DEVELOPMENTAL CROSSROADS

WHERE YOUR CHILD SUCCEEDS ONE STEP AT A TIME.

PERSONAL INFORMATION

Child's Name: First: Last: Middle:
Parent(s) Name(s):
Occupation(s):
Address Information: Street: City:
State: Zip: Phone: ( )
Work Phone: ( ) Cell: ( )
Email: Fax: ( )
Age of Child: ______________ Date of Birth: Month: Day: Year:
Child's Sex: Male/Female Weight of Child: _________________________
If your child has siblings, please give names and age :
Primary Pediatrician: Phone: ( )
Do you believe your pediatrician is knowledgeable about Autism, Asperger's, ADD/ADHD?
Is your pediatrician open to nutritional testing/supplementation/ABA treatments?
Other specialized physicians (Allergist, GI pediatrician, Geneticist):
Health Insurance Co.:
Accepted for Katie Beckett (Deeming Waiver) or other federally funded waivers?
Family History of Autism, Asperger's, ADD/ADHD, Developmental Delays (siblings, cousins, ect.)? If so, please give age, gender, diagnosis:
Please provide three things you would like to see from your child within 6 months:
1.
2.
3.

DEVELOPMENTAL CROSSROADS

WHERE YOUR CHILD SUCCEEDS ONE STEP AT A TIME.

PERSONAL INFORMATION

Describe your child, including his/her personal history. Please be as detailed as possible.

What age did you notice atypical behavior from your child?

Does your child have a diagnosis?

If yes, age what age: Diagnosis:

Please name physician that performed the diagnosis:

Did you notice these behaviors before this time or was your child reaching their developmental miles?

Was the onset sudden or gradual? If sudden, what event-illness happened that you think may have brought on your child's symptoms?

Anything that aggravates the behaviors that you observe such as food, transitioning from one location to another, sensations such as light, sound, touch, etc?

____

____

Sensory Sensitivities Continues on next page…

Developmental Crossroads
2854 Johnson Ferry Rd. Suite 150, Marietta, GA 30062
Phone: 770-428-1128 Fax: 770-428-1162 Web: www.developmentalcrossroads.com

DEVELOPMENTAL CROSSROADS
WHERE YOUR CHILD SUCCEEDS ONE STEP AT A TIME.

SENSORY PROCESSING	
PLEASE LIST SENSORY PROCESSING HYPER/HYPO ACTIVITY	
Circle all that apply	
Sensation to Touch: **Y N**	**Sensation to Sound: Y N**
Tags on shirts:	Hearing testing performed? **Y N**
Textures to specific clothing:	Hypersensitive to loud sounds:
Textures to food:	Hypersensitive to specific sounds like:
Flapping	
Peripheral vision (corner "eyeing")	Does your child close his/her ears:
Other:	Other:
Sensation to Taste: Y N	**Sensation to Sight: Y N**
Liquids	Colors:
Crunchy/crisp foods:	Light lines on floors or walls:
Smooth/think liquids/food (such as yogurt)	Twirling objects
Meats	Other:
Other:	
Vestibular: Y N	
Twirling in circles	
Relaxes when riding in car, spinning, swing:	

School: IEP, *Babies Can't Wait* (State Funded Programs)		
Does your child receive or in the past has received *Babies Can't Wait?*		
Current Therapies:		
Past Therapies:		
Does your child attend daycare?	If yes, where:	
Does your child attend a private school?	If yes, where:	
Does your child attend public school?	If yes, where:	IEP? **Y N**
****Please bring a copy of your child's IEP to the DAN! Intake**		

Medical History: THERAPIST(S)
Speech~Occupational~Physical~Other (not including Babies Can't Wait)

Type of Service	Length of Service (example: June 06-May 07)	School/Home Baby's Can't Wait?	Hours per week	Comments

Aggressive Behavior and ABA (Applied Behavior Analysis)

Does your child exhibit aggressive behavior to himself/herself or others? If yes, please explain:

Is your child currently taking prescription medication for these behaviors? If yes, please provide medications, dose, and time given.

