Comprehensive Evaluation Form

Child's Name: Date of Birth:

Date of Completion:

Thank you for choosing us to support the health and well-being of your child and family. It is an honor to serve you.

We understand that this evaluation form is long and includes some very personal questions. Wellness and illness are a complex interaction of the body, mind, heart and spirit. Answering these questions as honestly as possible will help us to understand what is happening with your child and what interventions might make a difference. Please know your answers are kept in confidence.

Family history (siblings, parents, aunt/uncles, cousin, grandparents): (Please check all that apply *and indicate whom the disorder affected*)

__ Allergies

__ Asthma

__ Celiac disease

__ Chronic Fatigue syndrome

__ Crohn's disease

__ Diabetes, Type I (insulin dependent)

__ Diabetes, Type II

__ Eczema

__ Food allergies/sensitivities/intolerances

__ Fibromyalgia

__ Genetic disorders

__ Irritable Bowel Syndrome

__ Inflammatory Arthritis (rheumatoid, psoriatic, ankylosing spondlylitis)

__ Lupus

__ Multiple Sclerosis

__ Obsessive Compulsive disorder

__ Parkinson's

__ Seizures

__ Tic disorders

__ Thyroid disorder, auto-immune (Hashimoto's)

__ Thyroid disorder (non-autoimmune)

__ Tourette disorder

__ Ulcerative colitis

__ Wheat (gluten) sensitivity

__ Yeast infections (including ringworm, thrush, cradle cap, vaginal, etc)

Family History(continued)

Neuropsychiatric Disorders/Mental Illnesses

__ ADHD

__ Alzheimer's/Dementia

__ Anxiety

__ Autism

__ Bipolar (manic depressive disorder)

__ Depression

__ PANS/PANDAS

__ Schizophrenia

__ Substance Abuse

What other medical family history should we be aware of?

Preconception/Conception

Did you conceive easily and intentionally? ☐Yes ☐No, describe:

Did you use fertility drugs, in-vitro fertilization, etc? ☐No ☐Yes, describe:

Mother ☐ Adopted, not known

How would you describe your general health the year prior to conception?

Did you have frequent antibiotic use as child or adult [strep, OM, sinuses, acne, etc]? ☐No

☐Yes, describe:

Did you have yeast infections as a child or adult? ☐No ☐Yes, describe:

Did you have frequent viral infections as a child or adult? ☐No ☐Yes, describe:

Were you over or under weight? ☐No ☐Yes, describe:

Did you have diabetes? ☐No ☐Yes

What stressors did you have in this year and how did you manage the stress?

What was your occupation?

Pre-Conception/Conception History (continued)

Father ☐ Adopted, not known

How would you describe your general health the year prior to conception?

What stressors did you have in this year and how did you manage the stress?

What was your occupation?

In-Utero/Pregnancy

Did you (mom or dad) have any of these exposures during your pregnancy? (Circle if yes and provide details): ☐ Adopted, not known

Newly built home	House exterminated for insects
Renovation of home	Chemical exposures
House painted (indoors/outdoors)	Mold exposures

Mother ☐ Adopted, not known

Did you have "silver" dental fillings (amalgams) at the time of pregnancy? ☐No ☐Yes, number: ___

Did you have any new silver fillings put in or old ones repaired/removed during pregnancy? ☐No ☐Yes

Did you receive any vaccines during pregnancy? ☐No ☐Yes, what?

