Peace Valley Holistic Center

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Directions: Fill out this Questionnaire. Email or Mail prior your first visit. Appointment will be made after evaluation.

Last Name: _____ First Name: _____

Street Address: _____

_____

City: _____ State: _____ Zip Code: _____

Country: _____

Phone Number (W) _____ Phone Number (H) _____

Email: _____

Child's Name: _____ Age: _____

Medical History

Diagnosis: _____

_____

_____

_____

Any difficulties during pregnancy? _____

_____

_____

Was birth caesarean, induced, long labor or particularly difficult? _____

_____

_____

Cried a lot in infancy? _____

_____

_____

Unusually good baby? _____

_____

_____

Responded to early interactive play? _____

_____

_____

Began to speak and regressed, describe? _____

_____

_____

At what age were symptoms seen?

Slow development?

Prone to ear infections?

Several courses of antibiotics in childhood?

Poor eye contact?

Non-verbal?

Echolalia?

Screams or laughs for no apparent reason?

Unsociable/Withdrawn?

Unusual or limited food preferences?

Disturbed Sleep

Patterns?

Sensitive to some sounds?

Dislikes being touched?

Behavior problems?

Temper tantrums?

Any allergies, describe?

Suffers from Asthma?

Suffers from Epilepsy?

Bed wetting after 5 yrs?

Mood swings?

Fidgety?

Unusually anxious and fearful?

Accident-prone?

Hyperactive?

Aggressive?

Poor co-ordination?

Injures self or others?

Does s/he use inappropriate movements such as rocking, whirling, hand flapping, describe?

List Current Medication if any?

Any current program of remediation, describe?

What are your main concerns?

School:

Address:

Phone:

General Practitioner | Doctor:

Office:

Address:

Phone: