SEE ALTERNATIVES Pediatrics

Comprehensive Evaluation Form

Child's Name: _____

Date of Birth: _____ Date of Completion: _____

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. The form may be emailed back to us at **info@seealternatives.com** or faxed at **843-920-0001**.

FAMILY HISTORY (Siblings, Parents, Aunts/Uncles, Cousins, Grandparents)

Please check all that apply and indicate whom the disorder affected.

- ☐ Allergies: _____
- ☐ Asthma (including childhood wheezing/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 spondylitis): _____
- ☐ 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): _____
- ☐ Rheumatic Fever: _____

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

Mother's health before and around conception of above mentioned child. ☐ *Adopted, not known*

Did the mother conceive easily and intentionally?
☐ Yes ☐ No, describe: _____

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

Does the mother have a history of miscarriages before or after this child?
☐ No ☐ Yes, describe: _____

How would you describe the mother's general health the year prior to conception?

_____

Did the mother have frequent antibiotic use as a child or adult (strep, OM, sinuses, acne, etc)?
☐ No ☐ Yes, describe: _____

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

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

Was the mother over or under weight?
☐ No ☐ Yes, describe: _____

Did the mother have diabetes? ☐ Yes ☐ No

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

_____

What was the mother's occupation?

_____

Father's health before and around conception of above mentioned child. ☐ *Adopted, not known*

How would you describe the father's general health the year prior to conception?

_____

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

_____

What was the father's occupation?

_____

IN-UTERO/PREGNANCY

Did either parent have any of these exposures during the pregnancy? ☐ *Adopted, not known*
Please check all that apply and provide details.

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

Mother ☐ *Adopted, not known*

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

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

Did mother receive any vaccines during this pregnancy? ☐ No ☐ Yes, what? _____

Did mother have any thyroid testing done during or after this pregnancy? ☐ No ☐ Yes, results: _____

Did mother have gestational diabetes during this pregnancy? ☐ No ☐ Yes

Did mother use any street drugs, alcohol, cigarettes/tobacco/e-cigs, prescription drugs (progesterone)?
☐ No ☐ Yes, what? _____

Any problems with the pregnancy? Please check all that apply and provide details.

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

Did mother experience any other health concerns during the pregnancy?
☐ No ☐ Yes, describe: _____

Did mother experience any new stressors or change in occupation during the pregnancy?
☐ No, same as above ☐ Yes, describe: _____

Father ☐ *Adopted, not known*

Did father experience any change in general health, stress level, or occupation during the pregnancy?
☐ No, same as above ☐ Yes, describe: _____

DELIVERY

Please check all that apply.

- ☐ Vaginal Birth
- ☐ C-Section (reason: _____)
- ☐ Vaginal Birth after C-Section
- ☐ Premature
- ☐ Full-Term

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

Was labor induced? ☐ No ☐ Yes, describe: _____

What medications were used during labor and/or delivery?

- ☐ None
- ☐ Antibiotics (group B Strep),
- ☐ Pitocin
- ☐ Anesthesia
- ☐ Oxygen
- ☐ Rhogam (# of shots: _____)

Birth Weight: _____ Apgar Scores: _____

Was there concern for birth trauma? ☐ No ☐ Yes, describe: _____

NEWBORN PERIOD (First Month of Life)

Were any of these given to the baby at the 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?

☐ No ☐ Yes, describe: _____

INFANCY/TODDLER (Birth to 2 Years)

Breast Fed? ☐ No ☐ Yes, how long? _____ Difficulty latching? ☐ No ☐ Yes

Formula? ☐ No ☐ Yes, when introduced: _____

Any difficulty tolerating breast milk or formula?

☐ No ☐ Yes, describe: _____

Any difficulty swallowing?

☐ No ☐ Yes, describe: _____

Any concerns about this child's growth or weight gain before age of 2?

☐ No ☐ Yes, describe: _____

INFANCY/TODDLER (continued)

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? ☐ No ☐ Yes, describe: _____

Reflux? ☐ No ☐ Yes, how treated? _____

"Crashing" 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 an 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 child's temperament as an infant and toddler:

_____

Describe your baby's sleep patterns in infancy:

_____

Describe your child's sleep patterns as a todder:

_____

INFANCY/TODDLER (continued)

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

_____

Was there any treatment for constipation? ☐ No ☐ Yes, how treated: _____

Fouls smelling gas/stools? ☐ No ☐ Yes, describe: _____

Gassy? ☐ No ☐ Yes, describe: _____

Blood in stool? ☐ No ☐ Yes, describe: _____

Mucus in stool? ☐ 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: _____

Check 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.

