The Starting Point

Targeted Nutrition for Children with Health Concerns
Including Autism & ADHD

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New Client Intake Form

Date:______________

Child's Name: ____ Date of Birth: ________________

Address & Postal Code: ____

Phone: _________________________________ Alternate Phone: ____________________________

Mother's Name: _________________________ Father's Name: ______________________________

E-mail Contact: ____

Family Doctor: ____

Other Health Care Providers: ____

How did you hear about The Starting Point: ____

What is the main reason for seeking nutritional support for your child?

What are your goals for your child?

1. ____

2.____

3.____

Current Diagnosis and/or Health Issues?

____

Successful Nutritional Therapies Used?

____

Unsuccessful Nutritional Therapies Tried?

____

Developmental History:

Breast / Bottle / Both? ____________________At what age was food introduced? ___________

Age sat at? _______ Age crawled at? _______Age walked at? _______Age talked at? ________

Symptoms became apparent at what age?

Speech Regression?
Motor Regression?
Social or Play Regression?

Do you have any other health concerns for your child?

____

____

Your Child's Current Weight? __________ Current Height? __________

Current Prescription Medication:

____

____

Known Drug / Medication Allergies:

____

____

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Behavior: Please check any that apply

__Biting
__Teeth Grinding
__Cries Easily
__Excessive Thirst
__Obsessive Interests
__Hitting
__Hyperactivity
__Mouthing Objects
__Inappropriate Laughing/Giggling
__Head Banging
__Sideways Glancing
__Tantrums
__Irritability
__Puts Hands in Pants
__Aggression
__Eye Rolling
__Hand Movements
__Mood Swings
__Anxiety
__Aggression
__Pushes on Eyes
__Excessive Jumping
__Difficulty with Transitions
__Unresponsive to Name

Other Behaviors: ____

Sensitivity To:
Sound / Touch / Smells / Lights / Food Texture / Under-Sensitivity

Speech:
Non-Verbal / Single words / Sentences / Conversational Language

Cognition:
Limited Understanding & Awareness / Follows Commands / Normal Understanding for Age

Motor Skills:
Delayed Gross Motor / Uncoordinated / Clumsy / Delayed Fine Motor / Toe-walking

Sleep:
Normal / Difficulty Falling Asleep / Frequent Waking / Wakes Crying or Screaming /Night Sweats

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Skin: Please check any that apply

___Recurrent Rashes

___Warts

___Cold Sores

___Dry Skin

___Red cheeks or ears

___Dark circles under eyes

___White tongue

___Bruises Easily

___Tender Scalp

___Cracked skin behind ear

___Cracked corners of mouth

___White spots on nails

___Eczema or Itching

___Hives

___Dandruff

___Psoriasis

Other: ____

Bowel Health: Please describe your child's stool

Frequency:

Consistency:

Color:

Smell:

Undigested Food / Mucus in Stool / Blood in Stool:

Diarrhea or Constipation:

Excessive Gas / Bloating:

Anal itching:

Other: ____

Immune: Please describe your child's immune system

How many colds / Flu per year?

Recurrent / Chronic fevers?

Recurrent illnesses / Infections?

History of Strep?

History of fungal /yeast infection / or parasitic infection?

Hay fever?

Approximately how many courses of antibiotics?

Anaphylactic Allergies?

Other: ____

Other Symptoms: Please check any that apply

____Abdominal Pain	___Sensitivity to Light	___Painful Urination
___Acid Reflux	___Frequent Headaches	___Weight Gain
___Bad Breath	___History of High Fevers	___Weight Loss
___Bed Wetting	___Itchy Vagina	___Wheezing
___Bleeding Gums	___Itchy Nose	___Vomiting Spells
___Body Odour	___Joint Pains	___Fatigue
___Congestion	___Nervousness	___Nosebleeds
___Cough	___Nightmares/Terrors	___Canker Sores
___Cries Easily	___Nervousness	

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Diet: Please list some meals that your child is currently eating

BREAKFASTS	OFFICE USE ONLY
Ex. Toast (Wonder bread) with homemade jam	
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
LUNCHES	OFFICE USE ONLY
Example: Wheat noodles in Spaghetti Sauce	
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
DINNERS	OFFICE USE ONLY
Example: BBQ Chicken with white rice and peas	
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

OFFICE USE ONLY____

____

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Please list some snack foods that your child typically enjoys:

____

____

Food Cravings? ____

Food Allergies / Intolerances? ____

Please describe your child's appetite:

____

____

Please list **all supplements** your child currently takes including brand names & current dosage:

____

____

____

Can your child swallow pills/capsules/tablets? Yes / No / I Don't Know

Family History: Please check anything that pertains to your family

____Addiction
____AD(H)D
____Allergies
____Autoimmune
____Autism
____Blood Disorders
____Cancer
____Celiac Disease
____Crohn's
____Ulcerative Colitis
____Depression
____Epilepsy / Seizures
____Genetic Disorders
____Heart Disease
____High Blood Pressure
____Kidney Disease
____Learning Disability
____Bipolar
____Diabetes
____Migraines
____OCD
____Multiple Sclerosis
____Schizophrenia

Is there anything else you would like me to know about your child or family?

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Upon completion, please scan and e-mail this form to TheStartingPoint@shaw.ca
Thank you.