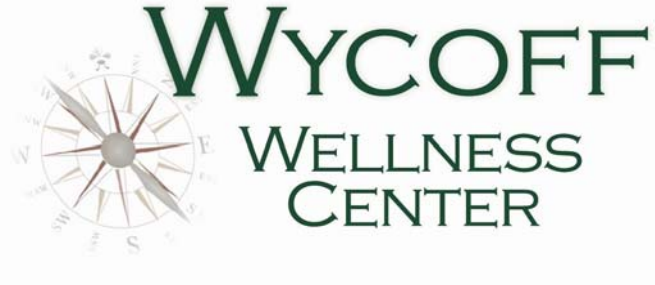

Wycoff Wellness Center
1226 Michigan Avenue
East Lansing, Michigan 48823
517-333-7270 (phone)
517-333-1801 (fax)
800-471-0255 (toll free)
wycoffwellness.com

Autism/ADHD & ADD Questionnaire

Personal Information					
Child's Name: First:		Last:			Middle Initial:
Parent(s) Name(s):					
Parent's Marital Status (Circle One): Married / Divorced / Other					
Address: Street:		City:			
State:	Zip:	Home Phone: ( )			
Work Phone: ( )		Cell: ( )			
E-Mail:		Fax: ( )			
Child's Date of Birth: Month:	Day:	Year:	Child's Sex (Circle One): M / F		
Local Pharmacy:			Phone Number: ( )		
Compounding Pharmacy:			Phone Number: ( )		
Primary Care Physician: Name:			Street:		
City:	State:	Zip:	Phone: ( )		
Health Insurance:					
Referred By:					
Siblings: Name:	Sex: (Circle One)		Birth Date:		
	Male / Female		Month:	Day:	Year:
	Male / Female		Month:	Day:	Year:
	Male / Female		Month:	Day:	Year:
Parent's Occupations(s):					
Note: Please bring a baby picture that we may look at and return.					
Diagnoses or explanation given to you about your child: (Date of diagnoses:___/_____/___)					
Other problems to be addressed:					

Describe your child to us, including his/her history. Please be as detailed as possible (you may use additional pieces or paper if needed):

- When did you first notice your child's problem:
- What did you first notice?
- Was the onset of your child's problem sudden or gradual?
- Was there any event or illness that you or others think brought on your child's symptoms?

Please make notation of any other event(s), action(s), etc. that you think may have some bearing/relationship to your child's condition. Again, be as detailed as possible and do not hesitate to mention anything, no matter how small or insignificant, that you believe is related to your child's problem(s).

MEDICAL HISTORY

Primary Doctor(s)

Name:	Phone Number:	City, State	Last Visit

Specialists (including Defeat Autism Now! Physicians)

Name:	Specialty:	Phone Number:	City, State	Last Visit

Nutritionist			
Name:	Phone Number:	City, State	Last Visit
Naturopath(s) and / or Homeopath(s)			
Name:	Phone Number:	City, State	Last Visit
Therapist(s)			
Name:	Phone Number:	City, State	Last visit
Other			
Name:	Phone Number:	City, State	Last visit

PRENATAL HISTORY
Maternal age at delivery: _____ years Number of Dental Amalgams (silver fillings in mother):_____
Illnesses during pregnancy:
Medications taken during pregnancy:
Vaccinations received during pregnancy (influenza, tetanus, etc.):
Other complications during pregnancy:
Complications during labor and delivery:
Mode of delivery: C-section / vaginal (Circle one) If C-section, explain why:
If vaginal delivery, did you have forceps / vacuum extraction?
Medication(s) during labor and delivery?
Full term / premature (Circle one) How many weeks at delivery? _____weeks
Complications after delivery?

Medications given to child during hospital stay?