Did you have any thyroid testing done during your pregnancy? ☐No ☐Yes, results:

Did you have gestational diabetes during your pregnancy? ☐No ☐Yes

Did mother use any street drugs, alcohol, cigarettes/tobacco/e-cigs, prescription drugs (progesterone)

Any problems with the Pregnancy? (circle and provide additional details)

Bacterial infections	Viral infection
Antibiotics	Yeast Infection
Hospitalizations during pregnancy	Bleeding (which months?)
Excessive vomiting, nausea (>3weeks)	High blood pressure (pre-eclampsia/toxemia)

Any other health concerns during your pregnancy? ☐No ☐Yes, describe:

What stressors did you have in this year and how did you manage the stress? ☐same as above

What was your occupation? ☐same as above

Father ☐ Adopted, not known
How would you describe your general health the year prior to conception? ☐same as above

What stressors did you have in this year and how did you manage the stress? ☐same as above

What was your occupation? ☐same as above

Delivery

Circle answers:
Vaginal, C-section (reason: _______________), Vaginal Birth after C-Section

Premature or Full-term

Location of delivery: ☐Hospital ☐Birthing Center ☐Home Birth

Was labor induced? ☐No ☐Yes, describe:

Were medications used during labor, delivery? ☐No ☐Yes, circle: Antibiotics (group B Strep), Pitocin, Anesthesia, oxygen, rhogam (#of shots_____)

Birth Weight ___________ Apgar scores: ______________

Was there concern for birth trauma?

Newborn period (first month of life)

Were these given to baby at hospital?
Hep B ☐No ☐Yes

Antibiotics ☐No ☐Yes, describe:

Other Medications ☐No ☐Yes, describe:

Any antibiotics given after discharge? ☐No ☐Yes, describe:

Was there any jaundice? ☐No ☐Yes, describe:

Any complications, infections, etc in the first month of life for baby, mom or dad?

Infancy/Toddler (Birth to 2 years)

Breast Fed? ☐No ☐Yes, How long?

Difficulty latching?

Bottle Fed? ☐No ☐Yes, when introduced

Any difficulty tolerating breast milk or formula? ☐No ☐Yes, describe:

Any difficulty swallowing? ☐No ☐Yes, describe:

Comprehensive Evaluation Form

Any concerns about your child's growth or weight gain before age of 2? ☐No ☐Yes, describe:

At what age were foods introduced and how did introduction of solids go?

Did your baby experience?

Excessive drooling ☐No ☐Yes

Poor head control/floppy baby (low muscle tone) ☐No ☐Yes

Colic or reflux? ☐No ☐Yes

"Crashed" when sick → easily dehydrated or hospitalized ☐No ☐Yes

Number of times your child had antibiotics in the first 2 years of life? ______ For: ☐ Ear infections, ☐Other:

First antibiotic at _____ months

Was your child on prophylactic antibiotics during the first 2 years of life? ☐No ☐Yes, describe:

How old was your baby at his/her first illness?

History of ear infections treated with antibiotics? ☐No ☐Yes - How many times? _____

Tubes? ☐No ☐Yes

History of wheezing? ☐No ☐Yes, describe:

History of eczema? ☐No ☐Yes, describe:

Was your baby sick with a lot of colds as infant? ☐No ☐Yes, describe:

Did your baby have thrush? ☐No ☐Yes - How many times? ___

Did your baby have red ring around anus/cracking/bleeding? ☐No ☐Yes, describe:

Describe your baby's temperament as infant and toddler:

Describe your baby's sleep patterns in infancy?

Describe your child's sleep patterns as a todder?

Describe the texture of your child's bowel movements in the first 2 years of life.

Was there any treatment for constipation? ☐No ☐Yes, describe:

Fouls smelling gas/BMs? ☐No ☐Yes, describe:

Gassy? ☐No ☐Yes, describe:

Blood/Mucus? ☐No ☐Yes, describe:

Any surgeries or procedures during this time? ☐No ☐Yes, describe:

Any developmental concerns or delays? ☐No ☐Yes, describe:

Any regressions or loss of developmental skills? ☐No ☐Yes, describe:

Circle all that apply for the first 12 months of life.

- Did not crawl
- Dragged one side of body while crawling (for over one month)
- Could not stand when supported
- Did not search for objects that are hidden while he or she watches
- Said no single words ("mama" or "dada")
- Did not learn to use gestures, such as waving or shaking head
- Did not point to objects or pictures
- Experienced a dramatic loss of skills he or she once had.

Circle all that apply for the first 24 months of life.

- Did not walk by 18 months
- Failed to develop a mature heel-toe walking pattern after several months of walking, or walked only on the toes
- Did not speak at least 15 words
- Did not use two-word sentences by age 2
- By 15 months, did not seem to know the function of common household objects (brush, telephone, bell, fork, spoon)
- Did not imitate actions or words by the end of this period
- Did not follow simple instructions by age 2
- Could not push a wheeled toy by age 2
- Experienced a dramatic loss of skills he or she once had

Was your child immunized according to CDC schedule? ☐Yes ☐No, describe:

Do you feel immunizations have had an impact on your child's health? ☐No ☐Yes, describe:

Any known genetic or metabolic disorders? ☐No ☐Yes, describe:

Did you have any concerns about growth or weight gain after age 2? ☐No ☐Yes, describe:

Pre-School (age 2-5 years old)

Was your child very picky or selective about foods after 2 years? ☐No ☐Yes, describe (include how long and if this condition still persists)

Did you have concerns about your child's sleep pattern after 2 years old? ☐No ☐Yes, describe:

Pre-school (age 2-5 years old) Continued…

Antibiotic History

Did your child require antibiotics after the age of 2? ☐No ☐Yes, what for?

Does your child have a history of strep? ☐No ☐Yes, how many times? ____Treatment?

Did your child have ear infections after 2? ☐No ☐Yes, treatment:

At any time since birth has your child experienced any of the following exposures? (Circle if yes and provide details):

Newly built home

Renovation of home

House painted (indoors/outdoors)

House exterminated for insects

Chemical exposures

Mold exposures

Current

If the individual who this form is describing is 10 years or older, please have him/her participate in answering this section.

When was the last time you feel you/your child was well?

Did something trigger you/your child's change in health? ☐No ☐Yes, describe:

Is there anything that makes you/your child feel better?

Is there anything that makes you/your child feel worse?

List Current and ongoing problems in order of priority:

Describe Problem	Severity (mild, moderate, severe)	Prior treatment/approach	How well treatment worked? (excellent, good, fair, poor)
Ex: Difficulty focusing	*Severe*	*Ritalin*	*Fair*

If you need additional space, write more on another page.

Eating Pattern

Please provide a food diary for at least 3 days, ideally 7 days. Include every food and drink you/your child consumes, including the amount. Be honest, we cannot help unless we know what is really happening. Please attach diary to this form.

Does your child adhere to a special diet? ☐No ☐Yes, describe:

How many times each week does your family eat out?

Who does cooking and shopping in your household?

What factors apply to your child's current lifestyle and eating habits:
☐Fast eater ☐Erratic eating pattern ☐Eat too much ☐Dislike healthy foods

☐Time constraints ☐Eat more than 50% meals away from home ☐poor snack choices

☐sensory issues with food ☐Picky eater ☐Limited variety of foods <5/day ☐Prefers cold foods

☐Prefers hot foods ☐Every meal is a struggle ☐Most family meals together

☐Erratic meal times ☐use food as bribe or reward ☐Most meals eaten at the table

☐High juice intake ☐Low fruit/vegetable intake ☐High sugar/sweet intake

Sleep Pattern
Usual Bedtime: __________ Wake-up Time: __________ Does your child nap? ☐No ☐Yes, describe:

Check off items that describe your child's sleep pattern:
__ Falls asleep easily
__ Difficulty falling asleep most of the time
__ Difficulty falling asleep occasionally
__ Once asleep, stays asleep all night and body is peaceful and calm
__ Stays asleep all night but body is restless, tosses and turns (covers all torn up)
__ Awakens maybe once a night, and goes right back to sleep
__ Frequent night awakenings, does not go back to sleep easily
__ Not unusual to "be up for the day" at extremely early hour, e.g. 2 or 3 a.m.
__ Sleeps in own bed
__ Sleeps with parents
__ Sleeps more than normal
__ Sleeps less than normal
__ Snores
__ Has pauses in breathing where you are waiting for them to take another breath
__ Moans or cries in sleep
__ Sweats at night
__ Nightmares
__ Night terrors
__ Sleep walks
__ Other, describe ____

Does your child take anything to help sleep (melatonin, clonidine)? ☐No ☐Yes, amount, timing, and effectiveness:

Does your child consume caffeinated drinks? ☐No ☐Yes, describe:

Bowel pattern
What # on the Bristol stool chart (can use image from google) that corresponds with your child's typical bowel movement (check all that apply)?
☐1 ☐2 ☐ 3 ☐4 ☐5 ☐6 ☐7

Check off items that describe your child's bowel pattern. *If you don't see your child's stool any longer, ask your child these questions and/or ask them to hold flushing so you can observe the stools.*
__ Enormous bowel movements
__ Diarrhea **and** constipation
__ Undigested food present in stools
__ Mucus in the stools
__ Sandy or gritty-looking stools
__ Sticky stools, or child has trouble cleaning self after BM, uses too much toilet paper
__ Gas, bloating, or discomfort with fiber foods
__ Avoids foods with fiber because of gas, bloating, or discomfort

What does his/her breath smell like?
__ Not bad
__ Like freshly baked bread
__ Stinky, bad
__ Just like poop

Dental History
Does your child have silver mercury fillings? ☐No ☐Yes: how many? ____ When placed? ______

Does your child have any other dental work? ☐No ☐Yes, describe:

Does your child have tooth pain, problems chewing, gingivitis, other? ☐No ☐Yes, describe:

Other Health Issues
If these happened in the past but are not happening now, please put a star by the row.
GI and Immune:
☐No ☐Yes Skin is very pale
☐No ☐Yes Dark under-eye circles Circle: mild moderate dark very dark
☐No ☐Yes Puffiness under lower lashes
☐No ☐Yes Frequent runny nose / Seasonal allergies
☐No ☐Yes Frequent, brief grabbing at penis or vaginal area, as if felt a sharp pain
☐No ☐Yes Cheeks and ears sometimes flush bright red for no reason (Not when exercising or has a fever, just at odd random times)
☐No ☐Yes Eats inedible things (pica)
☐No ☐Yes Known or suspected allergies or sensitivities Please list: ____________________________
☐No ☐Yes Celiac disease
☐No ☐Yes Never gets sick
☐No ☐Yes Catches every cold "coming and going"
☐No ☐Yes Sinus infections How many? ___ Antibiotics: Y__ N__
☐No ☐Yes Do any smokers live in the home?
☐No ☐Yes Does your child seem less symptomatic when they have a fever?
☐No ☐Yes Strep infections
☐No ☐Yes Currently has some warts
☐No ☐Yes Molluscum contagiosum
☐No ☐Yes Cold sores (fever blisters)
☐No ☐Yes Asthma
☐No ☐Yes Eczema
☐No ☐Yes Rashes
☐No ☐Yes Hives
☐No ☐Yes Dermatographism (write on skin with fingernail and see letters on skin minutes-hours later)
☐No ☐Yes Ringworm

Yeast Screening:
☐No ☐Yes Silly, "drunken" laughter that is inappropriate
☐No ☐Yes Cheeks have bumpy red patches.
☐No ☐Yes Red ring right around the anus
☐No ☐Yes Rectal or vaginal itching
☐No ☐Yes Cracking or peeling hands or feet
☐No ☐Yes Ridged, discolored nails or toenails
☐No ☐Yes Jock itch or athlete's foot
☐No ☐Yes Geographic tongue (map-like)
☐No ☐Yes Toe-walking
☐No ☐Yes Urinary tract infections How many? ___
☐No ☐Yes Kidney infections
☐No ☐Yes Frequently grabs penis or vaginal area
☐No ☐Yes Spaced out, foggy, in a different world
☐No ☐Yes Cravings for desserts and sugary foods
☐No ☐Yes Depression or irritability
Check all that apply:
___ Wet hair smells funny or like a wet dog
___ Scalp is crusty or flaky
___ Dry flaky skin around the ears, eyebrows or nose
___ Persistent cradle cap

Has your child been prescribed or used Diflucan, Nystatin or other antifungals? ☐No ☐Yes, describe:

Mitochondrial screening section:
☐No ☐Yes Poor muscle tone
☐No ☐Yes Curved back, "C" shape when sitting
☐No ☐Yes Difficulty knowing self in space
☐No ☐Yes Tires easily
☐No ☐Yes Eye-hand coordination is poor
☐No ☐Yes Joints are hyper-flexible
☐No ☐Yes Expressive and Receptive speech is poor
☐No ☐Yes "Crashes" when they get sick (gets dehydrated or even hospitalized)?

ADHD screening section*:
☐No ☐Yes Active in womb
☐No ☐Yes Colicky or Fussy eater as infant
☐No ☐Yes Difficult to comfort as infant/young child
☐No ☐Yes Sensitive to noise or touch (now or in past)
☐No ☐Yes Difficulty toilet training as toddler
☐No ☐Yes Terrible – 2's on overdrive?
☐No ☐Yes Staring spells where appears unresponsive for brief period of time
*if being evaluated for ADHD also complete Vanderbilt Screening (parent and teacher) and online evaluation at https://addtypetest.com/. Forward email results to info@seealternatives.com.

Reflux screening section:
☐No ☐Yes Has known reflux
☐No ☐Yes Swallows or clears throat frequently
☐No ☐Yes Has the tooth enamel been eroded by gastric acid?
☐No ☐Yes Facial grimacing
☐No ☐Yes Gritting teeth
☐No ☐Yes Wincing

☐No ☐Yes Sighing, groaning
☐No ☐Yes Burping
☐No ☐Yes Pacing around the house, hyperactive, jumping up and down
☐No ☐Yes Puts off going to sleep
☐No ☐Yes Frequent waking at night
☐No ☐Yes Falls asleep propped up in bed, propped up on couch, or bent over a pillow

Signs of zinc deficiency:
☐No ☐Yes Has white dots or lines on fingernails
☐No ☐Yes Acne/sparse hair/psoriasis
☐No ☐Yes Canker sores
☐No ☐Yes Chews on toys, objects, clothing

Signs of an essential fatty acid deficiency:
☐No ☐Yes Keratosis pilaris
☐No ☐Yes Dry, coarse hair

Signs of a magnesium deficiency:
☐No ☐Yes Muscle twitches/tingling
☐No ☐Yes Sighing
☐No ☐Yes Salt craving
☐No ☐Yes Chews on toys, objects, clothing

Medications/Supplements/Treatments
List all medications and supplements your child has used, approximate dates of use.. In notes, please provide any reactions, details regarding your child's response, any information you want us to know about the medications. If you need additional space please write on additional page.

Medication/Supplement	Dates Used	Notes about medications

Prolonged or regular use of NSAIDS (Aleve, Advil/Motrin, etc)? ☐No ☐Yes, describe:

Prolonged or regular use of Tylenol? ☐No ☐Yes, describe:

Prolonged or regular use of anti-reflux medications? ☐No ☐Yes, describe:

What integrative health approaches have you utilized with your child?

☐Supplements, including multivitamins ☐Chiropractic care ☐Essential Oils (topical, internal)

☐Massage ☐Biofeedback ☐Hypnosis

☐Breathing Exercises ☐Yoga ☐Meditation

☐Acupuncture ☐Homeopathy ☐Energy healing

☐Prayer ☐Reflexology ☐Aromatherapy

☐Other:

Readiness Assessment

In order to improve your child's health, lifestyle modifications are required. On a scale of 5 (very willing) to 1 (not willing at all), how willing is your child and his/her caregivers to:

	Child/Teen	Mother	Father	Other caregiver
Significantly modify diet	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
Take nutritional supplements DAILY	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
Keep a record of everything eaten DAILY	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
Modify schedule (extracurricular activities, work/school)	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
Modify Sleep	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
Practice relaxation/stress management techniques	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
Engage in regular exercise	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
Reduce TV/Device time	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1

What might make it difficult for you to follow through on your commitment to make the changes above?

How supportive do you think the people in your household will be to implementing changes?

Spirituality Assessment

Does your family have spiritual beliefs that help you cope with stress/difficult times? ☐No ☐Yes, describe:

What importance does spirituality play in your family life? How has your spirituality influenced how you take care of your family?

Are you part of a spiritual community? ☐No ☐Yes, describe what support is provided for your family.

Adverse Childhood Events for Child

Place a check mark beside any of the following if they occurred at any point since your child was born…

__ Your child's parents or guardians were separated or divorced

__ Your child lived with a household member who served time in jail or prison

__ Your child lived with a household member who was depressed, mentally ill or attempted suicide

__ Your child saw or heard household members hurt or threatened to hurt each other

__ A household member swore at, insulted, humiliated, or put down your child in a way that scared your child OR a household member acted in a way that made your child afraid that s/he might be physically hurt.

__ Someone touched your child's private parts or asked your child to touch their private parts in a sexual way

__ More than once, your child went without food, clothing, a place to live, or had no one to protect him/her

__ Someone pushed, grabbed, slapped or threw something at your child OR your child was hit so hard that your child was injured or had marks

__ Your child lived with someone who had a problem with drinking or using drugs

__ Your child often felt unsupported, unloved, and/or unprotected

__ Your child was in foster care

__ Your child experienced harassment or bullying at school

__ Your child lived with a parent or guardian who died

__ Your child was separated from his/her primary caregiver through deportation/immigration

__ Your child has had a serious medical procedure or life-threatening illness

__ Your child often saw or heard violence in the neighborhood or in school

__ Your child was often treated badly because of race, sexual orientation, place of birth, disability or religion

How did parents respond to these events?

How did child respond to these events?

What type of supports did family have during these events (family, friends, child care, community services, counseling)?

Adverse Childhood Events and Resiliency for Parents

Being a parent is challenging, even more so with a child who has a medical condition. This assessment helps us support you in your parenting. Your answers will be kept confidential. M=Mother, F=Father [if your family is structured differently from this, please specify relationship] Please check the box if any apply to you.

While you were growing up, during your first 18 years of life:	M	F
Did a parent or other adult in the household swear at you, insult you, put you down or humiliate you OR act in a way that made you afraid you might be physically hurt?		
Did a parent or other adult in the household push, grab, slap, or throw something at you OR ever hit you so hard that you had marks or were injured?		
Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way? Or attempt to have oral, anal, or vaginal intercourse with you?		
Did you feel that no one in your family loved you or thought you were important or special? Or that your family did not look out for each other, feel close to each other, or support each other?		
Did you feel that you didn't have enough to eat, had to wear dirty clothes, had now one to protect you?		
Did you feel that your parents were to drunk or high to take care of you or take you to the doctor if you needed it?		
Were your parents ever separated or divorced?		
Was your mother (or other female adult) pushed, grabbed, slapped, had items thrown at her, kicked, bitten, hit, or threatened with a gun/knife?		
Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?		
Was a household member depressed or mentally ill, or did a household member attempt suicide?		
Did a household member go to prison?		
Did you experience harassment or bullying at school?		
Did you live with a parent or guardian who died?		
Did you have a serious medical procedure or life-threatening illness?		
Did you see or hear violence in your neighborhood or school?		
Were you treated badly because of race, sexual orientation, place of birth, disability or religion?		

I had people in my family who loved me.		
I had a trusted adult or family member who I could talk to about my concerns.		
As a youth, people noticed that I was capable and could get things done.		
I was independent and a go-getter.		
There are people I can count on now in my life.		

How did you deal with stressors as a child? How do you deal with stressors now?

Mother:

Father: