Brainstorm Health

PERSONAL DETAILS Date________________________

Full Name ____

Contact address ____

____

Postcode____

Tel No_____________________________MobNo_____________________________________

Email____

Date of Birth _______________Height _____________Current Weight___________________

FAMILY DETAILS

Full Name of Mother____

Full Name of Father____

Age of: Mother____ Father____ Brother(s) ________________ Sister(s) _________________

Contact details of parents if different to above ____

____

Name of GP ____

GP address ____

GP contact number ____

Do you give permission for your child's GP to be kept informed? Yes No

Please name any other health or educational specialist that you wish to be kept informed

____

SCHOOL DETAILS

Name and Address of School

____Postcode ____________

Contact Name at School __________________________Tel No ________________________

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Is your child in mainstream education?	Yes	No
Does your child receive educational support at school?	Yes	No
Has your child ever been given an educational statement?	Yes	No

Does your child have a diagnosis such as Autism, ADHD, ADD, PANDAS, PANS, Bipolar disorder, Schizophrenia, or any other diagnosis.

Yes No

If yes please describe the diagnosed condition(s), including information about the age of the diagnosis and the severity of the condition.

When did you first develop concerns about your child?

Does your child have any medical conditions or problems? Yes No

If yes please describe the medical condition, including information about the age at which it was identified, and the severity of the condition.

Does your child have speech? Yes No

If yes please describe the level of your child's speech.

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Did your child have any speech that was lost? Yes No

If yes please describe speech regression and at what age?

Did your child loose any social and /or motor skills? Yes No

If yes please describe loss of social and/ or motor skills and at what age.

Was the decline in health and function after a vaccination? Yes No

If yes please describe which vaccination it was and at what age.

Describe your child's sleep pattern currently, and whether it has changed significantly over time.

List all vaccinations (including those for foreign travel) and when they were given. Please describe any reactions which you noticed such as; fever, rash, diarrhoea etc.

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List all illnesses before 12 months of age.

List all illnesses after 12 months of age.

Describe frequency of ear infections, and at what age.

Describe frequency of streptococcal infections and at what age.

List all medical treatments, especially antibiotics your child has received. Please describe what they were for and at what age they were given.

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Describe any reactions your child has ever had to medication.

List laboratory tests performed to date.

Does your child suffer from food allergies? e.g. milk, wheat, soy, eggs, fish, nuts?

Yes No

If yes please describe the allergy in detail.

Has your child ever suffered anaphylaxis? Yes No

If yes please give full details of the incident.

Does your child carry an EpiPen? Yes No

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List all foods that are most commonly consumed.

List all Nutritional Supplements being currently taken. Please include brand names and dosage.

List any nutritional supplements which you feel have helped.

List all nutritional supplements which you feel have had a negative effect.

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List all current educational therapies such as Lovaas, ABA etc.

Which educational therapy has been most successful?

List all other therapies used and describe their effectiveness. Therapies could include; cranial osteopathy, NAET, homeopathy, reflexology, auditory integration etc.

From the list below please identify any symptoms, which your child is currently exhibiting or has ever exhibited in the past. Please place a circle around the most relevant answer.

Sleeplessness	Current	Never	Past
Pale complexion	Current	Never	Past
Excessive nose picking	Current	Never	Past
Always hungry	Current	Never	Past
Grinding teeth	Current	Never	Past
Itchy anus/probing anus	Current	Never	Past
Nail biting	Current	Never	Past
Nail or skin picking	Current	Never	Past
Hand flapping	Current	Never	Past
Temper tantrums	Current	Never	Past
Crying for no apparent reason	Current	Never	Past
Laughing for no apparent reason	Current	Never	Past
Bedwetting	Current	Never	Past
Frequent urination	Current	Never	Past
Red earlobes/pink cheeks	Current	Never	Past
Bad breath	Current	Never	Past
Distended abdomen	Current	Never	Past

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Hyperactive	Current	Never	Past
Angry/Aggressive	Current	Never	Past
Severe mood swings	Current	Never	Past
Strep throat	Current	Never	Past
Obsessive Compulsive Disorder	Current	Never	Past
Tick bites	Current	Never	Past
Low muscle tone	Current	Never	Past
Difficulty latching onto breast	Current	Never	Past
Constipation	Current	Never	Past
Poor articulation	Current	Never	Past
Tires easily	Current	Never	Past
Hypermobile	Current	Never	Past
Joint pains	Current	Never	Past
Eyes sensitive to bright lights	Current	Never	Past
Often looks out of corner of eyes	Current	Never	Past
Craves sweets	Current	Never	Past
Picky eater	Current	Never	Past
Irritable before meals	Current	Never	Past
Better behaviour after meals	Current	Never	Past
Hyperactive/irritable after meals	Current	Never	Past
Excessive mouth licking	Current	Never	Past
Easily agitated	Current	Never	Past
Defiant	Current	Never	Past
Vomiting/spitting up	Current	Never	Past
Colic	Current	Never	Past
Ear infection	Current	Never	Past
Excessive thirst	Current	Never	Past
Dark circles under eyes	Current	Never	Past
Congestion/runny nose	Current	Never	Past
Coughing/wheezing	Current	Never	Past
Seasonal allergies	Current	Never	Past
Hives, skin rashes, eczema	Current	Never	Past
Recurring Infections	Current	Never	Past
Diarrhoea	Current	Never	Past
Fatigue	Current	Never	Past
Learning difficulties	Current	Never	Past
Craves certain foods	Current	Never	Past
Cold hands and feet	Current	Never	Past
Night sweats	Current	Never	Past
Rapid heart rate	Current	Never	Past
Red spots on back of arms	Current	Never	Past
Poor balance/clumsy	Current	Never	Past
Can't stay focused on a task	Current	Never	Past
Can hear but doesn't listen	Current	Never	Past
Muscle cramps	Current	Never	Past
White flecks on nails	Current	Never	Past