DIETARY / NUTRITIONAL HISTORY

Breast fed - Yes / No (Circle one). If yes, for how long: _____

Bottle fed? Brand of formula? _____ Begun at what age? _____ For how long?_____

Foods? Begun at what age? _____ First foods?_____

_____

Whole milk - Yes / No (Circle one) If yes, begun at what age? _____

Known allergies to food? (Please list): _____

_____

_____

Suspected sensitivities to foods? (Please list): _____

_____

Food cravings? (Please list): _____

_____

Foods my child eats (Place check (✓) in appropriate column)

Food	Daily	3 – 5 times per week	1 – 3 times per week	Never or almost never	Used to eat a lot but no longer does
Cookies					
Candy					
Sweet foods					
Caffeine (soda, tea, etc.					
Chocolate					
Milk: Whole					
2%					
1%					
Skim					
Cheese					
Ice cream					
Salty foods					
Meat					
Pasta					
Bread: White					
Wheat					

Other					

Check (✓) the most appropriate description below of your child's diet:

_____ Mostly baby foods
_____ Mostly carbohydrates (bread, pasta, cereal, pop tarts, etc.)
_____ Mostly dairy (milk, cheese, ice cream, yogurt, etc.)
_____ Mostly vegetarian (vegetables, fruits, grains, etc.)
_____ Other – please describe: _____

Please describe your child's STOOL pattern (examples, daily, foul, large, mushy, etc.):

Please list the foods and beverages normally consumed by your child for three typical days:

Day 1
Breakfast:
Morning snack(s):
Lunch:
Afternoon snack(s):
Dinner:
Other:

Day 2
Breakfast:
Morning snack(s):
Lunch:
Afternoon snack(s):
Dinner:
Other:

Day 3
Breakfast:
Morning snack(s)
Lunch:
Afternoon snack(s):
Dinner:
Other:

FAMILY HISTORY
List any allergies, major illnesses, genetic diseases or problems for each of the following family members of your child:
Mother:
Father:
Siblings:
Maternal Grandparents:
Paternal Grandparents:
Others:

SOCIAL HISTORY
Who lives in the home with your child:
Are any children in your family adopted?
Pets in the house:
List the people most important in your child's life:
Recent changes, losses, births, deaths, divorce, remarriages or moves:
Recent travel:
Child's response to any of the above changes:
Is your child involved in any sports, music or other activities? Please describe:
How does your child interact with other children?
• With adults?
• What makes your child happy?
• Sad?
• Angry?
• Stressed?
• Sleep patterns (past and present)?
ENVIRONMENTAL HISTORY
Do you, your child, or any family members practice any relaxation management techniques? Please describe:
Circle the appropriate answers to the following questions:
Location of home: City / Suburban / Wooded / Farm Other (describe):
Water: City / Well Purification system: Yes / No If yes, please describe:
Type of heat: Electric / Gas / Oil / Other. If other, please describe:
Do you live near: Power lines / Woods / Industrial areas / Water ways?
If you live near water, list type: Swamp / River / Ocean / Lake / Other. If other, please describe:
Does your home have a lot of: Dust / Mold / Down or Feather items (pillows, upholstery, stuffed animals)? If so, please give details:
Any tick exposure? Yes / No / Unsure. If yes, what location on your child's body and what geographic location?
Describe any treatment / prophylaxis you had for the tick exposure:
Please check (✓) where appropriate:
_____ Live in tick infested area
_____ Frequent outdoor activities
_____ Hiking, fishing, camping, hunting, gardening
_____ Other household members with tick exposure and / or Lyme disease

_____ Tick found on household pets

_____ Vacation in high risk areas

Describe your child's bedroom (Circle - appropriate response):

Bedding: Synthetic / Down / Feather Mattress cover: Yes / No Crib / Junior Bed / Adult Bed

Flooring: Carpet: Wall to wall or area rugs? Wood? Glued down? Synthetic pad?

Window treatments: Shades / Blinds / Thin curtains / Valance / Other? If other, please describe:

Other items in room including furniture, toys, stuffed animals?

Flooring in other rooms:

Child's bathroom:

Living room:

Family room / play room:

If your child sensitive to or bothered by any of the following. Please check (✓) where appropriate and list specific products if possible:

_____ Perfume/cosmetics?
_____ Cleaning products?
_____ Soaps?
_____ Detergents?
_____ Dust?
_____ Other?
_____ Mold?
_____ Pollens / grasses?
_____ Animals (dander)?
_____ Gasoline?
_____ Paint?

Please list known medicine allergies:

Please list other occupational exposures in family members (for example: dental office, scientist, pharmacist, painter, building/construction, foundry worker):

DEVELOPMENTAL HISTORY

Please list age when the following skills were mastered and any problems associated with these skills:

First words: (Age:_____)

Phrases or sentences: (Age:_____)

Pulling to stand: (Age:_____)

Walking: (Age: _____)

Sitting up: (Age: _____)

Crawling: (Age: _____)

Running: (Age: _____)

Walking up and down steps without help: (Age:_____)

Jumping: (Age: _____)

Learned to pedal: (Age: _____)

Rode 2-wheel bicycle: (Age: _____)

Put on clothing: (Age: _____)

PLEASE BRING OR SUBMIT TO US ALL RECENT TEST RESULTS WITH THE FORM		
Please mark which tests have been done and provide date and results:		
Evaluation / Test	**Date**	**Results (normal, abnormal or unsure)**
24 Hour Amino Acids		
Amino Acid Screen		
Blood Chemistry Screen		
Blood Count (CBC)		
Blood Test (Fatty Acid)		
Blood Test (Food Allergies)		
CT Scan (specify area)		
Colonoscopy		
DMSA Loading Study		
EEG		
Folic Acid		
Fragile X Chromosome Study		
Hair Elements		
Hearing Test		
Immune Profile		
Intestinal Permeability		
Liver Detoxification Profile		
MRI (specify area)		
Organic Acids (fungal/bacteria - OAT)		
Organic Acids (Metabolism - OAT)		
PET scan		
Pinworm Prep		
Plasma Amino Acid		
Plasma or Serum Zinc		
RBC Elements		
Serum Ferritin (Iron Stores)		
Serum Methylmalonic Acid		
Serum Vitamin A Level		
Small Bowel Biopsy		
Stool Culture		
Stool Parasites		
Thyroid Profile/Testing		
Uric Acid (Blood or Urine)		
Urinary Peptides		
Urine Elements		
Urine Kryptopyrrole		
X-Rays (Specify type/area)		
Other:		

Major surgeries – Please describe and give dates:		
Surgery	Date(s)	Results

Major injuries – Please describe and give dates:		
Injury	Date(s)	Results

Illnesses – Please list appropriate dates and any complications:		
Illness	Date(s)	Complications
Ear Infections		
Sinus Infections		
Bronchitis		
Pneumonia		
Thrush		
Chicken Pox		
Seizures		
Mononucleosis (Mono)		
Eczema/Psoriasis/Cradle Cap		
Other (please list):		

CURRENT HEIGHT AND WEIGHT

HEIGHT: _____ WEIGHT: _____

IMMUNIZATIONS

Please indicate date any reactions for those immunizations that your child has received. If exact date isn't known, please approximate. "Bowel" refers to any bowel symptom such as diarrhea. "Swelling" refers to the site of the injection.

Diptheria/Pertussis/Tetanus (DPT)	Date	Bowel	Swelling	Crying	Seizure	Irritable	Fever	Other
DPT1								
DPT 2								
DPT 3								
DPT 4								
DPT 5								
Adult Diptheria/Tetanus (Td)								
H. Influenza Type B (HIB)	Date	Bowel	Swelling	Crying	Seizure	Irritable	Fever	Other
Hib 1								
Hib 2								
Hib 3								
Hib 4								
Polio (Circle Oral or Injection)	Date	Bowel	Swelling	Crying	Seizure	Irritable	Fever	Other
OPV 1 / Injection 1								
OPV 2 / Injection 2								
OPV 3 / Injection 3								
OPV 4 / Injection 4								
OPV 5 / Injection 5								

Measles/Mumps/Rubella (MMR)	Date	Bowel	Swelling	Crying	Seizure	Irritable	Fever	Other
MMR 1								
MMR 2								
Hepatitis B Vaccine	Date	Bowel	Swelling	Crying	Seizure	Irritable	Fever	Other
HBV 1								
HBV 2								
HBV 3								
Prevnar (pneumococcal)								
Miscellaneous	Date	Bowel	Swelling	Crying	Seizure	Irritable	Fever	Other
Varivax (Chicken pox)								
TB Tine Test								
Flu Vaccine (Influenza)								
Other								

MEDICATION OR SUPPLEMENTS									
Please check substances taken now or in the past and make the appropriate reaction									
Now	Past	Medication or Supplementation	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments
		Central Nervous System							
		Adderall							
		Amphetamine							
		Anafranil							
		Buspar							
		Chloral hydrate							
		Clonidine							
		Clozaril (clozapine)							
		Cogentin							
		Cylert							
		Deanol (Deaner, DMAE)							
		Depakene for behavior							
		Depakene for seizures							
		Depakote for behavior							
		Depakote for seizures							
		Desipramine							
		Dexedrine, dextroamphetamine							
		Dextromethorphan							
		Dilantin							
		Felbatol							
		Fenfluramine							
		Focalin							
		Gabitril							
		Haldol							
		Keppra							
		Klonopin							
		Lamictal							
		Lithium							
		Luvox							
		Mellaril							
		Mysoline							
		Naltrexone							

Now	Past	Medication or Supplement	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments
		Neurontin							
		Paxil							
		Phenobarbital							
		Orolixin							
		Prozac							
		Risperdal							
		Ritalin							
		Seroquel							
		St. John's Wort							
		Stelazine							
		Strattera							
		Tegretol							
		Thorazine							
		Tofranil							
		Topamax							
		Trileptal							
		Valium							
		Zarotin							
		Zonegran							
		Zyprexa							
		Antihistamines							
		Benadryl							
		Claritin							
		Singulair							
		Zyrtec							
		Antimicrobials							
		Amphotericin							
		Antibiotics (specify types and number of times used)							
		Bactrim (Septra)							
		Diflucan							
		Famvir							
		Humatin							
		Lamisil							
		Nizoral							
		Nystantin							
		Saccharomyces Boulardii							
		Sporonox							
		Transfer Factor (oral) / Colostrum							
		Valtrex							
		Zovirax							
		Digestion							
		Bethenecol							
		Digestive Enzymes							
		Pepcid							
		Peptidase enzymes							
		Probiotics							
		Supplements							
		Ca EDTA							

Now	Past	Medication or Supplement	Very Good	Good	None	Bad	Very bad	Bad then Good	Comments
		DMPS							
		DMSA (succimer, Chemet)							
		Folic Acid							
		Reduced Glutathione (Transdermal)							
		Reduced Glutathione (IV)							
		Reduced Glutathione (oral)							
		Melatonin							
		5-HTP							
		Activated Charcoal							
		Alka Seltzer Gold							
		Alpha Keto Glutarate (AKG)							
		Amino Acid Mix							
		Calcium							
		Cod Liver Oil							
		Curcumin							
		Deanol							
		DHA rich oils							
		Dimethylglycine (DMG)							
		EPA Rich Oils							
		Flax Oil							
		GABA							
		Glutamine							
		Human Growth Factor							
		IV Immune Globulin							
		Kutapressin							
		Magnesium							
		Manganese							
		Multivitamins (Specify type)							
		N-Acetyl Cysteine							
		Omega 6 Rich Oils							
		Oral Immune Globulin							
		Oxytocin							
		SaMe (SAM, Samyr)							
		Secretin (IV)							
		Secretin (Transdermal/sublingual)							
		Selenium							
		Steroids (oral)							
		Steroids (topical)							
		Taurine							
		TMG							
		Tyrosine							
		Vitamin A							
		Vitamin B3 (Niacin)							
		Vitamin B6							
		Vitamin C							
		Vitamin D							

Now	Past	Medication or Supplement	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments
		Vitamin K							
		Zinc							
		Others:							

THERAPIES AND DIETS									
Please indicate therapies and diets you have used and / or are using									
Now	Past	**Therapies**	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments
		Acupuncture							
		Auditory Training							
		Craniosacral							
		Energy Therapy (specify)							
		Homeopathy							
		HBOT – Hyperbaric Oxygen Therapy							
		Lovaas (ABA)							
		Naturopathy							
		Neural Therapy							
		Occupational Therapy							
		Osteopathy							
		Physical Therapy							
		Sensory Diet							
		Speech Therapy							
		Others:							
		Diets							
		Gluten Free (GF)							
		Casein Free (CF)							
		Yeast Free							
		High Protein / Low Carb							
		Salicylate Free							
		Low Phenolics							
		IgG reactive food avoidance							
		Specific Carbohydrate Diet (SCD)							
		Body Ecology Diet (BED)							
		Gut and Psychology Syndrome (GAPS)							
		Other:							

