFFECTING:						
CN	CENTRAL NERVOUS SYSTEM						
cnap	Clozaril (clozapine)	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNAP	Haldol	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNAP	Prolixin	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNAP	Risperdal	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNAP	Seroquel	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNAP	Stelazine	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNAP	Thorazine	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
cnap	Zyprexa	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNO	Antihistamine	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNO	Clonidine	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNO	Cogentin	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNO	Deanol (deaner, DMAE)	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNO	Dextromethorphan	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNO	Lithium	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNO	Naltrexone	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNO	St John's wort	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNs	Anafranil	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNs	Depakene for behavior	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNs	Depakene for seizures	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNs	Depakote for behavior	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNs	Depakote for seizures	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNs	Dilantin	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNs	Felbatol	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNs	Gabitril	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNs	Keppra	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNs	Klonopin	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNs	Lamictal	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNs	Luvox	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNs	Mysoline	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNs	Neurontin	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNs	Paxil	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNs	Phenobarbital	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNs	Tegretol	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNs	Topamax	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNs	Trileptal	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNs	Valium	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNs	Zarontin	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNs	Zonegran	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNs	Adderall	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNs	Prozac	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNs	Zoloft	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNet	Amphetamine	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNet	Cylert	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNet	Dexedrine, Dextroamphetamine	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNet	Fenfluramine	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?
CNet	Focalin	○	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	?

	Medication or Supplement <i>(please mark the response by checking in the appropriate columns)</i>		Comments.
			NEGATIVE, THEN GOOD
			DON'T KNOW
			VERY BAD
			BAD
			NO RESPONSE
		GOOD	
	Taking now?		
CNet	Ritalin	<input type="checkbox"/>	<input type="checkbox"/>
CNtr	Buspar	<input type="checkbox"/>	<input type="checkbox"/>
CNr	Chloral hydrate	<input type="checkbox"/>	<input type="checkbox"/>
CNtr	Valium	<input type="checkbox"/>	<input type="checkbox"/>
CNtr	Desipramine	<input type="checkbox"/>	<input type="checkbox"/>
CNtr	Mellaril	<input type="checkbox"/>	<input type="checkbox"/>
CNtr	Tofranil	<input type="checkbox"/>	<input type="checkbox"/>
CNtr	Klonapin	<input type="checkbox"/>	<input type="checkbox"/>
df	Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
df	Bactrim (Septra)	<input type="checkbox"/>	<input type="checkbox"/>
df	Biochoice	<input type="checkbox"/>	<input type="checkbox"/>
df	Bismuth	<input type="checkbox"/>	<input type="checkbox"/>
df	Colostrum	<input type="checkbox"/>	<input type="checkbox"/>
df	Diflucan	<input type="checkbox"/>	<input type="checkbox"/>
df	DIGESTIVE FLORA	<input type="checkbox"/>	<input type="checkbox"/>
df	Humatin	<input type="checkbox"/>	<input type="checkbox"/>
df	Lamisil	<input type="checkbox"/>	<input type="checkbox"/>
df	Nizoral	<input type="checkbox"/>	<input type="checkbox"/>
df	Nystatin	<input type="checkbox"/>	<input type="checkbox"/>
df	Probiotics (acidphilus, etc)	<input type="checkbox"/>	<input type="checkbox"/>
df	Saccharomyces boulardii	<input type="checkbox"/>	<input type="checkbox"/>
df	Sporonax	<input type="checkbox"/>	<input type="checkbox"/>
df	Transfer factor (oral)	<input type="checkbox"/>	<input type="checkbox"/>
df	Yodoxin	<input type="checkbox"/>	<input type="checkbox"/>
Dg	Bethanecol	<input type="checkbox"/>	<input type="checkbox"/>
Dg	DIGESTION	<input type="checkbox"/>	<input type="checkbox"/>
Dg	Digestive enzymes	<input type="checkbox"/>	<input type="checkbox"/>
Dg	Pepsid	<input type="checkbox"/>	<input type="checkbox"/>
Dg	Peptidase Enzymes	<input type="checkbox"/>	<input type="checkbox"/>
Dg	Probiotics	<input type="checkbox"/>	<input type="checkbox"/>
Dtx	DETOXIFICATION	<input type="checkbox"/>	<input type="checkbox"/>
Dtx	DMPS	<input type="checkbox"/>	<input type="checkbox"/>
Dtx	DMSA (succimer, Chemet)	<input type="checkbox"/>	<input type="checkbox"/>
Dtx	Reduced glutathione (transderm)	<input type="checkbox"/>	<input type="checkbox"/>
Dtx	Reduced glutathione IV	<input type="checkbox"/>	<input type="checkbox"/>
Dtx	Reduced glutathione oral	<input type="checkbox"/>	<input type="checkbox"/>
M	B6 & Magnesium	<input type="checkbox"/>	<input type="checkbox"/>
M	Brain child supplements	<input type="checkbox"/>	<input type="checkbox"/>
M	Folic Acid	<input type="checkbox"/>	<input type="checkbox"/>
M	Melatonin	<input type="checkbox"/>	<input type="checkbox"/>
M	Multivitamin high potency	<input type="checkbox"/>	<input type="checkbox"/>
M	Multivitamin regular potency	<input type="checkbox"/>	<input type="checkbox"/>
m	Nutrition and Metabolism	<input type="checkbox"/>	<input type="checkbox"/>
M	Super Nu Thera	<input type="checkbox"/>	<input type="checkbox"/>
M	Ultra Clear Sustain	<input type="checkbox"/>	<input type="checkbox"/>
M	Vitamin B3 (Niacin)	<input type="checkbox"/>	<input type="checkbox"/>
M	Vitamin B6	<input type="checkbox"/>	<input type="checkbox"/>
Maa	5 HPT	<input type="checkbox"/>	<input type="checkbox"/>
Maa	Alpha Keto Glutarate	<input type="checkbox"/>	<input type="checkbox"/>