Strategies that alleviate the aggressive behavior?

Has your child received ABA services?

When did the services begin? _____/_____/_____

How many hours/week of services did your child receive?

Is your child receiving services currently?

Have you seen improvements, setbacks, or no change in your child's behavior from ABA?

Did your child respond well to his/her therapist?

Did you feel the overall programs were suited for the needs of your child?

What would you change about your previous ABA services?

___

___

DEVELOPMENTAL CROSSROADS

WHERE YOUR CHILD SUCCEEDS ONE STEP AT A TIME.

MEDICAL HISTORY: Labor and Pregnancy

Age of mother during pregnancy?

Medications during pregnancy?

Complications during pregnancy?

Complications during labor and delivery?

If vaginal delivery, did you have forceps/vacuum?

Medication(s) during labor and delivery?

Full term/premature? (circle) How many weeks?_______________

Medications given to child during hospital stay?

Complications after delivery?

Was your child breast fed? If yes, for how long?____

Any allergies to breast milk or infant formula? If yes, please explain: _____________________________

DEVELOPMENTAL CROSSROADS
WHERE YOUR CHILD SUCCEEDS ONE STEP AT A TIME.

MEDICAL HISTORY: MAJOR INJURIES

INJURY	DATES	RESULTS

MINOR INJURIES

(head injuries or other accidents that you didn't receive hospitalization, but were alarmed)

INJURY	DATES	TREATMENT

ILLNESSES ~ Please list appropriate dates and any complications:

ILLNESS	DATES	COMPLICATIONS
Ear infections		
Sinus infections		
Bronchitis		
Pneumonia		
Thrush		
Chicken Pox		
Seizures		

ANTIBIOTICS

Has your child received any antibiotics or antivirals? Yes/No (circle one)
If yes, for what condition(s) and for how long?____
How old was your child when antibiotics/antivirals was given?__________________
Did the condition(s) reoccur? Yes/No (circle one) ____
How many times has your child been on a antibiotic cycle?____________________________________
Any adverse reactions to the medication (behavior change, GI problems, ect.)?Yes/No (circle one)
If yes, please explain: ____

DEVELOPMENTAL CROSSROADS

WHERE YOUR CHILD SUCCEEDS ONE STEP AT A TIME.

MEDICAL HISTORY: IMMUNIZATIONS

Please indicate date and "yes" or "no" to any reaction below. "Bowel" refers to any bowel symptoms such as diarrhea, "Swelling" refers to the site of the injection. Leave plank if you don't have records.

Diptheria/Pertussis/Tetanus	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**Other**
DPT1								
DPT2								
DPT3								
DPT4								
H Influenza Type B	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**Other**
Hib 1								
Hib 2								
Hib 3								
Hib 4								
Polo(circle oral or injection)	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**Other**
OPV 1/injection 1								
OPV 2/injection 2								
OPV 3.injection 3								
OPV 4 injection 4								
OPV 5 injection 5								
Measles/Mumps/Rupella	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**Other**
MMR 1								
MMR 2								
Hepatitis B Vaccine	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**Other**
HBV 1								
HBV 2								
HBN 3								
Miscellaneous	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**Other**
Varivax (chicken pox)								
Flu Test								
Other								

DEVELOPMENTAL CROSSROADS
WHERE YOUR CHILD SUCCEEDS ONE STEP AT A TIME.

MEDICAL HISTORY

Please mark which diagnostic testing has been done and provide date and results if available.

EVALUATION/TEST	DATE	RESULTS (normal, abnormal or unsure)
CT Scan (specific area)		
Colonoscopy		
EEG		
Folic Acid		
Fragile X Chromosome Study		
Hearing Test		
MRI (specific area)		
PET Scan		
Stool Parasites/Culture		
Thyroid		
X-Rays		
Quantitative plasma amino acid assays to detect phenylketonuria		
Genetic testing specifically high resolution chromosome analysis (karyotype)		
Formal audiological hearing evaluation		
Tests for celiac antibodies		
Other:		

D E V E L O P M E N T A L   C R O S S R O A D S
W H E R E   Y O U R   C H I L D   S U C C E E D S   O N E   S T E P   A T   A   T I M E .

