Please submit the completed Health History Form by mailing / faxing to:

Whether you are seen at the Warrenville, IL Clinic or any of our Outreach Clinics, please contact us at:

Pfeiffer Medical Center
4575 Weaver Parkway
Warrenville, IL 60555-4039
Phone: 630-505-0300
Fax: 630-836-0667

Electronic Communication: If you would like to use email communication, please provide your email address. Please note that we cannot send private medical information by email due to privacy concerns. If the patient is a minor, please list the email address of the parent/legal guardian.

Email Address: __________________________@________________________
□ Patient □ Parent/Guardian

I would like email communication for:
□ Appointment Reminders
□ General announcements of new services, programs, upcoming events, research and Marketing.

PLEASE NOTE: WE ARE NOT A “COVERED ENTITY” UNDER MEDICARE GUIDELINES, AND CANNOT BILL MEDICARE FOR OUR SERVICES.

PLEASE ALSO NOTE: WE CANNOT ACCEPT PATIENTS WHO ARE PREGNANT.

How did you hear about Pfeiffer Treatment Center?
□ CNBC □ Reuters □ FaceBook Are you a Former Patient? □ Yes □ No
□ Family Member □ Friend □ Brochure If yes, Date last seen: ____________
□ Internet - if so:
□ Google Search □ Google Advertisement
□ Pfeiffer Treatment Center website (www.hriptc.org)
□ Yahoo advertisement □ Other website: __________________________

□ Print or Broadcast Media (please provide details):
□ Autism File □ Chicago Parent □ Chicago Special Parent □ Other: __________________________
□ Presentation/Informational Seminar (Location/Date): __________________________
□ Conference (Location/Date): __________________________
□ Other: _____________________________________________________________________
□ Professional Referral (please provide specific information on the next page)
HEALTH HISTORY FORM

PATIENT INFORMATION
* Required Information

*NAME: ____________________________________________
  Last          First          M.I.

*ADDRESS: _____________________________________________
  Number      Street      Apt.

  City        State        Zip Code

Complete the parent information only if the patient is a minor.

Mother’s Name: ____________________________
Father’s Name: ____________________________ or
Legal Guardian’s Name: ____________________________

EMERGENCY CONTACTS
1. NAME: ____________________________________________
   PHONE: (____) _____-__________

2. NAME: ____________________________________________
   PHONE: (____) _____-__________

GUARANTOR INFORMATION

*NAME: ____________________________________________

*ADDRESS: _____________________________________________
  Number      Street      Apt.

  City        State        Zip code

EMAIL: __________________@____________________

Insurance Group # _____________________________

***Please include a copy of the front and back of your insurance card with this form.

*Employer: ____________________________
*Employer Address: ____________________________

*Employer Phone: (____) _____-__________

PROFESSIONAL REFERRAL:

NAME: ____________________________

PROF. TITLE: ____________________________

Address: ____________________________

Phone: (____) _____-__________

*If Legal Guardian, please include documents showing legal guardianship with this form.

FINANCIAL RESPONSIBILITY: I understand that all professional services are charged to the patient, and are due and payable on the date that services are rendered unless other arrangements have been made with the financial counselor. I agree to pay all such charges in full immediately upon presentation of the appropriate statement.

Guarantor’s Signature ____________________________ DATE: ____________________________

DATE OF BIRTH (DOB): _______/_____/__________

GENDER: ☐ Male ☐ Female

AGE: ________  WEIGHT: ________ lbs.

PHONE: (____) _____-__________

Does the Patient have:

*Federal Medicare ☐ Yes ☐ No
Federal Tricare Insurance ☐ Yes ☐ No
State Medicaid ☐ Yes ☐ No

** Please include a copy of your insurance card.

☐ Parent ☐ Legal Guardian ☐ Spouse
☐ Other: ____________________________

☐ Parent ☐ Legal Guardian ☐ Spouse
☐ Other: ____________________________

☐ Parent ☐ Legal Guardian* ☐ Spouse
☐ Other: ____________________________
Home: (____) _____-__________
Work (____) _____-__________
Cell: (____) _____-__________
*SS # - ______-_______
*DOB # _____/_____/______

