FALCONE CENTER
FUNCTIONAL, COSMETIC & INTEGRATIVE MEDICINE

191 Presidential Boulevard, Suite B104
Bala Cynwyd, PA 19004
215-586-3304

Dear New Patient,

We would like to welcome you to The Falcone Center. Enclosed you will find the following documents:

1. Welcome Letter
2. Fee Schedule (Sign and Return)
3. Office and Financial Policy Form (Sign and Return)
4. Office Policies Regarding Treatment and Supervision
5. Initial Visit Information
6. Autism information sheet
7. Diet and Allergen removal information
8. Patient Questionnaire (Complete and Return)
9. Metabolic Assessment Form
10. HIPAA privacy policy (Complete and Return)
11. ATEC form (Complete and Return)

What is not enclosed but is also required prior to your visit:

1. A letter from you stating your current concerns about your child
2. A typed history of the child's health, birth to present, from the parents view.
3. List of all current medications and supplements including dosages
4. List of all current therapies including hours and frequency (i.e. ABA, PT, OT)
5. Current IEP or Early Intervention Evaluation if available
6. 5 day food and beverage log including approximate time of consumption, type of food and quantity. Please include any current dietary restrictions
7. Copies of pertinent medical records and evaluations which may include

   a) Pediatric Records
   b) Neurological Evaluations
   c) Psychologist Evaluations
   d) Reports from diagnosing physician e) Lab test from the past two years

Please mail requested information back to our office and we will contact you to schedule your appointment. Appointments will not be scheduled without requested information. We understand that this is a considerable time

commitment to collect all of the data but want to make your visit as useful as possible. If you have any questions, feel free to contact us.

2016 Fee Schedule

191 Presidential Boulevard, Suite B104
Bala Cynwyd, PA 19004
215-586-3304

Initial Consultation..... $500

A $500 non-refundable deposit due upon scheduling initial appointment.

Please have all necessary forms returned to us at the time you schedule your initial appointment so that we may begin our review process and plan for your visit.

Follow-up Visits (15-30 minutes) $250 (30-45 minutes) $375

Fees are at 15 minutes increments

Phone consultations are based on the actual time spend on the phone plus the additional time it takes for the doctor to finish completing a “Summary” sheet.

A current and valid “on file” credit card is used for prepayment of the initial office visit, phone consultations, and for payment of missed appointments.

All fees are due at the time of your appointment.

Scheduled appointments are “guess-timates” for the amount of time needed for routine cases for the type of consultation it was anticipated to be. However, if the appointment cannot be completed within the scheduled time, for whatever reason, including additional questions and concerns that the parents want answered, the doctor will either

1) End the consultation before it is finished and have the patient rescheduled for additional time.

2) Spend the entire allotted time reviewing lab data, explaining treatment options, etc. and complete the write-up portion at a later time.

Cases that turn out to be complex or need more time to complete, for whatever reason, will be billed at the customary physician rate for the extra time that is needed to complete the write-up process at a later point and time.

_____

Patient/Parent Signature Date

OFFICE AND FINANCIAL POLICIES FOR THE FALCONE CENTER

Thank you for choosing the Falcone Center. We are committed to providing you with quality, personal care and treatment and appreciate your commitment to adhere to this Office/Financial Policy Agreement. Agreement with this policy is required for all medical care and treatments.

