**Seizures-Related Disorders Health Questionnaire**

*(Includes children without an official diagnosis who may have ADD, ADHD,*

*Sensory Processing Disorder, Autism etc.)* ***Please use black ink***

Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Age\_\_\_\_\_\_\_ Date of Birth: Month\_\_\_\_\_\_\_\_\_Day\_\_\_\_\_\_\_\_\_Year\_\_\_\_\_\_\_\_\_\_

Sex: Male: \_\_\_\_ Female: \_\_\_\_ Weight: \_\_\_\_\_

Age of Seizure Disorder Diagnosis?\_\_\_\_\_\_\_\_ Official Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is child classified as Autism Spectrum Disorder \_\_\_ Moderate \_\_\_Severe \_\_\_?

Symptoms became apparent at what age? \_\_\_\_\_\_

What signs and symptoms first became noticeable that alarmed you as a parent? (Please list as many initial developmental problems as possible, i.e. poor eye contact, aggressive behavior, etc.):

What developmental issues does your child currently suffer from that is different from above?

**Other Health Issues:**

Does your child suffer with other health problems: \_\_\_Allergies \_\_\_Asthma \_\_\_Constipation \_\_\_Diarrhea \_\_\_Eczema\_\_\_ Kidney Problems \_\_\_Lung Disease \_\_\_ Diabetes \_\_\_Thyroid Disease \_\_\_Heart Disease

\_\_\_Autism\_\_\_ Repeated Infections \_\_\_Other, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your child’s condition change following an illness, infection and/or seizure disorder (such as a febrile seizure) \_\_\_No \_\_\_Yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Digestive Health:**

Does child have periodic loose stools/diarrhea?\_\_\_ Yes \_\_\_ No

Offensive Gas \_\_\_Yes \_\_\_No Undigested Food Stuff in Stools \_\_\_Yes \_\_\_No

Is your child potty trained?\_\_\_Yes \_\_\_No? Does your child suffer with reflux/heartburn? \_\_\_Yes \_\_\_No

Is your child currently taking an acid-blocking medication such as Pepcid, etc. ?\_\_\_Yes \_\_\_ No

Did digestive problems occur following a particular vaccine? \_\_\_Yes \_\_\_No \_\_\_

Does your child produce formed stools? \_\_\_Yes \_\_\_ No

Have they ever produced formed stools? \_\_\_Yes \_\_\_ No

**Antibiotic History:**

How many courses of antibiotics has your child received in their lifetime (approx): \_\_\_ 0 \_\_\_ 1-5 \_\_\_5-10 \_\_\_10-15 \_\_\_15-20 \_\_\_20+

Main reason for antibiotic use: \_\_\_Ear Infections \_\_\_Bronchitis \_\_\_Pneumonia \_\_\_Sinus Infection \_\_\_Intestinal Infection \_\_\_Other (please explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was your child ever treated for a yeast infection following antibiotic use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Drug Allergies:** \_\_\_\_No/Unknown \_\_\_\_Yes (explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Environment:**

How old is your current home?\_\_\_\_\_\_\_

Has your child lived in a home that had lead-based paint? \_\_\_Yes \_\_\_No

Is your flooring carpet \_\_\_ hardwood \_\_\_ tile\_\_\_ Do you have carpeting in the bathrooms \_\_\_\_\_\_\_\_\_\_\_\_

Has there ever been any exposure in the home to molds? \_\_\_Yes \_\_\_No, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use commercial cleaners in the home? \_\_\_Yes \_\_\_No

Has your child used or slept in fire retardant clothing or bedding? \_\_\_Yes \_\_\_No

Is your child exposed to outside pesticides and fungicides? \_\_\_Yes \_\_\_No

Please list pets and/or farm animals your child is exposed to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mothers Pregnancy and Labor:**

Did Mom have any complications during pregnancy, i.e. \_\_\_High Blood Pressure\_\_\_ Seizures \_\_\_ Diabetes\_\_\_Infections that antibiotic treatment \_\_\_Viral Infections (Flu, Mono)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does Mom know her Rh status? \_\_\_ (+ or -) Blood Type \_\_\_

Did Mom receive Rhogam during pregnancy? \_\_\_Yes \_\_\_No

Did Mom receive any vaccinations during pregnancy? \_\_\_Yes \_\_\_No, which ones \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did Mom receive any vaccinations after pregnancy while breastfeeding? \_\_\_Yes \_\_\_No

Was your child delivered vaginal\_\_\_ or C-section\_\_\_ Labor induced with pitocin? \_\_\_\_Yes \_\_\_\_\_No

Forceps and/or suction devices used \_\_\_\_\_\_\_\_\_\_ Was there any concern for birth trauma? \_\_\_\_\_\_\_\_\_

**Mother’s Medical History:**

\_\_\_Low Thyroid \_\_\_ Autoimmune Thyroid \_\_\_ Parathyroid problems \_\_\_ Nightblindness (difficulty seeing at night) \_\_\_Autoimmune Disorders (Lupus, Connective Tissue, Rheumatoid Arthritis)

Mercury Fillings in Mouth \_\_\_ Yes \_\_\_No, If so, how many \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other diseases, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did Mom have any dental work done during pregnancy? \_\_\_Yes \_\_\_No

Did mom have mercury fillings removed while breastfeeding child? \_\_\_Yes \_\_\_No

**Family History:**

Is there a family history of Developmental Disorders, i.e. Autism, PDD? Please explain:

Is there a family history of other Neurological Disorders, i.e. Multiple Sclerosis, etc?

