**Anke Zimmermann, BSc, FCAH**

**Classical and Modern Homeopathy**

**6550 Throup Road**

**Sooke, BC**

**V9Z 0W6**

**778-352-0806**

**Autism/Developmental Concerns Intake Form**

Date

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

Date of Birth \_\_\_\_\_\_\_\_\_\_ Present Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Blood group if known: \_\_\_\_

Mother’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel. Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel.Office/cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel. Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel.Office/cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email (only used for office communication) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Primary Address

City Province: Postal Code:

Siblings, names and ages \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Practitioners

Who referred you to this office:

Would you like to receive my newsletter, sent out about 4 times a year? \_\_\_\_\_\_\_\_\_\_\_\_\_

*Dear Parent/guardian,*

*Welcome to my practice. This questionnaire will help me to understand and assess your child. I am the only person who will review this survey and your confidentiality is strictly maintained. The questionnaire is quite detailed, I don’t expect you to remember every date, try to be close.*

*If you have questions or concerns about this questionnaire, please contact me and I will help you to decide how best to solve the issue.*

***Please be sensitive to the fact that some people are not able to tolerate the odour of cigarettes, perfume, cologne or after-shave lotions. Please come to the office smoke and fragrance Please also note that there is a dog on my property in case you are allergic or afraid of dogs. I offer in-person as well as distance appointments via skype or zoom.***

**FEE SCHEDULE**

**Initial consultations include research on your case and plan of action preparation**

**Fee schedule is subject to change without notice**

Initial Consultation, 60 minutes $190.00

First Follow-Up, 45 minutes $140.00

Regular Follow-Up, 30 minutes $ 95.00

Quick Check-in, 15 minutes $ 50.00

Telephone consultation......................................varies with amount of time spent

Email consultations…………………………….…minimum 15 minutes, $50.00

NSF cheques................................................................................................$30.00

Medical - Legal reports......................................varies with amount of time spent

Failure to keep a scheduled appointment...........................cost of scheduled visit

All fees must be paid at the time of the visit including services, remedies and supplements and costs of laboratory tests.

**Please note: Form of payment is accepted are cash, cheque, debit, credit, email transfer or paypal.**

.**ACKNOWLEDGMENT**

.

In order to avoid any confusion or misunderstanding, I request that all clients read and acknowledge the following:

* + That you understand that Anke Zimmermann works within the homeopathic scope of practice, is not a medical doctor, and employs some methods which are not orthodox medical practice at this time, for example applied kinesiology.
  + That you understand that the services here and/or referral to other health professionals is based upon the assessment of health status revealed through personal history and interview, physical assessment and laboratory testing.
  + That you understand that Anke Zimmermann uses natural therapeutics for the correction of physical, mental or energetic imbalances, primarily homeopathy.
  + That you understand homeopathic care is not covered under MSP at the present time and, therefore, you are responsible for any fees incurred while under care. Homeopathic care is covered under certain private insurance plans and I will do my utmost to provide the appropriate documentation to your insurer upon request.
  + That you are here as a client and are not attending my office for any other reason without making your intention known to myself or my staff.

**Please be informed that you are required to give at least 1 business day notice in case you need to cancel or reschedule any appointment, including the initial one. I regret that otherwise I will need to charge you for the missed appointment**.

I greatly appreciate your consideration in this matter.

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

Date Patient’s/Guardian Signature

**Consent for Care**

Anke Zimmermann, BSc, FCAH will take a thorough case history, and may perform a physical examination related to your concern if desired and indicated.

It is very important that you inform Anke of any disease process that your child is suffering from and any supplements/medications/over the counter drugs that he or she is currently taking.

There are some health risks associated with the use of homeopathic remedies, herbs and supplements. These include but are not limited to the following:

* Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs, the duration is usually short.
* Homeopathic remedies may stimulate healing or detoxification reactions, which may include loose stools, increased perspiration, skin eruptions and nasal discharges, among others. These reactions are uncommon and normally pass within a few hours to days.
* Herbal tinctures can taste bad and may occasionally cause headaches or stomach discomfort.
* Nutritional supplements sometimes cause stomach discomfort.
* Some clients experience allergic reactions to certain supplements and herbs. Please advise Anke immediately if you think that you or your child have experienced an allergic reaction.
* Please let Anke know immediately should you experience any negative side-effects from any of your homeopathic and wellness care.