Our office policies for Functional, Cosmetic and Integrative Medicine Patients

1. All payments are pre-paid at the time of service unless other arrangements have been made. We accept cash, credit cards and in-state personal checks (PA or NJ) with driver's license present as we process checks immediately. There is a $40 service charge for returned checks.
2. Office hours are by appointment only. As a courtesy to other patients, we request you arrive 15 minutes ahead of your appointment. If you arrive more than 10 minutes late, you may be asked to reschedule.
3. We specialize in Functional, Cosmetic and Integrative Medicine. As a specialty practice, all patients are expected to have a primary care physician to handle their routine and emergency medical care. We will not be available to you after normal business hours for sick calls, prescription refills or other general medical care.
4. For emergencies, call 911 or go to the local emergency room. For non-emergent issues that CANNOT wait until regular office hours, please call our office at 215- 586-3304. There will be a charge for calls after business hours. Please see Fee Schedule.
5. ParentsareexpectedtoprovidetheFalconeCenterstaffwithanappropriate telephone number where they can be reached for telephone consults.
6. We will not respond to email questions regarding a patient's health.
7. The staff at the Falcone Center will make two (2) attempts to call on the day of the scheduled consult. If you miss your appointment time, you will be charged the full amount for that missed appointment.
8. We schedule considerable blocks of time for your appointments. Cancellation of appointments less than 72 hours prior to appointment date will result in loss of the total appointment fee. Two (2) consecutive missed appointments or three (3) in one calendar year may result in the discharge from the practice.

- • □New Patients. We require credit card information for new patients (Visa, Mastercard or Amex) to ensure appointment time. If a new patient fails to call with 72 hours notice of cancellation or show for his/her scheduled appointment, he/she will be billed $500.
- • □Established Patients. If an established patient fails to call with 72 hours notice of cancellation or show for his/her appointment, he/she will be charged a minimum of $125 or the cost of the allotted appointment time.

9. Long distance children (Greater than 120 miles) are to be brought to the clinic on a quarterly basis during the first year of treatment unless otherwise specified by the health care provider. Failure to do so will result in discharge from the clinic. Allowances will be made during the winter months due to weather.

10.Patient update forms are to be sent to the clinic via email or US Mail delivery on a monthly basis. The form will be provided to you by the clinic staff.

11.Please check your prescriptions prior to your upcoming appointment. We prefer to renew prescriptions at the time of the visit to assure accuracy. All prescription requests are taken during regular office hours and filled within 3 working days. Controlled medications are not refilled over the phone at any time. If a prescription medication is not covered by insurance, it is the patient's responsibility to contact their insurance company to ask what "alternative medications" are covered.

12.Standard lab tests should be drawn seven (7) days prior to your appointment unless otherwise instructed. Specialty lab tests can take up to eight weeks for results. We ask that you schedule your tests at an appropriate time to ensure that we receive the results from the laboratories prior to your next visit.

13.You are entitled to your record; however, we do charge a processing fee of $25.00 and require fourteen days notice for record copying. Records requests must be submitted in writing.

14. All special letter requests require a two weeks notice. The processing fee for this service is $50-100 payable prior to sending the letter. We will not write letters of medical necessity for issues that are repeatedly rejected by insurance companies. The doctor will occasionally write a letter if they feel strongly that there may be a chance of reimbursement. When written, such a letter will be billed at the hourly rate and charged to the family.

15. Letters to attorneys will be charged at the doctor's hourly rate. A retainer fee for the estimated time it will take the doctor to write the letter must be paid in advance by the attorney's office or by the patient's family.

16. Legal cases will not be accepted.

17. Cases involving parental jurisdiction issues, where both parents do not agree in writing that they want the Falcone Center to treat their child using the biomedical approaches they use, will not be accepted to the practice.

18. Medicare and Medicaid patients cannot be accepted as patients unless they agree to be seen outside the system on a "private pay" arrangement. If they choose to be seen, they will need to sign an agreement stating they will not submit claims to Medicare or Medicaid and that they understand they are

responsible for all payments at the time of services. The doctor is not a Medicare/Medicaid provider and does not use UPIN number.

19. It is important to understand that Dr. Falcone often orders diagnostic tests from specialty laboratories and uses numerous biomedical treatments, most of which do not qualify for insurance reimbursement.

Would you like to be added to our eblast list so that we can send you information regarding our monthly news and events? YES NO

o I hereby acknowledge that I have received a copy of the Notice of Privacy Practices

o I have received the Falcone Center OFFICE AND FINANCIAL POLICY 3 page documents and Fee Schedule. By signing this Office/Financial Policy, I agree that I have read and understand the terms of this policy.