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Chewing on clothes/non food objects	Current	Never	Past
Repetitive actions	Current	Never	Past
Rocking	Current	Never	Past
Head banging	Current	Never	Past
Self-harming	Current	Never	Past
Biting self or others	Current	Never	Past
Dry hair and/or nails	Current	Never	Past
Seizures	Current	Never	Past
Sensory processing difficulties	Current	Never	Past
Excessive sweating	Current	Never	Past
Difficulty falling asleep	Current	Never	Past
Night waking	Current	Never	Past
Difficulty waking	Current	Never	Past
Painful urination	Current	Never	Past
Black specks in stool	Current	Never	Past
Sandy or crumbling stool	Current	Never	Past
Kidney stones	Current	Never	Past
Excessive Staring	Current	Never	Past
Geographic tongue	Current	Never	Past
Excessive belching	Current	Never	Past
Excessive wind	Current	Never	Past
Refusal to eat	Current	Never	Past
Sensitive to texture of food	Current	Never	Past
Mucous in stool	Current	Never	Past
Blood in stool	Current	Never	Past
Pale brown/yellow stool	Current	Never	Past
Undigested bits of food in stool	Current	Never	Past
Sensitive to clothes	Current	Never	Past
Ridges on nails	Current	Never	Past

INFORMATION ABOUT PREGNANCY AND BIRTH

Was the labour induced?	Yes	No
Was it a long labour?	Yes	No
Were forceps used?	Yes	No
Was C-section performed?	Yes	No
Was the baby premature?	Yes	No
Was the baby late?	Yes	No
Was the baby deprived of oxygen?	Yes	No
Did the bay cry after delivery?	Yes	No

Describe unusual events during pregnancy?

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What were the 5 most common foods/drinks you had during pregnancy?

Describe any particular cravings you had during pregnancy.

List any supplements you took during pregnancy?

List any medication, including over the counter medication you took during pregnancy?

Describe your level of activity, including any exercise, during pregnancy.

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Did you smoke during pregnancy? Yes No

If yes please comment on how regularly you smoked during pregnancy.

Did you drink alcohol during pregnancy? Yes No

If yes please comment on how regularly you had alcohol during pregnancy.

Did you take any recreational drugs during pregnancy? Yes No

If yes please describe the type of drug and frequency.

If you suffered from any of the following symptoms or conditions during pregnancy, please list them and describe the severity: excessive morning sickness, water retention, high blood pressure, preeclampsia, gestational diabetes, protein in urine.

Describe any other major health problems both before and during pregnancy.

Describe any current health problems.

Describe any medical or dental treatment received during pregnancy.

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Describe toxic metal exposure during pregnancy such as increased consumption of tuna/swordfish/marlin/shark, vaccinations, RhoGAM® injections and so on.

What did your baby weigh at birth?

What was the APGAR score?

Please describe the length of time your child was (or is being) breastfed.

Please describe any difficulties with breastfeeding.

Did/does your child experience colic? Yes No

Please list any formula milk your child was or is being given.

INFORMATION ABOUT WEANING AND FEEDING HABITS

At what age was your child weaned?

At what age was wheat introduced?

At what age were rye, oats and barley introduced?

At what age was egg introduced?

At what age were foods containing peanuts introduced?

At what age were citrus fruits introduced?

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Please list any foods/drinks/chemicals your child has ever had a reaction to, either physically or behaviourally or both, and describe the severity of the reaction in detail.

List any special diets your child has ever been on such Gluten Free (GF), Casein Free (CF), GFCF, GAPS, SCD, FODMAP, Low Oxalate, Low salicylate, Feingold etc.

Describe any benefits you have noticed as a result of the special diet.

Which foods does your child dislike?

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Which foods may your child find difficult to give up?

Does your child have a good appetite? Yes No

Has your child ever experienced eating disorders such as anorexia or bulimia?

Yes No

If yes please describe in detail the eating disorder and the severity of the condition.

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FAMILY HEALTH HISTORY *(Please specify which family members are affected e.g. mother, father, sister, brother grandmother, grandfather, aunt, cousin, of the child under review)*

	Member(s) of Family
Allergies (asthma, eczema, hay fever, hives	
Early heart disease	
Heart attacks	
Diabetes	
Obesity	
Strokes	
Alzheimer's	
Neural defects	
Cancers	
Migraines	
Headaches	
Sinusitis	
Rheumatoid Arthritis	
Irritable Bowel Syndrome	
Inflammatory Bowel Disease	
Coeliac Disease	
Epilepsy	
Depression	
Schizophrenia	
Miscarriages	
Infertility	
Dyslexia	
Dyspraxia	
Asperger's Syndrome	
Autism	
Sensory Integration Problems	
Other	

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Food Diary

Please provide a sample of a typical days eating plan for your child. Please be as precise as possible

Breakfast
Lunch
Dinner
Snacks
Drinks

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I (or Parent/Guardian if under 18 years of age) ______________________________
give consent for Stella Chadwick of Brainstorm Health to provide Nutritional Therapy, NAET and Live Blood analysis services for me (or my child).

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Please include any additional information which may be helpful for us to know.

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