



Last Name: _____

ADD/ADHD Questionnaire

Please fill out the following questionnaire. Please include copies of any **lab tests** that have been run and a **photo** of your child.

Name (child) _____ Height: _____ Weight: _____
 _____ Date of birth: _____ Age: _____
 _____ Diagnosis: _____
 _____ Referred by: _____

Parents: Single / Married / Unmarried / Separated / Divorced Child lives with: _____

Mother's Name _____ Phone (H) _____
 Address: _____ Phone (W) _____
 _____ Phone (C) _____
 Mother's Email _____

Father's Name _____ Phone (H) _____
 Address: _____ Phone (W) _____
 _____ Phone (C) _____
 Father's Email _____

What conditions or symptoms are most significant? _____

What is your level of knowledge on nutrition intervention for ASDs ?

- Very well read
- Have done some reading and have started dietary intervention
- Very new to all of this

How can a nutrition consultant best support you? _____

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Therapies/Protocols (*Indicate: what you are you interested in, are using, or tried in past*)

DAN! Protocol _____ Diet Intervention _____ NAET, Bioset _____

Sensory integration _____ Chelation _____ Yeast protocol _____

Homeopathy _____ Energy work _____ Other _____

PRENATAL/INFANT

Number of children in family and order (i.e. 2nd of 3 children) _____

Names/ages other children _____

Describe the pregnancy _____

Was child breast-fed? How long _____

Did the child receive formula? What type (cow, soy)? _____

What was the reaction to formula? _____

Did child have thrush as a baby? _____

Was the *mother* exposed to any chemicals or medications during pregnancy, or received any amalgam fillings or vaccinations (including Rh immune globulin or flu shot)?

HEALTH HISTORY OF CHILD

Describe the health history of the child from birth (i.e. ear infections, illnesses, viruses):

How many times has the child received antibiotics and at what age? Please describe

Does child have heavy metal or other toxicity? _____

Is child currently taking any medication? _____

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Please list **supplements** child is taking (or include separate sheet):

Have you tried cod liver oil and was there any improvement? _____

DIET

Is child on any of the following diets?

GFCF _____ Specific Carbohydrate Diet _____ Yeast diet _____

Feingold _____ Body Ecology Diet _____ Low oxalate _____

Other/Combination of... _____

Vegetarian (eat eggs and dairy) Yes / No _____

Vegan (No eggs or dairy) Yes / No _____

Eat fish? How often and what type? _____

Please describe any special diet or variation of the diets above that child is on:

Do you (circle one) suspect or know that your child is:

Gluten sensitive _____ **Casein** sensitive _____ Explain _____

Has child tried a strict gluten/casein-free diet? _____ If yes, for how long? _____

Did you notice a reduction in symptoms? _____

Does your child have any other **food sensitivities**?

Eggs	Corn	Sugar	Soy
Chocolate	Peanuts	Citrus	
Other _____			

Does child have any significant food cravings, or demand or sneak food? _____

Phenols/Salicylates

Are you familiar with phenols, salicylates, and faulty sulfation? _____

Do you suspect your child has a **phenol sensitivity**? _____ Is there a reaction -[hyperactivity, red cheeks, aggression, etc.] to the following phenols/salicylates? (circle):

- Apples/juice Grapes/raisins Tomatoes Berries/Bananas/other fruit
- Curry powder/Spices Nitrates/nitrites Preservatives Artificial colors/flavors
- Sulfites Fragrance/perfume Aspirin Tylenol (acetaminophen)

Does your child only eat foods of certain **textures**? _____

Are there any **textures** your child will *not* eat? _____

Does he/she tend to focus on one **taste** (sweet, bitter, sour, salty, spicy) _____

Are there any **tastes** he/she will not eat? _____

Favorite foods: _____

What food does your child typically eat (please also complete the “food/mood” diet record):

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Drinks _____

DIGESTION AND ELIMINATION

Does child have frequent gas or bloating? _____

Does gas have a strong odor? _____

Does child appear to have abdominal pain? _____

Does child have diarrhea or soft, unformed stool? _____

Does child have constipation? _____

Does child have heartburn or acid reflux? Does child take antacids or acid blockers?

Does child get nauseous or vomit? _____

Does child have yeast or bacterial overgrowth? _____

Describe any other digestive issues? _____

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How frequently does child have a bowel movement? _____

What is consistency of stool?

Formed like a brown banana _____

Unformed, soft, or ribbon-like _____

Small balls formed into banana, or “rabbit-pellets” _____

Very large diameter _____

FAMILY HISTORY

Do *mother or father* have any food sensitivities? _____

Does *mother* have any heavy metal toxicity or exposure? _____

Common Familial Disorders

Please indicate any family history of the following and list family member affected, mark paternal or maternal with a “p” or “m”. For example: p-grandmother, m-aunt

ADD/ADHD _____ Depression, postpartum, SAD, bipolar _____

Asperger’s or other ASDs _____ High estrogen/low progesterone _____

Alcohol/chemical dependency _____ Threatened or actual miscarriage _____

Epilepsy _____ Diabetes/hypoglycemia _____

Rheumatoid arthritis _____ Impaired immune function _____

Food/environmental allergies _____ Recurring yeast (vaginal, foot, etc.) _____

Impaired fat digestion/loose stools _____ Recurring sinus infections _____

Asthma _____ Dermatitis/rashes _____

IBD/Crohn’s disease _____ Multiple chemical sensitivity _____

Cancers of GI Tract _____ Fibromyalgia or chronic fatigue _____

Schizophrenia _____ Active Epstein-Bar virus _____

Alzheimer _____ Hypothyroid _____

Other psychiatric condition _____ Autoimmune/inflammation _____

Symptom Checklist

*Please rate the following behaviors or symptoms on a scale of 1 to 7 (1 mild; and 7 very true or severe) as they appear **today**. This will help determine how the child progresses.*