Patient's Name_____
Patient Signature or Legal Guardian: _____
Print Name: _____Date: _____

Patient Signature or Legal Guardian: _____
Print Name: _____Date: _____

OFFICE POLICY REGARDING TREATMENT AND SUPERVISION OF AUTISTIC CHILDREN

The biomedical treatment of Autism is challenging at any time. In the setting of a child taken out of his or her routine (i.e. a medical visit) it can be an extreme test for all. This policy is to optimize the communication, teaching and therapeutic environment for all involved.

Only one child will be allowed into the treatment room at a time.

In addition to the DECISION MAKING parent(s) or guardian(s), a childcare provider for the child must be present in the treatment room as well. This is to insure that the decision makers can focus on the conversation and treatment plan without the distractions of childcare.

In the event of divorced or separated parents, consent from all parties will be required. Biomedical treatment is complex and requires full time administration. If all involved in the

households are not onboard, it is unlikely that treatment will be effective. The Falcone Center is uninterested in being in the middle of parenting disagreements and will not engage in a treatment plan without the consent of all concerned parties.

If more than one child is to be seen on any given day you must insure adequate

childcare for the children not in the treatment room. This generally should be a responsible ADULT(s) with the skills and resources to manage the child's (children's) special needs.

These policies are not meant to be burdensome. They are intended to improve communication because our therapeutic approach is complex, time consuming and requires great dedication to the process.

We understand the challenges of parenting special needs children. Missed appointments represent not only a cost to us, but also a lost opportunity for other patients to have been helped. We require 72 hours notice of cancellation to avoid a Missed Appointment Fee. Your credit card will be charged for the full amount of appointment time that was scheduled ie. $500.00 per hour, $250 per half hour. Billing is in 15 minute increments. It is your responsibility to remember your appointment.

Signature Date

Signature Date

Your Initial Visit with Dr. Victoria Falcone

Unlike initial office visits you may have had with other doctors in the past, the initial visit with Dr. Falcone will be different in many ways. Probably the most obvious way is that the doctor will be studying the information you have provided, taking notes and asking clarifying questions. The more complete the information you provide, the better the physician's initial assessment.

The initial visit will proceed as follows:

The doctor will review the information provided and ask clarifying questions. She will complete a focused physical exam. Because your initial office visit was prepaid in full, once the doctor completes the exam, there may be some initial suggestions provided and then you will return home.

Once you leave, the doctor will immediately order any medications she will want your child to begin and finish studying the information provided. During this review time, a list will be created which will be used for future consultations to quickly and comprehensively review your child's complete case. This will allow the doctor to create a plan of action for your child.

In general, when you leave the office after your initial visit, you will receive no billing information. This will follow about two weeks later by mail or email in a packet. The packet will contain a) a coded Superbill to submit to your insurance company in case you are eligible for out of network reimbursement ; b) a copy of your child's treatment list called a "Summary of Key Points" c) a "Sign Out Sheet" which will be a list of all prescriptions for medication and lab tests, instructions about obtaining laboratory specimens correctly, the "next steps" you are to make to begin the treatments being suggested, your "next steps" for follow-up appointments, and pertinent comments relating to your child, how to obtain additional information etc.

The Initial Office Visit will not be an office visit to answer many of your questions. The purpose of the Initial Office Visit is to give the doctor the information she needs to begin developing a treatment plan for your child. Rest assured that your questions will be

addressed during follow- up visits.

To obtain more information on biomedical treatment we recommend you read the following:

"Children with Starving Brains" by Jacqueline McCandless "Healing the New Childhood Epidemics" by Dr. Ken Bock "The Myth of Autism" by Dr. Michael Goldberg

As every parent knows, the disorder is complex. It is time consuming and an easy answer does not exist. The more information you provide the doctor, the more efficient we can be in making

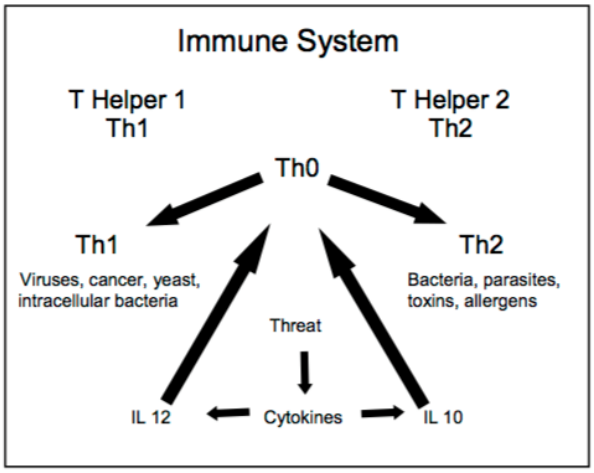
treatment decisions.

