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Developmental and Behavioural Concerns Intake Form

If your child has more general health concerns please use the General Child Intake Form. This is a word document, please type in the form. If you don't have Word you can convert it to pdf and/or use Google docs.

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. If you attend in person, 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 phone or zoom.

FEE SCHEDULE

Initial consultations include a review of the intake form and other materials, research on your child's case and usually an initial care plan. Sometimes more information is required before I can design a comprehensive initial care plan.
Fee schedule is subject to change without notice.

Initial consultation, 60 minutes	$450.00
Extended follow-up, 60 minutes	$240.00
Extended follow-up, 45 minutes	$180.00
Regular follow-up, 30 minutes	$120.00
Quick check-in, 15 minutes	$65.00

Email consultations……minimum 15 minutes, $65.00
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 booking.

Please note: Forms of payment accepted are cash, cheque, credit card, e-transfer or paypal.

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ACKNOWLEDGMENT

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In order to avoid any confusion or misunderstanding, Anke Zimmermann requests 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 support and correction of physical, mental or energetic imbalances, primarily homeopathy.
- That you understand that you are responsible for any fees incurred while under care. Homeopathic care is covered under certain private insurance plans, and Anke will do her utmost to provide the appropriate documentation to your insurer upon request.
- That you are here as a client and are not attending Anke's office for any other reason without making your intentions known to her.

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

We 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 child's concerns if 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. Vitamins containing Niacin (B3) may cause temporary flushing and itching.
- Some people experience allergic reactions to certain supplements and herbs. Please advise Anke immediately if you think that your child has experienced an allergic reaction.
- Please let Anke know immediately should your child experience any negative side-effects from any homeopathic remedies, herbs or supplements.

Important points to note:

- **Anke Zimmermann does not guarantee 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, however, you will have to pay for the costs of copying and mailing the records.
- 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 care 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: _____

Developmental and 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. If you don't have Word you can upload the document to Google docs and edit there.)

What are the main reasons your child is attending this office?

- **Please describe each concern in detail.**
- **Name and describe the concern first (ie child bangs head).**
- **Then list the very first time that you noticed each concern and carefully describe any factors that you suspect may have played a role in its onset and development.**
- **If you need more space just keep tying, this is a word document and will adjust.**

Important:

- **Please leave space between points for easier reading.**
- **Break up large chunks of texts into paragraphs, no more than five lines long**
- **Use sub-headings**
- **Use a font of at least 10-11/**
- **Justify to the right**

1) _____
_____
_____
_____

2) _____
_____
_____
_____

3) _____
_____
_____

4) _____

_____

_____

5) _____

_____

_____

Add more if needed

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

Use this check list to help you remember anything you have not yet mentioned please:

☐ 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:

Important: Please provide detail for any items checked above:

_____

_____

_____

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 seems to upset the child?

What seems to calm the child?

Has your child ever had homeopathic care before? Please describe what was given, when and what result were, at least roughly

Is your child currently taking any medication? Please describe with name and doses and any improvements or negative effects noted.

Is your child currently taking any supplements? Please describe with names and dosages, ie child is taking vit D at 4000 IU a day, vit C at 500 mg twice a day etc. When did supplements start? Have any improvements been noted from them?

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 your 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

<u>Prenatal/Pregnancy</u>

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

☐ Difficulty in conception, IVF
☐ Maternal injury. Describe:
☐ Hospitalization. Reason:
☐ X-rays: Reason
☐ Medications. Reason:
☐ Vaccinations. Reason:
☐ Exposure to chemicals. Describe
☐ Ultrasounds – how many? If more than two, for what reason?
☐ Traumatic events. Describe:
☐ Work situation. Describe:
☐ Alcohol or drug use. Describe:

☐ Living close to highway. Describe
☐ Living in agricultural area where pesticides were used. Describe
☐ Living close to coal-powered power plants (mercury). Describe
☐ Fish consumption during pregnancy. Describe

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
☐ Cell phone exposure, please describe how many minutes/hours a day
☐ Computer exposure, please describe how many minutes/hours a day

☐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 the infant born full-term? ☐ Yes ☐ No
If premature, how early?
If premature, how much time spent in NICU (phthalate exposure)?
If overdue, how late?
Was the labour induced? If Pitocin was used, for how many hours?
Reason for induction?
Birth weight: Apgars (if known): at 1 minute _____ at 5 minutes
Type of anesthetic used: ☐ None ☐ Spinal ☐ Local ☐ General
Length of time anaesthetic was used, how many hours?
Length of active labor: Describe any complications during delivery:

Check all of the following that applied to the delivery:

☐ Spontaneous ☐ Breech ☐ Forceps
☐ Headfirst ☐ Multiple births ☐ Cord around neck ☐ Meconium aspiration

☐ Cesarean; Reason: _____
☐ Medications given to mother after delivery for pain control after C-section, episiotomy
_____

<u>Infancy</u>

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 at birth
☐ Vaccines given at or shortly after birth, which ones?
☐ Antibiotics given at or shortly after birth
☐ Circumcised
☐ Tylenol/acetaminophen given for circumcision

☐ Placement in the NICU (If so, for how long? _____)
☐ Length of stay in hospital: Mother _____ Infant _____
☐ Breast-fed ☐ Formula
☐ Commercial baby food given, how often, brands if you know (some are linked to lead exposure.)

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

Exposures:

☐ Vaccinated – please attach vaccination records in organized form as per the parent manual and enter them again into the timeline.

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

☐ EMF exposure, cell phones, tablets, wifi, how many hour a day?
☐ Insecticides and herbicides used in the home and garden, which ones, when, how often?
☐ Living close to farms where herbicides/insecticides are used

☐ Living close to highways, close to coal burning power plants, 5G towers?

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_____
Rode tricycle _____ rode bike _____

Can your 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 your 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 _____
Jumping with both feet _____

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

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 –Diagnosis:
suspected seizures, describe:
seizures diagnosed, type:
☐ Genetics – Diagnosis:
☐ Psychiatry – Diagnosis:
☐ Psychology – Diagnosis:
☐ Gastroenterology – Diagnosis:
stomach/intestinal problems, type:
☐ Endocrinology – Diagnosis:

Diagnostic Testing (check all that apply)

☐ EEG (brain wave test) – Results:
☐ MRI – Results:
☐ CT Scan – Results:
☐ Ophthalmology Evaluation – 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
☐ ☐ 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 your 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, when began: _____
☐ Social Skills, age when began
☐ Other - describe:

Timeline

Each line below represents a year in your child's life. Please draw a timeline of all major events in his or her life. I realize this may be a bit repetitive and I apologize, but the timeline is almost the most important information for me. **Use the previously organized vaccine and medication records and record them here again, please.**

Please indicate in chronological order all vaccinations, 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 indicate when certain symptoms began.

Please also indicate when he or she started school, changed schools, graduated, etc. Please use additional pages if you wish to include more information.

Please use the timeline example in the parent manual appendix as a model.

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 13 months_____
Age 14 months_____
Age 15 months_____
Age 16 months_____
Age 17 months_____
Age 18 months_____
Age 19 months_____
Age 20 months_____
Age 21 months_____
Age 22 months_____
Age 23 months_____
Age 24 months_____
(Please add additional months/times if anything of note happened at other times)
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