Is there a family history of Asthma, Allergies, Autoimmune Disorders (Lupus, Rheumatoid Arthritis, etc.)?

Is there a family history of Clotting or Blood Disorders, Strokes, Hemophilia, Platelet Disorders?

Is there a family history of Psychiatric Disorders, i.e. Depression, Schizophrenia, etc.?

Is there a family history of Genetic disorders?

Is there a family history of Seizures, Vaccine Reactions?

Is there a family history of Celiac Disease, or Gluten Intolerance?

**Vaccination Status:**

Has child received all the recommended vaccinations for their age? \_\_\_\_ Yes \_\_\_\_ No

Has your child received: \_\_\_DTP \_\_\_ DTaP \_\_\_ MMR \_\_\_Hib \_\_\_Hep B \_\_\_OPV \_\_\_IPV

\_\_\_Pneumonia \_\_\_Chicken Pox \_\_\_Flu \_\_\_Others (please list)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel your child’s behavior changed after a particular vaccination? \_\_\_Yes \_\_\_\_\_No. If yes, please indicate which vaccine(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long after the above vaccine(s) did your child become symptomatic? (ex: Minutes, days, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your child receive any vaccinations when they were sick? \_\_\_Yes \_\_\_No, Please explain\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your child suffer any vaccine reactions? \_\_\_Fever \_\_\_ Inconsolable screaming \_\_\_Excessive lethargy\_\_\_\_\_ Rash \_\_\_\_\_ Welts at injection site \_\_\_Vomiting \_\_\_Seizures \_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication Usage:**

Has child taken steroid medication? \_\_\_Yes \_\_\_No If Yes, which kind \_\_\_Inhaled \_\_\_oral

Has child taken medication for yeast/candida infection? \_\_\_No \_\_\_Yes, Please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is child currently taking medication for yeast? \_\_\_Yes \_\_\_No

Are they taking supplements for yeast? \_\_\_Yes \_\_\_No, Please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list other medication child is currently taking:

**Supplements:**

Please list all supplements child is currently taking, including nutritional oils, i.e. Cod Liver, Flax, etc:

**Diet:**

Is child on a Gluten-Free Diet? \_\_\_Yes \_\_\_No

Is child on a Casein-Free Diet? \_\_\_Yes \_\_\_No

Has child benefited by being on a GF/CF diet:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is child on a Specific Carbohydrate Diet? \_\_\_\_\_ Is child on a Low Oxalate Diet? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Diet?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Biomedical Therapies:**

Has child received Secretin? \_\_\_Yes \_\_\_No. If yes, have they benefited?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is child receiving Cod Liver Oil? \_\_\_Yes \_\_\_No. Any benefits?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has child received IVIG (Intravenous Immunoglobulins) \_\_\_Yes \_\_\_No Any benefits?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is child currently receiving IVIG therapy \_\_\_Yes \_\_\_No

Does child currently have Mercury/Amalgam/Silver Fillings? \_\_\_Yes \_\_\_No

Has child received Mercury Chelation w/DMSA \_\_\_Yes \_\_\_No. DMPS \_\_\_Yes \_\_\_No EDTA \_\_\_Yes \_\_\_No Any benefits from chelation therapy?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has child received Chelation Therapy for other Heavy Metals besides Mercury? \_\_\_Yes\_\_\_\_ No, If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child taken antifungals in the past, i.e. Nystatin? \_\_\_Yes \_\_\_No Diflucan? \_\_\_Yes \_\_\_No

Is child taking Transfer Factor? \_\_\_Yes \_\_\_No Colostrum \_\_\_Yes \_\_\_No

Valtrex \_\_\_\_Yes \_\_\_\_No Low Dose Naltrexone (LDN) \_\_\_\_ Yes \_\_\_\_No Actos \_\_\_\_ Yes \_\_\_\_ No

Spironolactone \_\_\_\_Yes \_\_\_ No

Other Biomedical Therapies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has Parent Attended a “Great Plains” seminar \_\_\_Yes \_\_\_\_ No Other biomedical Autism Conferences \_\_\_Yes \_\_\_No

Online seminars or classes \_\_\_Yes \_\_\_No Other biomedical autism support groups \_\_\_Yes \_\_\_No

What autism-related books have you read? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Internet articles or websites \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What biomedical therapies are you interested in? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Important Information:** If pertinent, please take the time to tell us more about the medical history of your child in relation to their autism diagnosis. If more space is needed you may use the back of this document or send extra pages with the other office paperwork.