The success we see is often relative to where a child was before treatment when compared to how the child is found to be following treatment. Some children make considerable progress and others remain severely autistic. Our hope is that every child will achieve a better quality of life.

What is Autism?

We believe that the symptoms that fall under the heading of Autistic Spectrum Disorders are a result of having an immune system that does not function correctly.

Let's look at the immune system. This diagram is from the work of Dr. Paul Cheney who is a pioneer in the field of Chronic Fatigue Syndrome.



Look at the bottom of the diagram. A threat comes into the body, such as a virus, and special chemicals called Cytokines recognize it and release a specific cytokine, in this case Interleukin 12 (IL 12 on your diagram) that triggers a process that turns TH0 (TH null cells that have not yet been assigned a job) into Th1 cells that fight viruses. Look at Th1 side of the diagram. You can see that the Th1 handles viruses, cancer, yeast, and intracellular bacteria. Look at the Th2 side. You can see that the Th2 side handles extracellular bacteria, parasites, toxins, and allergens. In a normal, healthy immune system the Th1 and 2 sides are triggered as needed. In an unhealthy immune system the function seems to be stuck on the Th2 side.

There is a theory that certain viruses actually mimic IL 10 resulting in Th0's becoming Th2's. This shift to the Th2 side allows the viruses to flourish unchecked; however, it also can result in lower

NK cells and T cells. For some children this shift can be fairly continuous and for others it can be intermittent.

How does this result in Autistic Spectrum Disorder symptoms? Have you ever experienced a brain fog as a result of allergies or an illness? It is thought that this is caused by a temporary decrease in blood flow to parts of the brain in order to protect them from the illness or allergies. We think that the same mechanism is at work in autism. What happens when you cut off circulation to your hand? Eventually the tissue will die. Tissue needs blood in order to stay healthy. Tissue in a child needs adequate blood flow to develop and grow. If you decrease the blood flow to parts of the brain to a child, normal development will not take place. NeuroSPECTS look directly at the blood flow in the brain and these tests have shown that children with Autistic Spectrum Disorder have decreased blood flow to the parts of the brain that involve communication and personality development. Other parts of the brain are involved when the child has symptoms of other Spectrum Disorders such as Attention Deficit Disorder with or without Hyperactivity, Oppositional Defiant Disorder, as well as other disorders.

There have been studies done with the NeuroSPECTS showing before treatment, during, and after treatment. With treatment, normal blood flow appears to return, and the child can begin to catch up.

What is the Treatment?

1. Medication: Antivirals, antibiotics, SSRI's, immune modulators, antifungals, allergy medications, and supplements are some of the things that we use depending on your child's history, physical, and blood work.
2. Allergen control
3. Diet

Allergen Control

Look back at your diagram. See under the Th2 on the right hand side where it says allergens? Allergens, like viruses, have the ability to really trigger the immune system. If you have allergies and are currently rubbing your eyes, blowing your nose, coughing, and sneezing, you know what pollen can do. In order to keep the immune system in balance you have to reduce the amount of allergens that trigger it.

What you can do to reduce Allergens

Pollen

1. Keep windows closed during pollen season
2. Stay inside the house from 5-10 am
3. Wear masks while doing yard work
4. Shower, bathe, and wash hair before going to bed
5. Take off shoes before coming into the house
6. Change clothes after playing out in the yard
7. Use filtered screens
8. Use air conditioning
9. Do not hang wash outside during pollen season

Mold

1. Look for sources of mold in your home and remove. Mold will grow where it is damp, so bathrooms, kitchens, basements, and window sills are favorite hangouts for mold.
2. Continue all of the air cleaning control that you used for pollen during mold season. Mold season is whenever the air is very humid.
3. Bleach does kill mold but it is toxic to the environment and to people if you inhale or swallow it.
4. Sunlight, heat, vinegar, or scrubbing with hot soap and water will work sometimes.
5. There are natural products such as Tea Tree Oil that work and are available on the internet and

   at health food stores.