***Please include a copy of the front and back of your insurance card with this form.
ALLERGIES/REACTIONS TO MEDICATIONS: ( rash, hives, swelling, shortness of breath)

CURRENT PRESCRIPTIONS/OVER THE COUNTER MEDICATIONS/
NON PFEIFFER NUTRIENTS

<table>
<thead>
<tr>
<th>MEDICINE/Route</th>
<th>DOSE/How often</th>
<th>DATE STARTED</th>
<th>LAST TAKEN</th>
<th>RESPONSE</th>
<th>D/C'd (ofc. use)</th>
<th>RN INITIALS/Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<td>14.</td>
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MEDICATION FAILURES:

RN SIGNATURE: ___________________________ Date: __________________

<table>
<thead>
<tr>
<th></th>
<th>YES – NO</th>
<th>YES - NO</th>
<th>YES - NO</th>
<th>YES - NO</th>
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<tbody>
<tr>
<td>DO YOU SWALLOW PILLS ?</td>
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<td>INTERESTED IN COMPOUNDING?</td>
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<tr>
<td>ANTIHISTAMINES IN PAST 3 MONTHS?</td>
<td></td>
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<tr>
<td>ALLERGY SHOTS/DROPS IN PAST 3 MONTHS?</td>
<td></td>
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<tr>
<td>TOTAL DAILY ZINC:</td>
<td></td>
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</tbody>
</table>

Patient Name: ___________________________________________________________ DOB: ___/___/____
**HEALTH HISTORY FORM**

**Patient Medical History** (check if applicable)

<table>
<thead>
<tr>
<th>□</th>
<th>In the Past - or</th>
<th>□</th>
<th>In the Past - or</th>
<th>□</th>
<th>In the Past - or</th>
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<tbody>
<tr>
<td>□</td>
<td>Acne</td>
<td>□</td>
<td>Esophagitis</td>
<td>□</td>
<td>Hypothyroidism</td>
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<tr>
<td>□</td>
<td>Eczema</td>
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<td>Peptic Ulcer Disease</td>
<td>□</td>
<td>Hypothyroidism</td>
</tr>
<tr>
<td>□</td>
<td>Psoriasis</td>
<td>□</td>
<td>Gastric Esophageal Reflux</td>
<td>□</td>
<td>Alzheimers Disease</td>
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<tr>
<td>□</td>
<td>Allergic Rhinitis</td>
<td>□</td>
<td>Pancreatitis</td>
<td>□</td>
<td>Parkinsons Disease</td>
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<td>□</td>
<td>Chronic Sinusitis</td>
<td>□</td>
<td>Colitis</td>
<td>□</td>
<td>Dementia</td>
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<tr>
<td>□</td>
<td>Asthma</td>
<td>□</td>
<td>Irritable Bowel Syndrome</td>
<td>□</td>
<td>Seizure Disorder</td>
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<tr>
<td>□</td>
<td>Arthritis/Rheumatoid/Lupus</td>
<td>□</td>
<td>Inflammatory Bowel Disease</td>
<td>□</td>
<td>Fibrocystic Breast Cancer</td>
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<tr>
<td>□</td>
<td>Chronic Fatigue Syndrome</td>
<td>□</td>
<td>Gall Bladder Dysfunction</td>
<td>□</td>
<td>Endometriosis</td>
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<tr>
<td>□</td>
<td>Multiple Sclerosis</td>
<td>□</td>
<td>Hepatitis</td>
<td>□</td>
<td>Fibroid Tumors</td>
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<tr>
<td>□</td>
<td>Collagen Vascular Disease</td>
<td>□</td>
<td>Liver Disease</td>
<td>□</td>
<td>Poly cystic Ovarian Disease</td>
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<tr>
<td>□</td>
<td>Fibromyalgia</td>
<td>□</td>
<td>Kidney Problems</td>
<td>□</td>
<td>PMS</td>
</tr>
<tr>
<td>□</td>
<td>Multiple Chemical Sensitivities</td>
<td>□</td>
<td>Urinary Tract Infections</td>
<td>□</td>
<td>Postpartum Depression</td>
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<tr>
<td>□</td>
<td>Heart Disease</td>
<td>□</td>
<td>Thrus</td>
<td>□</td>
<td>Menopause</td>
</tr>
<tr>
<td>□</td>
<td>Stroke</td>
<td>□</td>
<td>Athlete's Foot</td>
<td>□</td>
<td>Glaucoma</td>
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<tr>
<td>□</td>
<td>Hypertension</td>
<td>□</td>
<td>Tinea Nigra/Fingernail</td>
<td>□</td>
<td>Night-Blindness</td>
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<tr>
<td>□</td>
<td>High Cholesterol/High Triglycerides</td>
<td>□</td>
<td>Ringworm</td>
<td>□</td>
<td>Other: __________</td>
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<tr>
<td>□</td>
<td>Diabetes</td>
<td>□</td>
<td>Yeast Infections</td>
<td></td>
<td></td>
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<tr>
<td>□</td>
<td>Cancer</td>
<td>□</td>
<td></td>
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</tbody>
</table>