MEDICATION OR SUPPLEMENTS

Please check box if substances are being taken currently or in the past.

Now	Past	Medication or supplement	Very good	Good	None	Bad	Very bad	Bad then good	Comments
		Antihistamines							
		Benadryl							
		Claritin							
		Sigulair							
		Zyrtec							
		Digestive Flora							
		Antibiotics(# of times)_							
		Bactrim							
		Diflucan							
		Lamisil							
		Nizoral							
		Nystatin							
		Saccharomycles B.							
		Sporonax							
		Colostrum							
		Yodoxin							
		Digestion							
		Bethenecol							
		Digestive enzymes							
		Peptidase enzymes							
		Probiotics							
		Detoxification							
		DMPS							
		DMSA							
		Glutathione (TC)							
		Glutathione (IV)							
		Glutathione (oral)							
		Folic Acid							
		Melatonin							

DEVELOPMENTAL CROSSROADS
WHERE YOUR CHILD SUCCEEDS ONE STEP AT A TIME.

MEDICATIONS OR SUPPLEMENTS

Please check box if the med/supp taken is taken now, in the past and check the appropriate reaction.

Now	Past	Medication or supplement	Very good	Good	None	Bad	Very bad	Bad then good	Comments
		Multivitamin (specify)							
		Vitamin A							
		Vitamin C							
		Vitamin B3 (Niacin)							
		Vitamin B6							
		5 HTP							
		Alpha Keto Glutarate (AKG)							
		Deanol							
		Dimethylglycine (DMG)							
		GABA							
		Glutamine							
		SAMe (Samyr)							
		TMG							
		Taurine							
		Tryptophan							
		Tyrosine							
		Amino Acid Mix							
		Manganese							
		Calcium							
		Magnesium							
		Selenium							
		Zinc							
		Human Growth Factor							
		Kutapressin							
		Sectretin							
		Steroids (oral or top.)							
		DHA oils							
		EPA oils							
		Omega 6 oils							
		Cod liver oil							
		Flax oil							

Developmental Crossroads
2854 Johnson Ferry Rd. Suite 150, Marietta, GA 30062
Phone: 770-428-1128 Fax: 770-428-1162 Web: www.developmentalcrossroads.com

DEVELOPMENTAL CROSSROADS
WHERE YOUR CHILD SUCCEEDS ONE STEP AT A TIME.

MEDICATIONS OR SUPPLEMENTS									
Please check box if the med/supp taken is taken now, in the past and check the appropriate reaction.									
Now	**Past**	**Medication or supplement**	**Very good**	**Good**	**None**	**Bad**	**Very bad**	**Bad then good**	**Comments**
		Other							
		Activated Charcoal							
		Alka Gold							
		Carbatrol							
		Tranxene							
		Famvir							
		Valtrex							
		Zovirax							
		Nicaderm							
		Other supplements not listed							
		Other medications not listed							

Developmental Crossroads
2854 Johnson Ferry Rd. Suite 150, Marietta, GA 30062
Phone: 770-428-1128 Fax: 770-428-1162 Web: www.developmentalcrossroads.com

DEVELOPMENTAL CROSSROADS
WHERE YOUR CHILD SUCCEEDS ONE STEP AT A TIME.

DIETARY/NUTRITIONAL HISTORY

Breast-fed? Yes/No (circle one): If yes, how long?______________________

Bottle-fed? Brand of formula?_______________Begun at what age?_______How long?_______

Introduced solid foods at what age?_________ First foods?______________________________

Whole milk? Yes/No (circle one) If yes, began at what age?_________

Know allergies to food? Yes/No (If yes, please list)_____________________________________

Suspected sensitivities to food? Yes/No (Please list)_______________________________________

____

Food cravings? Yes/No (Please list)____
____
____

SPECIAL DIETS

Please check box if the special diet is taken now, in the past and check the appropriate reaction.