Dust Mites

Dust mites grow inside furniture and furnishings such as mattresses, sofas, pillows, cushions and rugs. They prefer natural fibers to synthetic fibers. Dust mites come out of your mattress and pillow at night and feed on your dead skin cells. After feasting they defecate on your skin and the mite feces is inhaled into your lungs which can trigger an allergic response in sensitive individuals. If you don't want this to happen:

1. Cover your mattresses and pillows
2. Wash sheets weekly
3. Wash blankets and spreads weekly
4. Remove carpeting in bedroom or use a miticide product on the carpets every 6 months
5. Dry everything in a hot dryer

Diet Control

Food can be an allergen. The most common food allergens in the American diet are wheat, dairy products, sugar, chocolate, eggs, peanut butter, soy, and artificial colors, flavoring, and preservatives. If you are sensitive to any of these products your immune system will react to them just as it does any other trigger. This is why we ask you to eliminate wheat, dairy, large amounts of sugar, chocolate, and artificial colors, flavors, and preservatives from your child's diet. If you suspect that your child is sensitive to anything else it should also be eliminated.

An essential component to the success of our treatment plan is diet. Although you may not see the outward evidence of food allergies or intolerances, it is possible that they are present.

If you answer yes to any of the following questions then food allergies or intolerances could be an issue:

- • ∟Do you ever notice that your child's ears have turned red?
- • ∟Does your child have frequent stomach problems?
- • ∟Does your child have dark circles under his or her eyes?
- • ∟Do you notice changes in your child's behavior after ingesting certain foods?
- • ∟Is the day after Halloween predictably bad behavior day?

  We may ask that you begin a gluten-free and casein-free diet. The diet is a challenge for everyone in the beginning, but with planning it certainly can be done, and after a while it becomes routine.
  That means limiting sugar and eliminating all food products that contain the following:

  - • ∟Wheat

- Oats
- Rye
- Barley
- Dairy
- Chocolate
- Artificial coloring and flavoring

If hyperactivity is an issue, we may place your child on the Feingold Diet.

We do not expect you to see anything dramatically different when you put your child on this diet.

A few people have, but most don't. It is the cumulative effect of the three steps—medication, allergen control, and diet—that will help your child's immune system get back to normal. What works the most? In some children allergen control is huge, in others it is the medication, and in others it is the diet. Doing one without the others is like taking an unloaded rifle into battle; you look good, but in the long run you probably won't make out very well. Medication alone is not the answer. You have to do all three things.

The medical approach that we use is based on NIDS protocol, the SCIA protocol and various other Functional medicine principles. If you want to learn about this approach, use the following websites:, www.NIDS.net, www.functionalmedicine.org, www.SCIA.com, and www.neuroimmunedr.com. Dr. Doris Rapp has written a number of books about removing allergens from the home. You can find her books in most libraries.

FALCONE CENTER

FUNCTIONAL, COSMETIC & INTEGRATIVE MEDICINE

191 Presidential Boulevard, Suite B104
Bala Cynwyd, PA 19004
215-586-3304

PERSONAL INFORMATION		
Date Questionnaire Received:	Date of Completion by Caregiver:	
Child's First Name:	Last:	MI:
Child's D.O.B.	Sex:	
Parents names:		
Address: Street	City:	
State: Zip Code:	Home Phone number:	
Cell phone mother:	Cell phone father:	
E-mail address mother:		
E-mail address father		
Siblings: Name:	M/F	D.O.B.
Parents Occupation (s) Mother:		
Father:		
Referred by:		
Primary Care Physician:		
Street Address:	City:	State:
Zip Code:	Phone number:	
Fax number:		
Preferred Pharmacy:		
Phone number:	Fax number:	
Previous Doctors:		
Please bring several pictures of your child, that we may keep, specifically portraying the changes he or she has experienced i.e. if you child has regressed; bring in pictures that clearly show them before regression and after regression. You should keep a weekly video diary as he/she undergoes treatment.		