Check 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

INFANCY/TODDLER (continued)

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: _____

Does the child have 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 (Ages 2–5)

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: _____

Antibiotic History

Did your child require antibiotics after the age of 2?

☐ No ☐ Yes, for what? _____

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? Please check all that apply 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 this form is describing is 10 years or older, please have him/her participate in answering this section.

School: _____ Grade: _____

Please describe academic performance and any concerns about school:

_____

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

_____

Did something trigger your child's change in health?

☐ No ☐ Yes, describe: _____

Is there anything that makes your child feel better?

_____

Is there anything that makes your child feel worse?

_____

What would you like to accomplish with your child's health/well-being?

_____

Please list current and ongoing problems in order of priority:

Describe the Problem	**Severity** (mild, moderate, severe)	**Prior Treatment/ Approach**	**Effectiveness of Treatment** (excellent, good, fair, poor)
Example: Difficulty focusing	*Severe*	*Ritalin*	*Fair*

If you need more space, please attach an additional page.

EATING PATTERN

Please provide a food diary for at least 3 days (ideally 7 days). Include every food and drink your child consumes, including the amount. Be honest! We cannot help unless we know what is really happening. Food diary can be found on the final page of this form. Please attach additional sheets if needed.

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? Check all that apply.

- ☐ Fast eater
- ☐ Erratic eating pattern
- ☐ Eats too much
- ☐ Dislikes healthy foods
- ☐ Time constraints
- ☐ Eats more than 50% meals away from home
- ☐ Poor snack choices
- ☐ Sensory issues with food
- ☐ Picky eater
- ☐ Limited variety of foods (less than 5 per day)
- ☐ Prefers cold foods
- ☐ Prefers hot foods
- ☐ Every meal is a struggle
- ☐ Most family meals together
- ☐ Erratic meal times
- ☐ Uses 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: _____ Usual Wake-up Time: _____

Does your child nap? ☐ No ☐ Yes, describe: _____

Please check all 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 their 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 them sleep (melatonin, clonidine)?

☐ No ☐ Yes, amount, timing, and effectiveness: _____

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

BOWEL PATTERN

What number on the Bristol stool chart (search google for images) 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

Please indicate if your child is experiencing any of these by checking "yes" or "no." If your child has experienced something previously, check the "previous" box.

GI and Immune:	No	Yes	Previous
Skin is very pale	☐	☐	☐
Dark under-eye circles (If yes: ☐ mild ☐ moderate ☐ dark ☐ very dark)	☐	☐	☐
Puffiness under lower lashes	☐	☐	☐
Frequent runny nose / Seasonal allergies	☐	☐	☐
Frequent, brief grabbing at penis or vaginal area, as if they felt a sharp pain	☐	☐	☐
Cheeks and ears sometimes flush bright red for no reason (Not when exercising or has a fever, just at odd random times)	☐	☐	☐

OTHER HEALTH ISSUES (continued)

GI and Immune (continued):	No	Yes	Previous
Eats inedible things (pica)	☐	☐	☐
Known or suspected allergies or sensitivities. If yes, please list: _____	☐	☐	☐
Celiac disease	☐	☐	☐
Never gets sick	☐	☐	☐
Catches every cold "coming and going"	☐	☐	☐
Sinus infections. If yes, how many? _____ Antibiotics? ☐ Yes ☐ No	☐	☐	☐
Do any smokers live in the home?	☐	☐	☐
Does your child seem less symptomatic when they have a fever?	☐	☐	☐
Strep infections	☐	☐	☐
Currently has some warts	☐	☐	☐
Molluscum contagiosum	☐	☐	☐
Cold sores (fever blisters)	☐	☐	☐
Asthma	☐	☐	☐
Eczema	☐	☐	☐
Rashes	☐	☐	☐
Hives	☐	☐	☐
Dermatographism (write on skin with fingernail and see letters on skin minutes/ hours later)	☐	☐	☐
Ringworm	☐	☐	☐

Yeast Screening:	No	Yes	Previous
Silly, "drunken" laughter that is inappropriate	☐	☐	☐
Cheeks have bumpy red patches	☐	☐	☐
Red ring right around the anus	☐	☐	☐
Rectal or vaginal itching	☐	☐	☐
Cracking or peeling hands or feet	☐	☐	☐
Ridged, discolored nails or toenails	☐	☐	☐
Jock itch or athlete's foot	☐	☐	☐
Geographic tongue (map-like)	☐	☐	☐
Toe-walking	☐	☐	☐
Urinary tract infections. How many? _____	☐	☐	☐
Kidney infections	☐	☐	☐
Frequently grabs penis or vaginal area	☐	☐	☐
Spaced out, foggy, in a different world	☐	☐	☐
Cravings for desserts and sugary foods	☐	☐	☐
Depression or irritability	☐	☐	☐

OTHER HEALTH ISSUES (continued)

Yeast Screening (continued):

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: _____

PANS/PANDAS Screening :	No	Yes	Previous
Did symptoms change suddenly after an infection (strep, flu, cold/cough)?	☐	☐	☐
Obsessions/compulsions, describe: _____	☐	☐	☐
Anxiety/phobias (especially separation anxiety), describe: _____	☐	☐	☐
Emotional outbursts, including aggression	☐	☐	☐
Changes in handwriting/drawing, describe: _____	☐	☐	☐
Regression in developmental skills or behavior (ex: babytalk, tantrums, etc)	☐	☐	☐
Urinary accidents (day or nighttime)	☐	☐	☐
Tics, describe: _____	☐	☐	☐
Refusal to eat food, describe: _____	☐	☐	☐
Changes in sleep pattern, describe: _____	☐	☐	☐
Decline in school performance, describe: _____	☐	☐	☐

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

OTHER HEALTH ISSUES (continued)

ADHD Screening*:	No	Yes	Previous
Active in womb	☐	☐	☐
Colicky or fussy eater as infant	☐	☐	☐
Difficult to comfort as infant/young child	☐	☐	☐
Sensitive to noise or touch (now or in past)	☐	☐	☐
Difficulty toilet training as toddler	☐	☐	☐
Terrible – 2's on overdrive?	☐	☐	☐
Staring spells where appears unresponsive for brief period of time	☐	☐	☐

**If your child is being evaluated for ADHD, please also complete Vanderbilt Screening (parent and teacher) and online evaluation at https://addtypetest.com and forward email results to info@seealternatives.com.*

Reflux Screening:	No	Yes	Previous
Has known reflux	☐	☐	☐
Swallows or clears throat frequently	☐	☐	☐
Tooth enamel has been eroded by gastric acid	☐	☐	☐
Facial grimacing	☐	☐	☐
Gritting teeth	☐	☐	☐
Wincing	☐	☐	☐
Sighing, groaning	☐	☐	☐
Burping	☐	☐	☐
Pacing around the house, hyperactive, jumping up and down	☐	☐	☐
Puts off going to sleep	☐	☐	☐
Frequent waking at night	☐	☐	☐
Falls asleep propped up in bed, propped up on couch, or bent over a pillow	☐	☐	☐

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

Signs of an Essential Fatty Acid Deficiency:	No	Yes	Previous
Keratosis pilaris	☐	☐	☐
Dry, coarse hair	☐	☐	☐

Signs of Magnesium Deficiency:	No	Yes	Previous
Muscle twitches/tingling	☐	☐	☐
Sighing	☐	☐	☐
Salt craving	☐	☐	☐
Chews on toys, objects, clothing	☐	☐	☐

MEDICATIONS/SUPPLEMENTS/TREATMENTS

List all medications and supplements your child has used and approximate dates of use. In the notes, please provide any reactions, details regarding your child's response, any information you want us to know about the medications. If you need more space, please attach an 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 are your child and his/her caregivers to make the following modifications?

Modification	Child/Teen	Mother	Father	Other
Significantly modify diet				
Take nutritional supplements DAILY				
Keep a record of everything eaten DAILY				
Modify schedule (extracurricular activities, work/school)				
Modify sleep				
Practice relaxation/stress management techniques				
Engage in regular exercise				
Reduce TV/device time				

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

Have any of the following occurred at any point since your child was born? Please check all that apply.

- ☐ 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 threaten 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 he/she 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 treated badly because of race, sexual orientation, place of birth, disability or religion

How did the parents respond to these events?

_____

How did the child respond to these events?

_____

What types of support did the 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. (If your family is structured differently from mother/father, please specify relationship). Please check the box if any apply to you.

While you were growing up, during your first 18 years of life:	**Mother/ Parent A**	**Father/ Parent B**
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 no 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, alcoholic, or 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.	☐	☐

Mother/Parent A:

How did you deal with stressors as a child?

_____

How do you deal with stressors now?

_____

Father/Parent B:

How did you deal with stressors as a child?

_____

How do you deal with stressors now?

_____

ADDITIONAL INFORMATION

Is there anything else we should know about your child that was not covered in the previous questions? Please use this space to include additional information if needed.

FOOD DIARY

Please use this form to provide a food diary for at least 3 days (ideally 7 days). Include every food and drink your child consumes, including the amount. You can attach additional sheets if needed.

Day	Breakfast	Lunch	Dinner	Snacks
Day 1				
Day 2				
Day 3				
Day 4				
Day 5				
Day 6				
Day 7				