**Psychiatric History**

<table>
<thead>
<tr>
<th>□</th>
<th>Diagnosed - or</th>
<th>□</th>
<th>Symptoms or Suspected</th>
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<th>Symptoms or Suspected</th>
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<tbody>
<tr>
<td>□</td>
<td>ADD</td>
<td>□</td>
<td>Anxiety Disorders</td>
<td>□</td>
<td>Psychotic Disorders</td>
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<tr>
<td>□</td>
<td>ADHD</td>
<td>□</td>
<td>Generalized Anxiety Disorder</td>
<td>□</td>
<td>Schizophrenia</td>
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<tr>
<td>□</td>
<td>PDD/Autism spectrum</td>
<td>□</td>
<td>Phobic Disorder</td>
<td>□</td>
<td>Schizoaffective Disorders</td>
</tr>
<tr>
<td>□</td>
<td>Oppositional Defiant Disorder</td>
<td>□</td>
<td>Panic Disorder</td>
<td>□</td>
<td>- Bipolar Type</td>
</tr>
<tr>
<td>□</td>
<td>Conduct Disorder</td>
<td>□</td>
<td>Obsessive Compulsive Disorder</td>
<td>□</td>
<td>- Depressive Type</td>
</tr>
<tr>
<td>□</td>
<td>Behavior Disorder</td>
<td>□</td>
<td>Post Traumatic Stress Disorder</td>
<td>□</td>
<td>Delusional Disorder</td>
</tr>
<tr>
<td>□</td>
<td>Tics/Tourettes</td>
<td>□</td>
<td>Acute Stress Disorder</td>
<td>□</td>
<td>Dissociative Disorder</td>
</tr>
</tbody>
</table>

**Eating Disorders**

<table>
<thead>
<tr>
<th>□</th>
<th>Major Depressive Disorder</th>
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<tbody>
<tr>
<td>□</td>
<td>Bipolar I Disorder</td>
</tr>
<tr>
<td>□</td>
<td>Bipolar II Disorder</td>
</tr>
<tr>
<td>□</td>
<td>Cyclothymic Disorder</td>
</tr>
</tbody>
</table>

**Family History** (Please indicate relatives using the key below. Other relatives may be listed if believed significant/relevant.)

Patient is adopted, information is not available.

<table>
<thead>
<tr>
<th>ADD/ADHD</th>
<th>Thyroid</th>
<th>Bipolar</th>
<th>Arthritis</th>
<th>Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violence</td>
<td>Ulcers</td>
<td>Alcohol/Drug Abuse</td>
<td>Depression</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Panic Attacks</td>
<td>Heart Disease</td>
<td>Suicide Attempt</td>
<td>Kidney Problems</td>
<td>Psoriasis</td>
</tr>
<tr>
<td>Asthma</td>
<td>Stroke</td>
<td>Depression</td>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>Early Senility</td>
<td>Hypertension</td>
<td>Schizophrenia</td>
<td></td>
<td></td>
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<tr>
<td>Alzheimer’s</td>
<td></td>
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</tbody>
</table>

**KEY:**

- M = Mother  
- MGM = Maternal Grandmother  
- MGF = Maternal Grandfather  
- MA/MU = Maternal Aunt/Uncle  
- S = Sister  
- F = Father  
- PGM = Paternal Grandmother  
- PGF = Paternal Grandfather  
- PA/PU = Paternal Aunt/Uncle  
- B = Brother

**Other:**

**Patient Name:** ____________________________  
**DOB:** ____/____/_____
# HEALTH HISTORY FORM

**Chief Complaint:** List the symptoms or problems you would like the Pfeiffer Treatment Center to address, #1 being most important:

1. 
2. 
3. 
4. 
5. 
6. 
7. 