For the following sections, If you already submitted this information in your typed narrative or email you do not need to repeat the information. Simply write "See Narrative" in sections below.

Please list diagnoses and explanations (including dates) given for child's condition:

When did you notice your child's problem?

Was the onset sudden or gradual?

Was there any event or illness that you or others think brought on your child's symptoms?

Please make note of any other event, actions etc. that you think may have some bearing/relationship to your child's condition. Again, be detailed as possible and do not hesitate to mention anything no matter how small or insignificant, that you believe is related to your child's progress

Family History (If yes please describe):

	Yes	No	Describe
A) Learning Disorder			
B) Psychological Disorder			
C) Autoimmune Disease			
D) Rheumatoid Arthritis			
E) Lupus			
F) Migraines			
G) Allergies			
H) Genetic Disorders			
I) Chromosomal Abnormalities			
J) Dementia/Alzheimers			
K) Parkinsons Disease			
L) Other			

Birth History

Birth Weight: Birth Length: Length of Pregnancy:

Method of delivery: Vaginal C-section

Maternal age at delivery: # of pregnancies/births prior After this child

Duration of Labor in hours:

Mode of delivery: C-section/vaginal? If C-section explain why:

If vaginal, were forceps or vacuum used?

Medications (s) during labor and delivery?

Other complications of pregnancy or delivery?

If Yes, what illness?

In what month of pregnancy was the illness?

Medications taken for illness?

Medications or Immunizations given while in the hospital:

Any delayed breathing or other issues at birth?	
In the first 4 weeks of life did the baby have:	
A) Infection	
B) Yellow Jaundice	
C) Blood Transfusions	
D) Convulsions	
Feed in Infancy:	
A) Formula	How Long?
B) Breast	How Long?
Age solid foods started?	
What were the initial food preferences in the first two years of life?	
DIETARY/NUTRITIONAL HISTORY	
Place an X in the most appropriate descriptions below of your child's diet: _____ Mostly baby food _____ Mostly carbohydrates (bread, pasta, etc.) _____ Mostly dairy (milk, cheese, etc.) _____ Mostly meat _____ Mostly Vegetarian _____ Other Describe Additional Information not included in Food and Beverage log	
Please describe your child's stool pattern (Examples: daily, foul, large, mushy, light colored. etc.	

Illnesses – If Yes Give Age or Date			
	Yes	No	Age/Date
A) Measles			
B) German Measles			
C) Mumps			
D) Chicken Pox			
E) Scarlet Fever			
F) Whooping Cough			

Has child ever had:	Yes	No
A) Asthma		
B) Hay Fever		
C) Eczema		
D) Hives		
E) Frequent ear infections		
F) Trouble hearing		
G) More than 6 colds a year		
H) Pneumonia		
I) Anemia		
J) Rheumatic Fever		
K) Heart Murmur		
L) Bedwetting after age 5		
M) Kidney or Bladder Infections		
N) Frequent Urination		
O) Red or Brown Urine		
P) Frequent Nightmares		
Q) Difficulty sleeping		
R) Convulsions		
S) Tonsillitis		

Major Surgeries – Please describe and give dates

Surgery	Dates	Results

Major Injuries Please describes and give dates:

Injury	Dates	Result (s)

IMPORTANT – Please provide copies of most recent results of the following:
BLOOD WORK URINE TESTS STOOL TESTS

Vitamins, Minerals, and Supplements Please list all you have given your child.

Continue on a separate paper if necessary.			
Brand Name (or Generic)	Dosage	Time of day given	Currently taking Yes/no

Herbal/homeopathic and or other therapies- Please list any other medications of this type(s) your child has used.

Medical Therapy	Time when taken	Effect

Do you, your child, or any family members practice any relaxation, stress, and management's techniques? Please describe. Use other side if necessary.