Now	Past	Diet	Very good	Good	None	Bad	Very bad	Bad then good	Comments
		Gluten Free							
		Casein Free							
		Yeast Free							
		High Protein/Low Carb							
		Salicylate Free							
		Low Phenolics							
		Specific Carbohydrate Diet							
		Other							

Developmental Crossroads
2854 Johnson Ferry Rd. Suite 150, Marietta, GA 30062
Phone: 770-428-1128 Fax: 770-428-1162 Web: www.developmentalcrossroads.com

D E V E L O P M E N T A L   C R O S S R O A D S

W H E R E   Y O U R   C H I L D   S U C C E E D S   O N E   S T E P   A T   A   T I M E .

DIET

Please list the foods and beverages normally consumed by your child for three typical days.

DAY 1
Breakfast:
Morning snack(s):
Lunch:
Afternoon snack(s):
Dinner:
Other:
DAY 2
Breakfast:
Morning snack(s):
Lunch:
Afternoon snack(s):
Dinner:
Other:
DAY 3
Breakfast:
Morning snack(s):
Lunch:
Afternoon snack(s):
Dinner:
Other:

ENVIRONMENTAL HISTORY

Is your child sensitive or suspect they may be sensitive to or bothered by any of the following please indicate. If not, leave plank.

Item	Yes		Yes	Reaction:
Perfumes/cosmetics		Pollens/grass		
Cleaning products		Animals		
Soaps		Gasoline		
Detergents		Paint		
Dust		Feathers (pillow)		
Mold				

Other know sensitivities:

____

____

DEVELOPMENTAL CROSSROADS
WHERE YOUR CHILD SUCCEEDS ONE STEP AT A TIME.

STOOL PATTERN/EXCRETION

Is your child potty trained? Yes/No (circle one) If yes, how old?___________________

Does your child have regular bowl moments (daily) Yes/No (circle one)

If not, how many times does your child have a bowel movement a week?__________________

Explain your child's spool texture and color on a usual day? (runny, floaters, mushy, grey, brown, beige, hard, firm, large, bloody, ect.)
____

Does your child have stomach bloating, pass gas and/or belching? (Circle if any one, or all)

Does your child's stool have a *very* offensive odor? YES/NO (circle one)
If yes, please explain:____

Any food particles within stool? Yes/No (circle one)

Any abnormal color to your child's urine without taking supplements/meds (amber, bright yellow, brown)? Yes/No (circle one) If yes, how long ago?____________________________

Any odor to your child's urine? Yes/No (circle one) If yes, how long ago?_________________

Have you seen a red ring around the anal area? Yes/No (circle one) If yes, how long ago?_____________________________

Have you seen any skin reactions on your child (ringworm, hives, eczema, itching, redness, etc) ? Yes/No (circle one) If yes, please explain:____
Does your child have bad breath or body odor? Yes/No (circle one) If yes, for how long?____

Other Comments:____

____

____

Developmental Crossroads
2854 Johnson Ferry Rd. Suite 150, Marietta, GA 30062
Phone: 770-428-1128 Fax: 770-428-1162 Web: www.developmentalcrossroads.com

DEVELOPMENTAL CROSSROADS

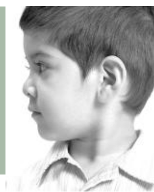
WHERE YOUR CHILD SUCCEEDS ONE STEP AT A TIME.

SIGNS AND SYMPTOMS

Please check box if any signs symptoms your child may demonstrate and note duration and details if appropriate:

No	*Description*	*Mild*	*Moderate*	*Severe*	*Duration*	*Unique details*
1	**Stimming (repetitive actions or movements)**					
2	**Rocking**					
3	**Head banging**					
4	**Self-mutilation**					
5	**Nail biting**					
6	**Hand/arm biting**					
7	**Nail/skin picking**					
8	**Aggressiveness (hitting, kicking, biting others)**					
9	**Mood swings**					
10	**Irritability/tantrums**					
11	**Fears/anxieties**					
12	**Hyperactivity**					
13	**Inability to concentrate/focus**					
14	**Always fidgety while sitting**					
15	**Impulsive**					
16	**Breath holding**					
17	**Dizziness**					
18	**Seizures**					
19	**Poor coordination**					
20	**Problems with buttons, ties, snaps or zippers**					
21	**Processing problems – visual, motor, language, ect.**					
22	**Problems with socialization**					
23	**Sensitive to crowds**					
24	**Sensitive to touch (clothing, tags, ect)**					
25	**Trouble remembering**					

DEVELOPMENTAL CROSSROADS
WHERE YOUR CHILD SUCCEEDS ONE STEP AT A TIME.