Are you pregnant? □ Yes □ No □ N/A
Are you breastfeeding? □ Yes □ No □ N/A

**WE CANNOT ACCEPT PATIENTS WHO ARE PREGNANT!**

All *starred* items must be filled in

*How many alcoholic drinks do you consume?*

None ____________ Per day/ week/ month  ________________________________

Past abuse? _______________________________________________________

*Any illegal drug use in year?_____________________

None ____________ Per day/week/Month_____________________

Past abuse? _____________________________________________________

Do you use tobacco? ________ Per day/week/month ____________________

List all Current Therapies (OT, PT, Speech, ABA, Psychiatrist, Therapist, Other):

Past Treatment & Response:

Hospitalizations – Dates & Reason

Surgeries – Dates & Reason

Patient Name: ________________________________________________________

DOB: ____/____/____
**Physical Health**

*Please note problems /diagnoses in the following areas, including dates of diagnoses:*

**Skin / Hair:**

**Ear, Nose, Throat:**

**Digestive / GI:**

Last Dental Visit/Status: ________________________________

**Heart / Circulatory / Cholesterol:**

**Respiratory:** (Allergies/Asthma/Other)

**Endocrine** (*thyroid, diabetes, etc.):*

**Liver:**

**Kidney / Urinary:**

**Neurologic:**

Head Injuries (dates, was there loss of consciousness?)

**Reproductive:**

**Female History:**

Age at first period _____

Number of pregnancies: ____  Miscarriages/abortions: ____  Births: ____

☐ PMS  ☐ Post Partum Depression

☐ Ovarian cysts  ☐ Irregular Periods  ☐ Endometriosis

☐ Hysterectomy  ☐ Menopause  ☐ Fibrocystic Breast Cancer

☐ Other: ________________________________

Last Menstrual Period: ________________________________

History of Yeast Infections: ________________________________

**Immune** (*cancer, Lupus, AIDS, ALS, etc.):*

**Sensory** (*vision, hearing, taste, smell, touch):*

**Last Primary Physician Visit:** ________________________________

Last Vision Exam: ________________  Last Hearing Exam: ________________

**Office use only**
**Patient Name:** ____________________________________________

**DOB:** ____/____/______

<table>
<thead>
<tr>
<th>Diet</th>
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<tbody>
<tr>
<td>☐ Regular</td>
<td>☐ Casein Free</td>
<td>☐ Gluten Free</td>
<td>☐ Vegetarian</td>
<td>☐ Feingold</td>
<td>☐ Body Ecology</td>
<td>☐ Specific Carbohydrate</td>
</tr>
</tbody>
</table>

Response to current diet: ________________________________

How long on current diet: ________________________________

Number of meals per day: _____ Number of snacks: _______

Appetite: __________________ Cravings: ______________________

Rate the intake of the foods below (circle)

<table>
<thead>
<tr>
<th>Sweets</th>
<th>Low</th>
<th>Avg.</th>
<th>High</th>
<th>Carbohydrates</th>
<th>Low</th>
<th>Avg.</th>
<th>High</th>
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</thead>
<tbody>
<tr>
<td>Protein</td>
<td>Low</td>
<td>Avg.</td>
<td>High</td>
<td>Fruit</td>
<td>Low</td>
<td>Avg.</td>
<td>High</td>
</tr>
<tr>
<td>Dairy</td>
<td>Low</td>
<td>Avg.</td>
<td>High</td>
<td>Vegetables</td>
<td>Low</td>
<td>Avg.</td>
<td>High</td>
</tr>
</tbody>
</table>

Main Beverage: _______________ Amount per day: _________________

Caffeine: _______ per day/week  ☐ Hypoglycemic symptoms

☐ Pica  ☐ Aversion to breakfast  ☐ Picky eater

**Bowel movements / Stooling**

Frequency: _____ per ______

Character of stools:

