Child Questionnaire

Today's Date: _____
Child's Name: _____ Age: _____ DOB _____
Height _____ Weight _____ Diagnosis (if any) _____
Parents names _____
Address _____
_____
Phone numbers: H: _____ W: _____ Cell: _____
Email: _____ Referred by: _____

* * * * *

Main reason for child's visit today: _____
Number of children in family and order (i.e. 2nd of 3 children) _____
Was child born prematurely? _____ If yes, how many weeks early? _____
Describe the pregnancy _____
Was child breast fed? _____ If so, how long? _____
If not, what formula did s/he have as an infant (cow, soy)? _____

Child's History: Please check what applies & describe:
Has had ear infections? _____ How many? _____ Has ear tubes? _____
Received antibiotics: _____ What ages? _____
Gets sick easily: _____ Describe: _____
Diarrhea or loose stool: _____
Constipation: _____
Gas pain: _____
Hyperactivity: _____
List any prescribed medication child is currently on & reason for taking: _____
_____
Has the child taken any medications in the past? Were they helpful? _____
_____
List any supplements the child is taking: _____
_____
Have any supplements caused problems? _____
_____
What type of activity/exercise does the child do? _____

If Autism or Developmental Delay please complete this section:
Age symptoms first appeared _____ Describe symptoms _____
_____
_____
List any events accompany onset of symptoms? _____
What current developmental delays are evident (speech, eye contact, etc.) _____
_____
Did child receive all standard vaccinations? _____
How did the child react to the vaccinations? _____
_____

Did anything out of the ordinary occur around the time of the MMR vaccine? (reaction, illness, impact on speech, etc?) _____
Does *birth mother* have any known food sensitivities? (wheat, dairy, corn…) _____
_____
Does *mother* have any chemical sensitivities or allergies? _____
Was *mother* exposed to any chemicals or medications during pregnancy, or received _____
amalgam fillings or vaccinations (including Rh immune globulin) during pregnancy? _____
_____

Previous Tests (all fill out):
Please summarize any results of tests run in the last year (i.e. positive for candida, no mercury toxicity, diagnosed with hypoglycemia). **Include copies of the test results when possible:**

Glucose/insulin tolerance (hypoglycemia) _____
Digestive Stool Analysis (digestion, microbial analysis, yeast/candida, parasites_____
_____
Detoxification profile (caffeine, acetaminophen, salicylates) _____
Intestinal Permeability (leaky gut) _____
Heavy metal and mineral analysis _____
Amino acid profile _____
Fatty acid analysis _____
Food allergy/sensitivity testing _____
Environmental allergy and chemical testing _____
Melatonin profile _____
Other? _____
_____

DIET:
Is child on Gluten Free Casein Free diet? _____ If so, for how long? _____
List any food sensitivities you are aware of: _____
_____
Child's 5 favorite foods: _____
List foods s/he won't eat: _____
_____
Number of sodas per week: _____ Number of glasses of water per day: _____
How much milk per day: _____ Sweets per day: _____

FAMILY HISTORY: Please indicate any siblings, parents, or relatives with a history of:
Attention Deficient Hyperactivity Disorder _____
Diabetes _____
Tourette's Syndrome _____
Autism _____
Schizophrenia _____
Depression _____
Learning disabilities _____
Dyslexia _____
Asperger Syndrome _____
Bipolar Disorder _____
Alzheimer's _____
Down Syndrome _____
Migraines _____
Hypoglycemia _____
Heart disease _____
Cancer _____
Arthritis (osteo or rheumatoid) _____
Chronic Fatigue Syndrome _____
Alcoholism _____
Eating disorders _____
Celiac disease _____
Irritable bowel syndrome _____
Other _____

Please let us know of any other pertinent information to add: _____

_____

_____

_____

_____

Child Neurotransmitter & Nutrition Questionnaire (CNNQ)

Name: _____ Age: _____ Sex: _____ Date: _____

* Please circle the appropriate number "0 - 3" on all questions below. 0 as the least/never to 3 as the most/always.

SECTION: GENERAL

- Does your child have any food sensitivities or allergies? (please list)

  _____

  _____
- List your child's 4 healthiest foods eaten regularly.

  _____, _____,

  _____, _____
- List your child's 4 unhealthiest foods eaten regularly.

  _____, _____,

  _____, _____
- How many times a week does your child eat candy? _____
- How many times a week does your child drink soda pop? _____
- Please list the top 4 foods your child craves regularly?