SIGNS AND SYMPTOMS						
Please check (✓) any signs/symptoms your child may demonstrate and note duration and details if appropriate:						
No.	Description	Mild	Moderate	Severe	Duration	Unique Details
1	Stimming (repetitive actions or movements)					
2	Rocking					
3	Head banging					
4	Self-mutilation					
5	Nail biting					
6	Hard / arm biting					
7	Nail / skin picking					
8	Aggressiveness (hitting, kicking, biting others)					
9	Mood swings					
10	Irritability / tantrums					
11	Fears / anxieties					
12	Hyperactivity					
13	Inability to concentrate / focus					
14	Always fidgety in his/her seat					
15	Impulsive					
16	Breath holding					
17	Dizziness					
18	Seizures					
19	Poor coordination					
20	Poor balance					
21	Problems with buttons, ties, snaps or zippers					
22	Processing problems – visual, motor, language, etc.					
232	Problems with social interactions					
24	Sensitive to crowds					
25	Trouble remembering					
26	Low self-esteem					
27	Fatigue					
28	Cold hands / feet					
29	Cold intolerance					
30	Heat intolerance					
31	Recurrent / chronic fever					
32	Flushing					
33	Difficulty falling to sleep					
34	Night waking					
35	Nightmares					
36	Difficulty waking					
37	Bed wetting / soiling					
38	Daytime wetting / soiling					
39	Numbness / tingling in hands or feet					
40	Headaches					
41	Blinking					
42	Tics					
43	Eye discharge					

No.	Description	Mild	Moderate	Severe	Duration	Unique Details
44	Dark circles / puffiness under eyes					
45	Night blindness in child/family					
46	Congestion					
47	Dripping nose					
48	Sensitivity to bright lights					
49	Earaches					
50	Ringing in ears					
51	Sensitive to sounds / noise					
52	Bad breath					
53	Nose bleeds					
54	Acute sense of smell					
55	Sore throats					
56	Hoarseness					
57	Cough					
58	Wheezing					
59	Geographic tongue					
60	Swollen gums					
61	Canker sores					
62	Dry lips / mouth					
63	Diarrhea					
64	Constipation					
65	Bloating					
66	Passing gas					
67	Belching					
68	Stomach aches					
69	Refusal to eat					
70	Sensitive to texture of food					
71	Difficulty swallowing					
72	Food craving					
73	Grinding teeth					
74	Mucous / blood in stools					
75	Anal itching					
76	Undigested food in stools					
77	Calf cramps					
78	Other muscle cramps / spasms					
79	Tremors					
89	Weakness					
81	Stiffness					
82	Eczema					
83	Psoriasis					
84	Hives					
85	Acne					
86	Seborrhea (cradle cap)					
87	Other rashes					
88	Easy bruising					
89	Itchy scalp					
90	Dry skin					
91	Oily skin					
92	Pale Skin					
93	Sensitivity to insect bites					
94	Sensitive to texture of clothes					

No.	Description	Milk	Moderate	Severe	Duration	Unique Details
95	Cracking / peeling hands					
96	Cracking / peeling feet					
97	Strong body odor					
98	Strong urine odor					
99	Strong stool odor					
100	Soft nails					
101	Thickening of nails					
102	Ridges / pitting of nails					
103	White spots of nails					
104	Brittle nails					
105	Any OCD (obsessive compulsive behaviors)					
106	Strategies to put pressure on abdomen					
107	Masturbation					
108	Thrush					
109	Low muscle tone					
110	Staring episodes					
111	Reflux					
112	Persistent colic					
113	Toe walking					
114	Positive behavioral / cognitive reaction					
	with illness					
	with fever					
	with antibiotics					
	when not eating					
115	Regression					
	with illness					
	with fever					
	with antibiotics					
	when not eating					

Describe any other symptoms you would like us to know about your child:

If you are already involved with biomedical interventions, what have been the most helpful to date:

Has your child had any negative reactions / responses to supplements, medications or other interventions? Yes or No (circle one). If yes, please describe response and indicate what caused it:

List any other history, pertinent thoughts or questions that you want to address:

Thank you for taking the time to help us help your child.