## Important points to note:

* **Anke Zimmermann does not guarantee treatment results.**
* A record will be kept of the health services provided to you. This record will be kept confidential and will not be released to others without your consent, unless required by law. You are entitled to a copy of your records at any time and to transfer of your records to another practitioner if desired.
* Anke will explain to you the exact nature of any care provided and will answer any questions you may have to the best of her ability.
* You are free to withdraw your consent and to discontinue are at any time.

I certify that I have read and understood the above **Consent for Care.**

Patient Name: (Please print name):

Signature of patient or guardian:

Date:

**Autism/Developmental/Behavioural Concerns Intake Form**

**(Please type the form, it’s a word document. You can highlight or bold the concerns, checking the boxes does not work, sorry)**

**Current concerns about your child**

Please check all that apply:

 aggression  hitting  self-injury  head-butting  pulls out own hair

 temper tantrums  biting  argumentative  cruel to animals

 nervousness  overactivity  inattentive  easily distracted

 depressed or anxious  inappropriate sexual behavior

 self-stimulatory behaviors: rocking, spinning, flapping hands, visual scrutiny

 sensory issues, sensitive to noise, clothing, brushing teeth

 preoccupations  has few friends  has no friends

 language difficulties  inappropriate chewing or licking of objects

 appetite/food selections  picky eating  eats things that aren’t food

 eats too much  weight loss/gain

 difficulty chewing/averse to chewing  difficulty swallowing  drooling  gagging

 toilet training  digestive/bowel problems

 sleep problems  sleeps in parents’ bed  has nightmares

 self-help skills  gross motor skills  fine motor skills  muscle tone

 won’t take baths  wets the bed  school adjustment

 Other:

Please provide detail for any items checked above:

Has your child been formally diagnosed? If so with what?

What do you find most difficult about raising your child? How do these issues affect/interfere with the child’s or family’s life?

What are the biggest concerns?

How long have these been a problem?

What do you think caused them?

What seems to upset the child?

What seems to calm the child?

Has your child ever had homeopathic care before? Please describe

**CHILD’S CURRENT LIVING SITUATION**

With whom does the child currently reside? (please mark all that apply)

 Biological Mother  Biological Father  Step-mother  Step-father

 Adoptive Mother  Adoptive Father  Foster Mother  Foster Father

 Grandparent

 Other (describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

If child does not live with BOTH biological parents, who has legal custody of the child?

Siblings: (please list whether the siblings live in the child’s home or not)

Name Age M/F

Full/Step/Half? Grade In child’s home?

Any developmental or other health concerns with siblings?

**DEVELOPMENTAL HISTORY**

(If re-evaluation, please skip to “medical history” and “checklist” on page 9 and add any updates.)

**Prenatal/Pregnancy**

Did the biological mother have any of the following immediately before/after or during pregnancy?

 Maternal injury. Describe:

 Hospitalization. Reason:

 X-rays: Reason

 Medications. Reason:

 Vaccinations. Reason:

 Exposure to chemicals. Describe

 Living close to highway. Describe

 Living in agricultural area where pesticides were used. Describe

 Ultrasounds – how many? If more than two, what reason?

 Traumatic events. Describe:

 Work situation. Describe:

 Alcohol or drug use. Describe:

 Difficulty in conception, IVF

**Did the biological mother have any of the following during pregnancy?**

 Emotional stresses/problems  Infections

 Rashes  Bedrest  Toxemia

 Anemia  Gained more than 35 pounds

 Excessive swelling  Vaginal bleeding

 Excessive nausea/vomiting  Flu  High blood pressure

 Kidney disease  Strep throat  Threatened miscarriage

 Rh incompatibility  Headaches  Urinary problems

 Severe cold  Measles/German measles  Other virus

 Special diet, describe:

 Premature Labor

Other:

Mother’s age at conception: \_\_\_\_\_\_\_\_\_\_

Father’s age at conception: \_\_\_\_\_\_\_\_\_\_\_

Did the mother have previous pregnancies?  No  Yes--how many, including miscarriages?