Food

In the past:	Yes	No
Were you breast fed	<input type="checkbox"/>	<input type="checkbox"/>
Problem "latching on"	<input type="checkbox"/>	<input type="checkbox"/>
Vigorous sucker	<input type="checkbox"/>	<input type="checkbox"/>
Good sucker	<input type="checkbox"/>	<input type="checkbox"/>
Poor sucker	<input type="checkbox"/>	<input type="checkbox"/>
Choke or gag on milk	<input type="checkbox"/>	<input type="checkbox"/>
Were you bottle fed	<input type="checkbox"/>	<input type="checkbox"/>
Did you refuse to chew solids	<input type="checkbox"/>	<input type="checkbox"/>
Exclusively breast-fed until		months
Exclusively formula fed until		months
Exclusively soy formula fed until		months
Exclusively milk based* formula until		months
Introduction of cow's milk at		months
Introduction of rice cereal		months
Introduction of wheat and other grains		months

*Enfamil, Similac, SMA, etc.

In the present do you eat:	Yes	No
A lot of ice cream	<input type="checkbox"/>	<input type="checkbox"/>
A lot of sweet food	<input type="checkbox"/>	<input type="checkbox"/>
A lot of sugar/candy	<input type="checkbox"/>	<input type="checkbox"/>
Large amounts of food	<input type="checkbox"/>	<input type="checkbox"/>
Only cold food	<input type="checkbox"/>	<input type="checkbox"/>
Only 3-5 foods daily	<input type="checkbox"/>	<input type="checkbox"/>
A lot of cookies	<input type="checkbox"/>	<input type="checkbox"/>
A lot of white bread	<input type="checkbox"/>	<input type="checkbox"/>
A lot of soda/diet soda	<input type="checkbox"/>	<input type="checkbox"/>
Only one or two foods daily	<input type="checkbox"/>	<input type="checkbox"/>
Only hot food	<input type="checkbox"/>	<input type="checkbox"/>
Milk at least once a day	<input type="checkbox"/>	<input type="checkbox"/>
Salty foods	<input type="checkbox"/>	<input type="checkbox"/>
Sensory issues with food	<input type="checkbox"/>	<input type="checkbox"/>

Past and Present Symptoms

Please check the best description of your symptoms (mild, moderate or severe) and indicate the time frame (occasional, frequent or always). If the problem is a current and main problem, please check the "main" column. If the problem was present in the past, please check the "PAST ONLY" column.

sort	Main ?	Symptom	MILD	MOD	SEV	Occ	Freq	Always	PAST ONLY	COMMENT
02Sev	<input type="radio"/>	Examines by sight	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
02Sev	<input type="radio"/>	Fails to blink at bright light	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
02Sev	<input type="radio"/>	Likes fans	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
02Sev	<input type="radio"/>	Likes flickering lights	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
02Sev	<input type="radio"/>	Looks out of corner of eye	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
02Sev	<input type="radio"/>	Poor vision	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
02Sev	<input type="radio"/>	Puts eye to bright light or sun	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
02Sev	<input type="radio"/>	Strabismus (crossed eye)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
03Cc	<input type="radio"/>	Adopts complicated rituals	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
03Cc	<input type="radio"/>	Collects particular things	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
03Cc	<input type="radio"/>	Corrects imperfections	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
03Cc	<input type="radio"/>	Draws only certain things	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
03Cc	<input type="radio"/>	Fixated on one topic	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
03Cc	<input type="radio"/>	Lines objects precisely	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
03Cc	<input type="radio"/>	Lines things in neat rows	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
03Cc	<input type="radio"/>	Repeats old phrases, sentences	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
03Cc	<input type="radio"/>	Repetitive play/objects	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
03Cc	<input type="radio"/>	Tidy	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
03Cc	<input type="radio"/>	Upset if things change	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
03Cc	<input type="radio"/>	Upset of things aren't right	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
04B	<input type="radio"/>	BEHAVIOR								
04Be	<input type="radio"/>	Aloof, indifferent, remote	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
04Be	<input type="radio"/>	Behavior purposeless	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
04Be	<input type="radio"/>	Bites or chews fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
04Be	<input type="radio"/>	Bites wrist or back of hands	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
04Be	<input type="radio"/>	Climbs to high places	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
04Be	<input type="radio"/>	Constant movement	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
04Be	<input type="radio"/>	Curious/gets into things	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
04Be	<input type="radio"/>	Destructive	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
04Be	<input type="radio"/>	Does opposite/asked	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
04Be	<input type="radio"/>	Extremely cautious	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
04Be	<input type="radio"/>	Falls gets hurt running climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
04Be	<input type="radio"/>	Head banging	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
04Be	<input type="radio"/>	Holds hands in strange pose	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
04Be	<input type="radio"/>	Hyperactive	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
04Be	<input type="radio"/>	Imitates others	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
04Be	<input type="radio"/>	Lost in thought, unreachable	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
04Be	<input type="radio"/>	Melt downs	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
04Be	<input type="radio"/>	Poor focus, attention	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

sort	Main ?	Symptom	MILD	MOD	SEV	Occ	Freq	Always	PAST ONLY	COMMENT
04Be	<input type="radio"/>	Poor sharing	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Be	<input type="radio"/>	Silly	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Be	<input type="radio"/>	Spends time with pointless task	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Be	<input type="radio"/>	Tantrums	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Be	<input type="radio"/>	Toe walking	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Be	<input type="radio"/>	Uninterested in live pet	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Be	<input type="radio"/>	Unusual play	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Be	<input type="radio"/>	Uses adults hand for activity	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Be	<input type="radio"/>	Watches television long time	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Ben	<input type="radio"/>	Doesn't do for self	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Ben	<input type="radio"/>	Hides skill/knowledge	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Ben	<input type="radio"/>	No purpose to play	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Ben	<input type="radio"/>	Rejects help	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Ben	<input type="radio"/>	Teases others	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Ben	<input type="radio"/>	Tries to control others	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Ben	<input type="radio"/>	Unable to predict actions	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Ben	<input type="radio"/>	Won't attempt/can't do	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Bes	<input type="radio"/>	Eye contact poor	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Bes	<input type="radio"/>	Finger flicking	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Bes	<input type="radio"/>	Flaps hands	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Bes	<input type="radio"/>	Jumps when pleased	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Bes	<input type="radio"/>	Licking	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Bes	<input type="radio"/>	Likes spinning objects	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Bes	<input type="radio"/>	Likes to flick finger in eye	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Bes	<input type="radio"/>	Likes to spin things	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Bes	<input type="radio"/>	Rhythmic rocking	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Bes	<input type="radio"/>	Sits long time staring	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Bes	<input type="radio"/>	Slapping books	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Bes	<input type="radio"/>	Stares at own hands	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Bes	<input type="radio"/>	Tooth tapping	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Bes	<input type="radio"/>	Whirls self like a top	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Bes	<input type="radio"/>	Wiggle finger front of face	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Bes	<input type="radio"/>	Wiggle finger side of face	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Bew	<input type="radio"/>	Insists on what wanted	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Bew	<input type="radio"/>	Lacks initiative	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
04Bew	<input type="radio"/>	Runs away	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
05Bov	<input type="radio"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
05Bov	<input type="radio"/>	Joint pains	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
05Bov	<input type="radio"/>	Leg pains	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