SIGNS AND SYMPTOMS (CONTINUED)

Please check box if any signs symptoms your child may demonstrate and note duration and details if appropriate:

No	*Description*	*Mild*	*Moderate*	*Severe*	*Duration*	*Unique details*
26	Heat intolerace					
27	Recurrent/chronic fever					
27	Flushing					
28	Difficulty falling to sleep					
29	Night wakes					
30	Difficulty waking					
31	Bed wetting/soiling					
32	Day wetting/soiling					
33	Numbness/tingling in hands/feet					
34	Headache					
35	Blinking					
36	Tics					
37	Eye discharge					
38	Dark circles/puffiness under eyes					
39	Night blindness in child/family					
40	Congestion					
41	Dripping nose					
42	Sensitivity to bright lights					
43	Earaches					
44	Ringing in ears					
45	Sensitivity to sounds/noise					
46	Bad breath					
47	Nose Bleeds					
48	Acute sense of smell					
49	Sore throats					
50	Hoarseness					
51	Cough					
52	Wheezing					
53	Swollen gums					
54	Whiteness in tongue					
55	Canker sores					
56	Dry lips/mouth					

DEVELOPMENTAL CROSSROADS

WHERE YOUR CHILD SUCCEEDS ONE STEP AT A TIME.

SIGNS AND SYMPTOMS (CONTINUED)

Please check box if any signs symptoms your child may demonstrate and note duration and details if appropriate:

No.	*Description*	*Mild*	*Moderate*	*Severe*	*Duration*	*Unique details*
57	Diarrhea					
58	Constipation					
59	Bloating					
60	Passing Gas					
61	Belching					
62	Stomach ache					
63	Refusal to eat					
64	Sensitive to texture					
65	Difficulty swallowing					
66	Food Cravings					
67	Grinding Teeth					
68	Mucous/blood in stool					
69	Anal inch					
70	Tremors					
71	Weakness					
72	Stiffness					
73	Exzema					
74	Psoriasis					
75	Hives					
76	Acne					
77	Seborrhea (cradle cap)					
78	Other rashes					
79	Easy bruising					
80	Itchy scalp					
81	Dry skin					
82	Oily skin					
83	Pale skin					
84	Sensitivity to insect bites					
85	Cracking/peeling hands					
86	Strong body odor					
87	Strong urine odor					
88	Strong stool odor					
89	Reflux					

SIGNS AND SYMPTOMS (CONTINUED)

Please check box if any signs symptoms your child may demonstrate and note duration and details if appropriate:

No.	*Description*	*Mild*	*Moderate*	*Severe*	*Duration*	*Unique details*
90	**Fatigue**					
91	**Canker sores**					
92	**Dry lips/mouth**					
93	**Soft nails**					
94	**Thickening of nails**					
95	**Ridges/pitting of nails**					
96	**White spots/lines on nails**					
97	**Brittle nails**					
98	**Toe walking**					
99	**Any OCD (obsessive compulsive) behavior**					
100	**Strategies to put pressure on stomach**					

DEVELOPMENTAL CROSSROADS

WHERE YOUR CHILD SUCCEEDS ONE STEP AT A TIME.

SIGNS AND SYMPTOMS (CONTINUED)
Describe any other sysmptoms you would like me to know about your child:
List any other history, pertinent thoughts or questions that you want to address:

****Bring current supplements, copies of laboratory results, or anything you feel will be importance to discuss to the DAN! Intake.**

Thank you so much for your time and patience.