Did mother receive prenatal care during this pregnancy?  No  Yes--beginning at month

During the pregnancy, was the baby:  Very active  Average  Rather quiet

Were there any unusual changes in the baby’s activity level during pregnancy?  No  Yes

**Delivery**

Was infant born full-term?  Yes  No

If premature, how early? If overdue, how late?

Birth weight: Apgars (if known): at 1 minute \_\_\_\_\_\_ at 5 minutes

Type of anesthetic used:  None  Spinal  Local  General

Length of active labor: Describe any complications during delivery:

Check all of the following that applied to the delivery:

 Spontaneous  Breech  Forceps

 Head first  Multiple births  Cord around neck

 Induced; Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Cesarean; Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Infancy**

Which of the following applied to the infant? (check all that apply)

 Breathing problems  Required oxygen  Required incubator

 Jaundice (Were bilirubin lights used?  No  Yes – How long? \_\_\_\_\_\_\_\_\_)

 Feeding problems  Sleeping problems  Infection

 Rash  Excessive crying  Seizures/convulsions

 Unusual appearance, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Bleeding into the brain

Did the infant require:  X-Rays  CT scans  Blood transfusions

 Vitamin K shot given

 Vaccines given at or shortly after birth, which ones?

 Antibiotics given at or shortly after birth

 Placement in the NICU (If so, for how long? \_\_\_\_\_\_\_\_\_\_)

 Length of stay in hospital: Mother \_\_\_\_\_\_\_\_\_\_\_ Infant \_\_\_\_\_\_\_\_\_\_\_

 Breast-fed  Formula

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Early Childhood History**

During this child’s first three years, were any special problems noted in the following areas?

 Frequent colds

 Ear infections

 Coughs/pneumonia

 Breathing problems

Colic

Constipation

Diarrhea

 Eating problems

 Failure to thrive

 Eczema/rashes

 Difficulty sleeping

 Irritability

 Temper tantrums

 Excessive crying

 Withdrawn behavior

 Poor eye contact

 Early learning problems

 Destructive behavior

Convulsions/Seizures  Twitching  Unable to separate from parent

Tics

Other

 Vaccinated – please attach vaccination records in organized form as per the parent manual

 Medications history – please attach medication records if available in organized form as per the parent manual. Please summarize them if they are more than 5 pages in length

Milestones - Indicate age when child:

\_\_\_\_\_\_ sat unaided \_\_\_\_\_ crawled \_\_\_\_\_\_ walked

\_\_\_\_\_\_ started solid foods \_\_\_\_\_ fed self with spoon \_\_\_\_\_\_ gave up breast ­­­­

\_\_\_\_\_\_ gave up bottle \_\_\_\_\_\_\_ gave up soother \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_ bladder trained-day \_\_\_\_\_ bladder trained-night \_\_\_\_\_\_ bowel trained

\_\_\_\_\_\_ rides tricycle \_\_\_\_\_ rides bike

Can child be described as clumsy/uncoordinated?  Yes  No

Having fine motor delay?  Yes  No

Which hand does your child use for: Writing/drawing? Eating? Cutting?

**Language development**

Indicate age when child begin babbling, such as repeating syllables, in attempts to communicate:

Using single words? Using phrases/short sentences? How is language now?

Have there been any hearing concerns?  No  Yes Hearing testing – date?

**Adaptive Skills**

Feeds self  No  Yes, beginning at age \_\_\_\_\_\_\_

Dresses self No  Yes, beginning at age \_\_\_\_\_\_\_

Bathes self  No  Yes, beginning at age \_\_\_\_\_\_\_

Helps with household chores  No  Yes, beginning at age \_\_\_\_\_\_\_

Knows first and last name  No  Yes, beginning at age \_\_\_\_\_\_\_

Says “please” and “thank you”  No  Yes, beginning at age \_\_\_\_\_\_\_

Able to walk up/down stairs  No  Yes, beginning at age \_\_\_\_\_\_\_

Has the child ever lost skills, which at one time he/she was able to perform?  No  Yes

If yes, please describe:

When your child is disruptive or misbehaves, what steps are you likely to take to deal with the

problem?

Who is mainly in charge of discipline?