(0) Not apply (1)Mild (7)Very true

Behavioral/emotional symptoms

Does not respond to requests by familiar people	0	1	2	3	4	5	6	7
Has picky eating habits	0	1	2	3	4	5	6	7
Throws frequent tantrums	0	1	2	3	4	5	6	7
Behaves aggressively, physically attacking others	0	1	2	3	4	5	6	7
Injures self with behavior (head-banging)	0	1	2	3	4	5	6	7
Frequent crying	0	1	2	3	4	5	6	7
Anxiety	0	1	2	3	4	5	6	7
Depression	0	1	2	3	4	5	6	7
Irritability	0	1	2	3	4	5	6	7
Panics easily or resists change	0	1	2	3	4	5	6	7
Behavior challenges 2-3 hours after meals	0	1	2	3	4	5	6	7
Hyperactivity	0	1	2	3	4	5	6	7
Spacey/Inattentive	0	1	2	3	4	5	6	7
Low impulse control	0	1	2	3	4	5	6	7

Physical Symptoms

Is physically inactive, or passive	0	1	2	3	4	5	6	7
Fatigue/low muscle tone	0	1	2	3	4	5	6	7
Hypersensitive (sound, touch, etc)	0	1	2	3	4	5	6	7
Insensitive to pain	0	1	2	3	4	5	6	7
Headache	0	1	2	3	4	5	6	7
Tics/Tourette's	0	1	2	3	4	5	6	7
Asthma	0	1	2	3	4	5	6	7
Bedwetting/daytime wetting	0	1	2	3	4	5	6	7
Red checks or streaks on face	0	1	2	3	4	5	6	7
Dark circles under eyes	0	1	2	3	4	5	6	7
Hives/rashes	0	1	2	3	4	5	6	7
Congestion/runny nose/allergy symptoms	0	1	2	3	4	5	6	7
Resistance to go to bed	0	1	2	3	4	5	6	7
Difficulty falling asleep	0	1	2	3	4	5	6	7
Night waking/nightmares/erratic sleep	0	1	2	3	4	5	6	7
Seizure activity	0	1	2	3	4	5	6	7

Please remember to include copies of any lab tests that have been run

- No tests have been run yet**

Food/Mood Record

1. Please write out child’s daily diet. (If diet varies, fill out a diet record for at least two days). Include portion size and any supplements or medications. Include time of day.
2. Additionally, record any symptoms experienced during or after eating, such as drowsy, irritable, energized. Include bowel movements.

<u>Time</u>	<u>Food/Supplements</u>	<u>Mood/Energy/Symptoms</u>
<i>Example</i> 9:00	<i>1 cup of Cheerios with 3/4 c of cow milk 1 Flintstone’s multi-vit/min, 500 mg vit C</i>	<i>10:00 Hyperactive Constipation</i>
<u>Breakfast</u>		
<u>Snack</u>		
<u>Lunch</u>		
<u>Snack</u>		
<u>Dinner</u>		
<u>Night-time Eating</u>		

Last Name: _____

Nutrition Consultant Service Agreement

On behalf of my child _____ I, _____, am consulting with Julie Matthews, Certified Nutrition Consultant to gain information on health and wellness. I understand that Julie Matthews is not a physician and that she does not dispense medical advice nor prescribe treatment. Rather, she provides information to enhance my knowledge of how nutritious foods, herbs, supplements, and lifestyle affect health.

Julie Matthews' training includes a two-year certification program in nutrition education and consultation from Bauman College. The methods of evaluation employed on my behalf, which may include diet, supplementation, and assessment analysis, are not intended to diagnose disease. I specifically authorize the use of these assessments, so that we can develop an appropriate dietary and health-supporting program for me and/or my child, and to monitor my progress towards achieving my health goals.

These services are not a substitute for medical care, and do not claim to diagnose, treat, or alleviate disease. Nutrition consultation services are not licensed by the state of California, they are alternative or complementary to the healing arts services licensed by the state. For medical diagnosis and treatment of disease, I would need to consult with a medical physician, or other licensed healing arts practitioner.

I am acting solely on behalf of myself and my child. I do not represent any other person, entity, and/or governmental agency.

My child currently is is not under the care of a physician for a health problem or medical condition. By providing the following information, I give Julie Matthews permission to contact his/her physician, _____, at the following phone number _____ on my behalf. The purpose of this contact would be to attain additional information from my doctor on his/her diagnosis or recommended treatment, in order that Ms. Matthews may best provide me with appropriate and complementary information. I know that Julie is not, and cannot be, a primary healthcare provider.

I agree to hold Julie Matthews and Healthful Living harmless for any claims or damages in association with our work together. This is a contract between Julie Matthews/Healthful Living and myself and a general release of liability for Julie Matthews and Healthful Living.

I understand Healthful Living has a 48-hour cancellation policy, and am aware that I will be charged a \$50 cancellation fee for a missed appointment if proper notice is not given (by phone NOT e-mail).

For prepaid and discounted Appointment Packages, unused portions are not refundable. It is highly recommended that Appointment Packages be fully utilized within 6 months of their original purchase date, as this best serves client and practitioner objectives for motivation and timely results. Portions of prepaid packages will be forfeited if unused after 9 months.

Mother's Signature: _____
Name: _____
For (child's name) _____
Date: _____

Father's Signature: _____
Name: _____
For (child's name) _____
Date: _____

{Please have mother and/or father sign form. Keep a copy for your records}