☐ Constipation  ☐ Diarrhea  ☐ Encopresis  ☐ Excess gas

☐ Stomach aches  ☐ Posturing

**Gut Treatment:**

Tests done: ________________________________________________

Treatment: ________________________________________________

Effectiveness: ______________________________________________

**Immune Function**

Immunizations current? ☐ Yes ☐ No

Adults 65 yrs & older: Pneumonia vaccine? ☐ Yes ☐ No

Reactions/Regressions related to immunizations:

☐ Frequent colds/infections  ☐ Environmental allergies/rhinitis

☐ Chemical Sensitivities  ☐ Other:

Frequency of Antibiotic Use: ________________________________

**Sleep: Time to Bed: ____________ Time Awake: ____________**

Difficulty: ☐ Falling asleep  ☐ Staying asleep  ☐ Waking

☐ Nightmares  Dream recall: ☐ None ☐ Dull ☐ Vivid

☐ Enuresis  ☐ Sleep Apnea  ☐ Restless Legs  Other: ____________

---

1 Simple carbohydrates such as bread, pasta, breakfast cereals, etc.

2 Drowsy after meals, shakiness/dizziness, irritability when hungry, craving sweets, etc.

3 An abnormal craving or appetite for nonfood substances, such as dirt, paint, or clay.

4 Accidental soiling of undergarments

5 Bedwetting

Patient Name: ____________________________________________  DOB: ____/____/______
### Cognitive / Executive Functions
- [ ] Problem staying on task
- [ ] Impulsivity
- [ ] Problems with memory
- [ ] Poor organization
- [ ] Sequencing\(^6\)
- [ ] Foggy brained
- [ ] Hyper behavior / fidgety
- [ ] Distractible
- [ ] Racing thoughts
- [ ] Problems with focus / concentration
- [ ] Loses things frequently

**Motivation:**  
- [ ] None
- [ ] Low
- [ ] Normal
- [ ] High

### Employment
- [ ] Full time
- [ ] Part time
- [ ] Position: ________________

**Time there:**  
- [ ] Student
- [ ] Homemaker
- [ ] N/A
- [ ] Retired
- [ ] Disabled
- [ ] Unemployed

### Sensory
- [ ] Light
- [ ] Sound
- [ ] Odors
- [ ] Tactile (clothing)
- [ ] Ringing in the ears
- [ ] Upper body pain\(^7\)
- [ ] Back pain
- [ ] Joint pain

**Headaches:**  
- [ ] Tension/muscle
- [ ] Migraine

**Frequency:** ________________

**Pain tolerance:**  
- [ ] High
- [ ] Avg.
- [ ] Low

### Social Development
Lives with whom *(include ages)*?

- [ ] Seeks Interaction
- [ ] Isolates
- [ ] Alienates
- [ ] Makes poor choices
- [ ] Parallel play
- [ ] Poor eye contact
- [ ] Divergent Gaze
- [ ] Misses social cues

If Child:  
- [ ] Prefers younger playmates
- [ ] Prefers older playmates

**Notes:**

### Personality and Behavior: Briefly describe:

---

\(^6\) Problems putting things in order, planning

\(^7\) Brain, face, neck, shoulder
**Brain Health**  *Star* questions must be answered.

Describe Typical Response to Stress:

Describe Temper:

**Anger Management:**
- ☐ Argues
- ☐ Verbal tantrums
- ☐ Destroys property
- ☐ Threats
- ☐ Aggressive to others
- ☐ Intentional harm

Frequency of Anger Outbursts: ________________

Intensity & Duration of Anger: ________________

**Behavior:** ☐ Oppositional Defiant ☐ Self Harm Behaviors:

Anxiety disorders (OCD, Panic, Nervousness, Worry): ________________

Depressive Disorders: ________________

*Suicide Risk* ☐ History of Attempt, Dates of Attempts ________________

*Treatment* ________________

*Past history of ideation, plan or intent* ________________

*In past 6 months* ☐ Thoughts ☐ Plan ☐ Preparation ☐ Intent

*Are you under a Psychiatrist’s care?* ________________

If answer is yes to suicidal ideation in past 6 months, Psychiatrist is necessary.