**MEDICAL HISTORY**

Has your child ever had:

Head injury Age \_\_\_\_\_ Describe

Loss of consciousness Age \_\_\_\_ How long? Describe

Allergies to food/medication List:

Adverse reaction to vaccines? Describe

Is the child up to date on immunizations?  Yes  If no, why not?

Surgery - Age\_\_\_\_\_ Reason

Describe

(if more than one surgery, please add)

Ear Infections: Age \_\_\_\_ Describe

Ear tubes?  No  Yes Date of surgery

**Doctors seen** (check all that apply)

 Pediatrician – Date of last visit (approximate is okay): \_\_\_\_\_\_\_\_\_ Diagnosis:

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

 Developmental Pediatrician – Date: \_\_\_\_\_\_ Diagnosis:

 Neurologist – Date: \_\_\_\_\_\_\_\_\_\_ Diagnosis:

suspected seizures, describe:

seizures diagnosed, type:

 Genetics – Date: Diagnosis:

 Psychiatry – Date: Diagnosis:

 Psychology – Date: Diagnosis:

 Gastroenterology – Date: \_\_\_\_\_\_\_\_ Diagnosis:

stomach/intestinal problems, type:

 Endocrinology – Date: \_\_\_\_\_\_\_\_\_ Diagnosis:

**Diagnostic Testing** (check all that apply)

 EEG (brain wave test) – Date: \_\_\_\_\_\_\_ Results:

 MRI – Date: \_\_\_\_\_\_\_ Results:

 CT Scan – Date: \_\_\_\_\_\_\_\_\_ Results:

 Ophthalmology Evaluation – Date: \_\_\_\_\_\_\_\_ Results:

 Chromosomal/DNA testing (Genetics) – Date: \_\_\_\_\_\_\_\_ Results:

 Other - Describe:

**CHECKLIST:** Please mark any of the following in each area that describe your child currently or in the past:

**Speech**

Past Current

  slow speech development

  doesn’t understand without gestures

  unusual tone or pitch

  repeats words/phrases over and over

  difficult to understand speech

  repeats questions, instead of answering them

  seldom speaks unless prompted

  repeats dialogue from movies/songs verbatim

  has language of his/her own (may sound like foreign language/jargon)

**Relating with other people**

Past Current

  prefers to be by self

  “in a world of his/her own”

  aloof, distant

  clings to people

  fearful of strangers

  not cuddly as baby

  doesn’t like to be held

  doesn’t recognize parent

  doesn’t play with other children

  prefers playing with younger or older children

**Imitation**

Past Current

  doesn’t imitate waving “bye-bye” or “patty cake” etc. (physical imitation)

  doesn’t repeat words/things said to him

  doesn’t repeat words generally**,** but usually did what he was asked to do

**Response to Sounds, Speech**

Past Current

  often ignores sounds

  often ignores what is said to him/her

  afraid of certain sounds

  really likes certain sounds (music, motors, etc.)

  seems to hear distant or soft sounds that most other people don’t hear or notice

  unpredictable response to sounds (sometimes reacts, sometimes doesn’t)

  responds to speech and sounds like other children of the same age

**Visual Response**

Past Current Past Current

  stares vacantly around room

  plays with turning lights on and off

  often doesn’t look at things

  distracted by lights – stares at certain lights

  likes to look at self in mirror

  very interested in small parts of an object

  likes to look at shiny objects

  looks at things out of the corners of eyes

  stares at parts of his/her body (e.g. hands)

  often avoids looking at people when they are talking to him

**Other Senses**

Past Current

  puts many objects in mouth

  likes vibrations

  licks objects

  doesn’t notice pain as much as most people

  overreacts to pain

  smells objects unusual or unfamiliar objects

  chews or eats objects that are not supposed to be eaten

**Emotional Responses**

Past Current

  temper tantrums

  laughs/smiles for no obvious reason

  overly responds to situations

  moods change quickly/for no apparent reason

  cries/seems sad for no obvious reason   often has blank expression on face

  little response to what is happening around him/her

Name some GOOD things about the child:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY MEDICAL/PSYCHIATRIC HISTORY**

Have any members of the biological mother’s or biological father’s families had any of the following problems or disorders (check all that apply):