Environmental History			
Circle appropriate answers to the following questions and describe:			
1) location of home: city/suburban/wooded/farm/ Other (Rural Village)			
2) Water: City/Well			
3) Type of heat: Electricity gas/oil/other (describe)			
4)Do you live near: Power lines/woods/industrial area/water			
5) If you live near water, what type? Swamp, river, ocean, other (describe)			
6) Does your home have a lot of dust, mold, down or feather items? If so describe.			
Describe your child's bedroom:			
Bedroom: Synthetic/down/ Mattress enclosed: yes or no Crib/Jr. Bed/ adult bed			
Flooring: Carpet Wall to wall area rug wood glued down synthetic pad			
Window treatments: Shades Blinds Thin curtains heavy curtains valance other (describe):			
Other items in room including furniture, toys, stuffed animals, etc.:			
Flooring in other rooms:			
Child's bathroom:			
Living Room:			
Family Play Room / play room:			
Is your child sensitive or bothered by the following?			
Perfumes/cosmetics		Pollens/grasses	
Mold		Animals (dander)	
Cleaning products		Gasoline	
Soaps		Paint	
Dust		Detergents	
Other			
Please list any other known allergies:			

IMMUNIZATIONS

MMR Dates: Reaction: YES NO

DTP Reaction: YES NO

FLU shot this year? YES NO

Describe any reactions to immunizations

Please place and X next to any signs/symptoms your child may demonstrate and duration and details if appropriate.

Description	Mild	Moderate	Severe	Duration	Unique Details
Stimming (repetitive actions)					
Head banging					
Self mutilation					
Thumb sucking					
Hand/ arm biting					
Nail /skin picking					
Aggressiveness(hitting, kicking, biting others					
Mood swings					
Irritability/tantrums					
Fears / anxieties					
Hyperactivity					
Inability to concentrate/focus					
Fidgety in seat					
Impulsive					
Dizziness					
Seizures					
Poor coordination					
Problems with buttons zippers, ties, or snaps					
Processing problems- visual motor, language, sensory, etc.					
Problems with social interactions					
Sensitive to crowds					
Trouble remembering					
Low self-esteem					

Fatigue					
Cold hands/feet					
Cold intolerance					
Recurrent/chronic fever					
Flushing					
Excessive sweating					
Difficulty falling asleep					
Night walking					
Nightmares					
Difficulty waking					
Bed wetting / soiling					
Daytime wetting/ soiling					
Numbness/ tingling hands and feet					
Headache					
Blinking					
Staring					
Sensitive to texture of clothes					
Cracking / peeling of hands					
Cracking/peeling of feet					
Strong body odor					
Soft nails					
Thickening of nails					
Hite spots/lines on nails					
Brittle nails					
Other Developmental Difficulties: Describe: Sensory Processing difficulty:					
Vestibular Dysfunctions:					
Auditory Processing Issues:					
Visual Skill Difficulty:					
Organization skill difficulty:					

Other strengths or weaknesses:

List any other pertinent thoughts, questions or topics you would like to discuss

Name: Date:

Metabolic Clearing Therapy Testing Scale

Rate each of the following symptoms based upon your health profile for the past 30 days.

Point scale
0= never or almost never have the symptom
1= occasionally have it effect is not severe
2= occasionally have it, effect is not severe
3 = frequently have it, effect is not severe
4= frequently have it effect is severe

Digestive tract

_____nausea or vomiting
_____ constipation
_____ bloated feelings
_____ belching or passing gas
_____ heartburn

Total _____

Ears

_____ itchy ears
_____ earaches, ear infections
_____ drainage from ear
_____ ringing in years, hearing loss

Total _____

Emotions

_____ Mood swings
_____ Anxiety, fear or nervousness
_____ Anger, irritability or aggressiveness
_____ Depression

Total _____

Energy/Activity

_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness

Total _____

Head

_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia

Heart

_____ irregular or skipped heartbeat
_____ rapid or pounding heartbeat
_____ chest pain

Total _____

Eyes	
_____ watery or itchy	Total
_____ swollen, reddened or sticky eyelids	
_____ bags or dark circles under eyes	_____
_____ blurred or tunnel vision	
(does not include near or far sightedness)	