  _____, _____,

  _____, _____
- List the medication(s) your child is currently prescribed and over the counter.

  _____

  _____
- Do you find it difficult as a parent to have your child on a special diet?

  _____

SECTION: A (K52)

- Does your child eat pasta, breads, and breaded foods? 0 1 2 3
- Does your child have symptoms (fatigue, hyperactivity, etc.) after eating wheat foods? 0 1 2 3
- Does your child eat dairy products? 0 1 2 3
- Does your child have symptoms (fatigue, hyperactivity, etc.) after eating dairy products? 0 1 2 3

SECTION: B (K53)

- Does your child eat fried fish? 0 1 2 3
- Does your child eat roasted nuts or seeds? 0 1 2 3
- Is your child **missing** essential fatty acid rich foods in his/her diet? (for example: avocadoes, flax seeds, olives) *(mark "0" if present, "3" if missing)* 0 1 2 3
- Does your child eat *fried* foods? 0 1 2 3

SECTION: C (K34)

- Is your child's mental speed slow? 0 1 2 3
- Does your child have difficulty with learning or memory? 0 1 2 3
- Does your child have difficulty with balance and coordination? 0 1 2 3

SECTION: D (K16)

- Does your child have stress? 0 1 2 3
- Does your child **not** have enough sleep and rest? *(mark "3" if not enough)* 0 1 2 3
- Does your child **not** have regular exercise? *(mark "3" if no exercise)* 0 1 2 3
- Does your child feel overly worried and scared? 0 1 2 3

SECTION: E (K16, K51)

- Does your child have temper tantrums? 0 1 2 3
- Does your child exhibit wild behavior? 0 1 2 3
- Does your child frequently yell or scream for unnecessary reasons? 0 1 2 3
- Does your child have an **inability** to nap or sleep when physically exhausted? *(mark "3" if unable)* 0 1 2 3
- Is your child overly talkative? 0 1 2 3
- Does your child fidget and squirm when seated? 0 1 2 3
- Does your child run and climb excessively when it is inappropriate? 0 1 2 3
- Does your child have difficulty playing quietly or engaging in leisure activities? 0 1 2 3

SECTION: F (K51)

- Does your child get excited easily? 0 1 2 3
- Does your child have anxiousness and panic for minor reasons? 0 1 2 3
- Does your child feel overwhelmed for minor reasons? 0 1 2 3
- Does your child find it difficult to relax when she/he is awake? 0 1 2 3
- Does your child have disorganized attention? 0 1 2 3

SECTION: G (K50)

- Does your child seem depressed? 0 1 2 3
- Does your child have mood changes with overcast weather? 0 1 2 3
- Does your child have symptoms of inner rage? 0 1 2 3
- Does your child seem uninterested in games or hobbies? 0 1 2 3
- Does your child have difficulty falling into deep restful sleep? 0 1 2 3
- Does your child seem uninterested in friendships? 0 1 2 3
- Does your child have symptoms of unprovoked anger? 0 1 2 3
- Does your child seem uninterested in eating? 0 1 2 3

SECTION: H (K49)

- Does your child have difficulty handling stress? 0 1 2 3
- Does your child have anger and aggression while being challenged? 0 1 2 3
- Does your child feel tired even after long sleeps? 0 1 2 3
- Does your child tend to isolate from others? 0 1 2 3
- Does your child get distracted easily? 0 1 2 3
- Does your child have constant need and desire for candy and sugar? 0 1 2 3
- Does your child have disorganized attention? 0 1 2 3

SECTION: I (K48)

- Does your child have difficulty with visual memory? 0 1 2 3
- Does your child have difficulty remembering locations? 0 1 2 3
- Does your child have fatigue or low endurance for learning activities? 0 1 2 3
- Does your child have difficulty with attention or low attention span or endurance? 0 1 2 3
- Does your child have slow or difficult speech? 0 1 2 3
- Does your child have uncoordinated or slow movement? 0 1 2 3

Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition.
For nutritional purposes only

PATIENT RELEASE FORM

Monica O'Sullivan, N.D., of Community Health & Healing and Janine Romaner, N.D., of Naturally Healthy, LLC, 3221 S. Cherokee Lane, Suite 1830, Woodstock, GA 30188 do not recommend or dispense prescription drugs, utilize surgery, X-rays or radiation therapy. We do not engage in the practice of medicine or represent ourselves as being licensed by the state of Georgia or any branch of the healing arts. If you are seeking allopathic medical services, you are urged to seek them from a qualified allopathic medical practitioner.

Dr. O'Sullivan, N.D. and Dr. Romaner, N.D. provides naturopathic and healing arts services to private persons by contract. Article 1 of the Constitution of the United States of America guarantees the right to contract. Additionally, we provide non-prescription health products for sale to private persons with whom we contract. Naturopathy is defined in Georgia Code, Chapter 43-34-2 as follows:

"Naturopathy is hereby defined as that philosophy and system of the healing arts embracing prevention, diagnosis and treatment of human ills and functions by the use of several properties of air, light, heat, cold, water, manipulation, with the use of such substances, nutritional as are naturally found in and required by the body excluding drugs, surgery, x-ray and radium therapy and the use of x-ray equipment."

I have read the above and understand what I read. I choose freely to have Dr. O'Sullivan, N.D. and/or Dr. Romaner, N.D. provide me with naturopathic services.

Furthermore, I understand that naturopathy is a system of health care that supports the body's ability to heal and regenerate itself. I understand that there are no promises regarding a "cure" for any disease whatsoever.

CANCELLATION POLICY

Because we see each client as important and offer a generous amount of time per session with each individual, we ask for your cooperation in return by showing up for appointments on time. For any appointment missed without a minimum of 24 hours advance notice (more is appreciated), you will be charged half the appointment fee.

_____

My Name or Parent, Guardian's Name

_____

Child or Dependents Name

_____

Date