sort	Main? ?	Symptom	MILD	MOD	SEV	Occ	Freq	Always	PAST ONLY	COMMENT
14Mus	<input type="radio"/>	Muscle tone tense	<input type="checkbox"/>							
14Mus	<input type="radio"/>	Muscle twitches	<input type="checkbox"/>							
14Mus	<input type="radio"/>	Poor muscle tone/limp	<input type="checkbox"/>							
14Mus	<input type="radio"/>	Tics	<input type="checkbox"/>							
15R	<input type="radio"/>	REPRODUCTIVE:	<input type="checkbox"/>							
15R	<input type="radio"/>	Age of first period								
15R	<input type="radio"/>	Boys: Large testicles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
15R	<input type="radio"/>	Early onset breast development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
15R	<input type="radio"/>	Early onset pubic hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
16U	<input type="radio"/>	URINARY:								
16U	<input type="radio"/>	Bed wetting after age 4	<input type="checkbox"/>							
16U	<input type="radio"/>	Odd urinary odor	<input type="checkbox"/>							
16U	<input type="radio"/>	Urinary hesitancy	<input type="checkbox"/>							
16U	<input type="radio"/>	Urinary tract infections	<input type="checkbox"/>							
16U	<input type="radio"/>	Urinary urgency	<input type="checkbox"/>							
16G	<input type="radio"/>	Pallor	<input type="checkbox"/>							
22	<input type="radio"/>	_____	<input type="checkbox"/>							
25	<input type="radio"/>	_____	<input type="checkbox"/>							

Environmental History (please indicate past and present exposures)		
Exposure:	Past	Present
Mold in bathroom		
Damp cellar		
Pest extermination - Inside		
Pest extermination - Outside		
Forced hot air heat		
Had water in basement		
Mold visible on exterior of house		
Heavily wooded or damp surroundings		
Mold in cellar, crawl space, or basement		
Moldy, musty school/daycare		
Tobacco smoke		
Well water		
Carpet in bedroom		
Carpet in most parts of house		
Feather or down bedding		

Some things about your parents:	
When were your parents married:	
If separated, when:	
If divorced, when	
If remarried, when	
Custody arrangements	
Mother - Personal	
Age at your birth	
Education	
Ethnicity	
Blood type	
Father - Personal	
Age at your birth	
Education	
Ethnicity	
Blood type	

Family Medical History	Mother's Side			Father's Side		
	Mother	Father	Sibling(s)	Grand-father	Grand-mother	Grand-father
Other						
First Cousin						
Alcoholism						
Allergies						
Anorexia						
Anxiety						
Arthritis						
Asthma						
Autism						
Autoimmune problems						
Bulimia						
Celiac disease						
Colitis						
Crohn's disease						
Depression						
Diabetes						
Eczema						
Endometriosis						
Food allergies						
Gout/high uric acid level						
Hay Fever						
Heart disease						
High blood pressure						
Hives						
Hypoglycemia						
Identical twins						
Irritable						
Left handedness						
Malabsorption						
Mental illness						
Mild respiratory allergy						
Milk (casein) sensitivity						
Mitral valve prolapse						
Obesity						
Retardation						
Schizophrenia Psychosis						
Stroke						
Strong moodiness						
Tendency to be "loner"						
Thyroid problem						
Wheat (gluten) sensitivity						
Yeast problems						

Thank you for taking the time and effort to complete this questionnaire. I suggest you make copies of it for your records.