BIO-MEDICAL CONFIDENTIAL HEALTH QUESTIONNAIRE:
CHILD:
Name:____
Birthdate_________________Age:___________________
Email:____
Home Phone; (_____)______-______________________
FAX: (_____)________-__________________________
Address:____
Referred by:______________________________________
Current Doctor(s):_________________________________
Father's Name:___________________________________Age_____DOB_______________ Mother's Name:__________________________________Age_____DOB_______________ Siblings, Gender and Ages:____
List those living in Primary Home:____
List those living in Seocndary Home:____
FATHER: Address: City: Age: Date of Birth: Profession:
Phone: (H) Zip: Phone: (0)
Place of Birth: Religion: General Health:
Past medical history: Illnesses in paternal family:
Alcoholism or addiction in father or father's family: Mental or emotional illness in father or father's family:
Depression: Anxiety: Bipolar: Psychosis: Obsessive Compulsive Disorder:

Personality Disorder: Hospitalizations: Psychotropic Medications Current Past
Learning disabilities:
Phone (H):_ .Zip: Phone (0):
_Place of Birth: Religion: General Health:
MOTHER: Address: City:
Age: Profession:
Amalgam fillings? How many? When placed? Past medical history
Illnesses in maternal family especially autoimmune:
Date of Birth:
Rh neg?
Alcoholism or addiction in mother or mother's family:_ Mental or emotional illness in mother or mother's family: Depression:
Psychosis: Personality Disorder: Psychotropic Medications Current Ever have bad reaction to any medicine or nutrient
Anxiety: Bipolar: Obsessive Compulsive Disorder: Hospitalizations:
Past
ANY HISTORY OF DYSLEXIA, AUTISM, AUTOIMMUNE DISORDER, ADHD, DOWN'S, ALZHEIMER'S OR MENTAL RETARDATION IN ANY RELATIVE ON EITHER SIDE OF FAMILY; please describe in detail

Child's Birth place: Type of delivery: Difficulty of Labor Condition at birth:
APGAR: Wt: Mother's age at delivery: Any amalgam fillings placed in mother during pregnancy or breast feeding? Complications during pregnancy or delivery:

How old when received vaccination What kind? Reaction?

Breast Fed/How long: Allergies Injuries
Infections Fevers

Treatment with antibiotics Reactions

Surgeries, tubes in ears

Seizures: Age of onset, type, accompanied by fever, timing re illnesses, injuries, vaccinations:

Vaccination history and describe any adverse reactions or changes in behavior after receiving:

Has your child had a disorder since birth, or later onset? Please describe development of problem

Describe general development:

History of sexual or physical abuse:

Results of chromosomal studies: EEG: MR] Amalgam fillings; how many and what age?
Take any medications regularly

Eating Patterns: Infant Formula base (milk, soy, etc) Toddler Currently Toilet and stool patterns: Frequency, Consistency, Odor: Past Sleeping patterns:
Currently Nightmares: Age walking began: Age speech began: Age started daycare: Any regression in speech noted,
Schooling: Academics: Learning; disorders, delays Disruptive/anti-social behavior in public
Teacher comments/reactions:

Present height Weight Size in relation to same age peers

Describe general personality:
Mood swings: Hyper or hypoactive'
Temper tantrums:_ Inconsolable crying spells:
Friends: Make easily: Keep: Relation to Adults:
Imagination pattern:_ Imaginary friends:
Motor development:_ Handedness:
Eye contact: Affection: Alertness:
Favorite activities: Repetitiousness
Relation to animals:_ Fears of dark, water, strangers:
Favorite foods Most disliked foods
Favorite object(s): Reaction to change

Unusual fears/phobias/attachments:

Sense of humor:

Closest personal bond (usually):

Has your child been given any diagnosis or needed special schooling?

Self-sufficiency:

List any special diets and reactions/results

List any laboratory studies undertaken and results (date and positive or negative if don't know actual values):

Organic acid

Stool analysis or other gastrointestinal studies Urinary peptides
Immune function tests
Fatty acid analysis Heavy metals studies Amino acids, Vit.
Zinc, other nutrients Hair analyses
24 hour EEG, neuroSPECT

Any others not listed

List any medications in vast and currently taking, times and doses

List any nutrients/vitamins currently taking, doses, any reactions

Do you have a personal opinion as to why your child is developmentally delayed?

Please give any other information that might be helpful in evaluating Your child: please send a current photo with siblings/family if possible.

Autism W/U;

Routine Labs
TSH, T4, T3
Ferritin
Blood Copper & Zinc
CMP
B12/Folate levels

GSDL
(800) 522-4762
www.gsdl.com
DMSA Provocation heavy metals
CDSA
Candidiasis assay

Metametrix Clinical Lab
4855 Peachetree Ind. Blvd
Norcoss, GA 30092
(770) 446-5483 VOX
(770) 441-2237 FAX

Pediatric ION w/ 40 Amino Acids

Immunosciences La Inc.
8693 Wilshire Blvd Ste 200

Beverly Hills, CA 90211
(310) 657-1077 VOX
(310) 657-1053 FAX

Streptococcal Peptides (M5, M12, M19) (IgG)
Gliadin Peptides Antibodies (IgG, IgM, IgA)
Casein Peptides Antibodies (IgG, IgM, IgA)
Antibodies to Hg Binding Antigen (Fibrillarin) (IgG, IgM, IgA) Dipeptidylpeptidase (DPP IV) Antibodies (IgG, IgM, IgA)
Anti-Myelin Basic Protein Antibodies (IgG, IgM, IgA)
Anti -Neurofilament Antibodies
Metallothionein (Cellular Level)
NK Cell Activity
Measles Antibodies (IgG, IgM)
VIRAL SCREEN #3:
Varicella Zoster Virus (IgG) Cytomegalovirus (IgG, IgM)
Epstein-Barr Virus or VCA (IgG, IgM)
Herpes Type 1 & 2 Virus (IgG, IgM)
Herpes Type 6 Virus (IgG, IgM)
Immunoglobulins, IgM, IgG, IgA
COST $1544 50% DISCOUNT AS PANEL = $772 PRE-PAID