**This is SERIOUS! If you can check current Plan, Preparation or Intent, contact your family / friend / mental health professional immediately, or call 911.**

Has there ever been a Psychiatric Evaluation? Yes___ No___

Please list dates and diagnosis:

Dementia / Degenerative disorders/ Memory Impairment:

Eating disorders:

Bipolar Disorder:
- Predominant Mood: ____________________________

Psychotic disorders:
- ☐ Hallucinations: ☐ Auditory ☐ Visual ☐ Tactile
- ☐ Disordered Thoughts ☐ Delusions ☐ Other: ☐ Paranoia

Seizure disorders:

Tics / Tourette’s: ☐ Clumsiness / accident prone

Office use only
**DEVELOPMENTAL ADDENDUM**

*Complete this section only for developmental disorders such as Autism Spectrum Disorders (ASD), Pervasive (and other) Developmental Disorders, etc.*

### Mother’s health during pregnancy
- Mother’s age at patient’s birth: _____
- Dental work:
- RhoGam:
- Immunizations:

**Note type, amount and frequency**
- Alcohol use:
- Tobacco use:
- Illicit drug use:
- Medications, Supplements, Herbs used:

### Mood disorders:

### Significant Illnesses:
- ☐ High blood pressure / Preeclampsia
- ☐ Toxemia
- ☐ Gestational diabetes

### Preterm labor @ _____ weeks

### Neonatal Health
- ☐ Low birth weight – Birth weight: _____ lbs. _____ oz.
- Birth events:
  - ☐ Cord around neck
  - ☐ Emergency C-section
  - ☐ Forceps use
  - ☐ Vacuum use
  - ☐ Fetal distress
  - ☐ Preterm delivery @ _____ weeks
- ☐ Other delivery problems:
  - ☐ Jaundice
  - ☐ Oxygen after birth
  - ☐ Ear infections
  - ☐ Colic
  - ☐ Antibiotics
  - ☐ Formula intolerance
  - ☐ Skin problems:

### Potential toxic exposures
- ☐ Home built before 1978
- ☐ Second hand smoke
- ☐ Parent or family occupation$^8$ / hobby$^9$:
- ☐ Immunizations (note reaction or regression)

### Water source$^{10}$:

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$^8$ Work with lead or other heavy metals, Lead/brass/bronze melting/ refining/ manufacturing, Rubber/plastic manufacturing, Painting, Demolition, Construction, Battery manufacture/recycling, Radiator manufacturing/repair, Soldering, Steel welding/cutting

$^9$ Glazed pottery, Stained glass, Painting, Firearms (shooting, reloading), Lead figurines, Antique toys, etc.

$^{10}$ Note if bottled, tap, well, filtered, softened, tested
### Developmental History

<table>
<thead>
<tr>
<th>Gross motor development:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fine motor development:</td>
<td></td>
</tr>
<tr>
<td>Sensory Integration:</td>
<td></td>
</tr>
<tr>
<td>□ Repetitive behaviors:</td>
<td></td>
</tr>
<tr>
<td>□ Disruptive behaviors:</td>
<td></td>
</tr>
<tr>
<td>Plays with toys appropriately?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Language development</td>
<td>□ Early □ Normal □ Late</td>
</tr>
<tr>
<td>□ Regressed – at what age? ______</td>
<td></td>
</tr>
<tr>
<td>Language functioning:</td>
<td>□ None □ Words □ Sentences</td>
</tr>
<tr>
<td>□ Repetitive □ Processing deficits</td>
<td>□ Echolalia □ Scripting</td>
</tr>
<tr>
<td>□ Able to understand / follow directions</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**

### Other

*Please note anything of concern not entered above, or give additional information if needed.*

### Contact Information

**Name of Current Primary Care Physician:**__________________________  
**Phone Number:** _____________________________________________

**Name of Current Psychiatrist:** ________________________________  
**Phone Number:** _____________________________________________

**Name of Current Therapist:** ________________________________  
**Phone Number:** _____________________________________________

**Patient Name:** ______________________________________________  
**DOB:** ____/____/_______