Chromosomal/genetic disorder  Autoimmune disease

 Tuberculosis  Polio  Gonorrhea

 Diabetes  Food allergies  Sickle-cell anemia

 High blood pressure  Stroke  Heart disease  Cancer  Kidney disease

 Alcohol/drug abuse  Depression  Physical/Sexual abuse

 Nervousness/Anxiety  Obsessive Compulsive Disorder  Seizures/epilepsy

 Schizophrenia  Developmental disorder  Speech/language delay

 Autism/PDD  Reading problem  Other learning disability

 Emotional disturbance/mental illness  Bipolar/manic-depressive disorder

 Tics/Tourette’s syndrome  Antisocial Behavior (assaults, thefts, arrests)

Childhood behavior disorder (aggressive/defiant/ADHD)

Other:

Has anyone in the family ever received special education services?  No  Yes - for what reason?

**Family Changes and Stressors:** Please indicate any major family stresses the family and/or child is currently experiencing or has experienced within the last year.

 Marital discord/fighting  Separation  Divorce

 Birth/Adoption of another child  Sibling conflict  Parent-Child conflict

 Custody disagreement  Single-parent family  Parent/sibling death

 Parent deployed extensively  Parent emotionally/mentally ill

 Involved in juvenile court  Abandonment by parent  Financial problems

 Parent substance abuse  Child Neglect  Physical abuse

 Sexual abuse  Parental disagreement about child-rearing

 Involved with Social Services/Child Protective Services

 Other, if not listed:

**SCHOOL HISTORY**

(If more space is necessary, please attach additional sheets or write on the back of this page.)

Current school:

Grade level:

Type of class:  Regular Ed  Special Ed  Resource  ED  Behavioral unit

Current # of: Students \_\_\_\_ Teachers \_\_\_\_ Aides \_\_\_\_ Does your child have a 1:1 Aide?

Has your child had special education testing in school?

 Psychological/Cognitive – Date: \_\_\_\_\_\_\_\_\_\_  Academic – Date: \_\_\_\_\_\_\_\_\_\_\_\_

 Speech/Language – Date:  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_

Is your child receiving any special education services at school?  Yes  No

Is your child on an IEP (Individual Education Plan)? \_\_\_\_ For what reason?

**SERVICES** - Please list services your child has received **through the school district**.

**(Please send copies of your most recent assessments/Individual Education Plan (IEP))**

Child’s age when school services began:

Individual Education Plan (IEP) eligibility:

Which services is your child CURRENTLY receiving?

 Speech therapy  Occupational therapy  Physical therapy

 Adaptive Physical Education  Discrete Trial Training (DTT/ABA)  Social Skills

 Other - describe:

**Private Services (Please bring copies of relevant reports to your first appointment.)**

Are you or your insurance company currently paying for services to address your child’s needs?  Yes  No

 Speech therapy Age when began: \_\_\_\_\_\_

 Occupational therapy Age when began: \_\_\_\_\_\_

 Physical therapy Age when began: \_\_\_\_\_\_

 Adaptive Physical Education Age when began: \_\_\_\_\_\_

 Social Skills Age when began: \_\_\_\_\_\_

 Nutritional interventions Age when began:

 Chiropractic care Age when began: \_\_\_\_\_\_

 Social Skills Age when began

 Other - describe:

Each line below represents a year in your child’s life. Please draw a timeline of all major events in his or her life. This will aid me in my assessment of your child. Please indicate in chronological order all accidents, illnesses, hospitalizations, surgery, broken bones, sprains, falls, traumatic and emotional events, major changes in your family’s and your child’s life up to this point in time. Please also indicate when he or she had vaccinations, started school, changed schools, graduated, etc. Please use additional pages if you wish to include more information.

Birth

Age 1 month\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age 2 months\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age 3 months\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age 4 months\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age 5 months\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age 6 months\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age 7 months\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age 8 months\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age 9 months\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age 10 months\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age 11 months\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age 12 months\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age 15 months\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age 18 months\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age 24 months\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age 3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age 4\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age 5\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age 6\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age 7\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age 8\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age 9\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age 10\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age 11\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age 12\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age 13\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age 14\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age 15\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age 16\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age 17\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age 18\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special Notes:

Thank you for completing this survey.

Anke Zimmermann, BSc, FCAH