Joints/Muscles	
_____ pain or aches in joints	Total
_____ arthritis	
_____ stiffness or limitation of movement	_____
_____ pain or aches in muscles	
_____ feeling or weakness or tiredness	

Lungs	
_____ chest congestion	Total
_____ asthma, bronchitis	
_____ shortness of breath	_____
_____ difficulty breathing	

Mind	
_____ poor memory	Total
_____ confusion	
_____ poor concentration	_____
_____ poor physical condition	
_____ difficulty in enacting decisions	
_____ stuttering or stammering	
_____ slurred speech	
_____ learning disabilities	

Mouth/Throat	
_____ chronic coughing	Total
_____ gagging, frequent need to clear throat	
_____ sore throat, hoarseness, loss of voice	_____
_____ swollen or discolored tongue, gums, lips	
_____ canker sores	

Weight	
_____ binge eating/drinking	Total
_____ craving certain foods	_____
_____ excessive weight	

_____ frequent illness	Total
_____ frequent or urgent urination	
_____ genital itch or discharge	_____

Name:	Date:
Skin _____ acne _____ hives, rashes, or dry skin _____ hair loss _____ flushing or hot flashes _____ excessive sweating	Total _____
Grand Total: _____	

Metabolic Assessment Form

Name:_____ Age:_____ Sex:_____

Part 1 Please list the 5 major health concerns in your order of importance:

1. _____

2. _____

3. _____

4. _____

5. _____

Part 2 Please circle the appropriate number "0-3" on all questions below.
0 as least/never to 3 as most/always.

Category 1

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relief by passing stool or gas	0	1	2	3
Alternating constipation/diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul smelling gas	0	1	2	3
More than 3 bowel movements	0	1	2	3
Use laxatives frequently	0	1	2	3

Category 2

Excessive burping or bloating	0	1	2	3
Gas immediately following meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting vegetables/ fruits; undigested foods in stools	0	1	2	3

Category 3

Stomach pain, burning or aching 1-4 hours after eating	0	1	2	3
Frequently use antacids	0	1	2	3
Feeling hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief from antacids, foods, milk, carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, caffeine	0	1	2	3

Category 4

Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3
Excessive passage of gas	0	1	2	3
Pain, tenderness, soreness on left side, under rib cage, bloated	0	1	2	3
Stool undigested, foul odor, greasy mucous-like, or poorly formed	0	1	2	3

Name_____ **Date**_____

Self-care Skills
0 none
1 with some assistance
2 with some supervision
3 independent

Toilet Trained
0 not trained
1 with some assistance
2 with some supervision
3 independent

Receptive Language:
Follows direction
0 does not
1 one step
2 two steps
3 three or more steps

Expressive Language (any form):
% Communication
0 none
1 basic needs
2 feelings and emotion
3 nl. communication

Motor
Gross
0 clumsy, avoids rec. activities
1 beginning to engage in rec. activities
2 engages with supervision
3 independently

Fine
0 does not engage/avoids
1 writes
2 writes legibly
3 writes and types

Utensils
0 eats with hands
1 eats with spoon mostly
2 eats with fork
3 uses all three

General Health
1 ill a lot
2 never ill
3 less episodes of illness
4 more episodes of illness
5 healthy

School Placement
0 5-1-4
1 2/15 1-1
2 12/15 1-1 with mainstream
3 mainstream

Reading
0 none
1 beginning
2 processing
3 age level

Math
0 none
1 beginning
2 processing
3 age level

Social Interaction
0 none
1 family only
2 adults
3 peers

Tantrums
0 daily
1 3 per week
2 5-10 per week
3 less than 5 per month
4 none

Self Injury
0 daily
1 3 per week
2 5-10 per month
3 less than 5 per month
4 none

Name_____ Date_____

Aggression
0 daily
1 3 per week
2 5-10 per month
3 less than 5 per month
4 none

Hyperactivity
0 present
1 decreasing
2 not present

Tics
0 present
1 decreasing
2 not present

Repetitive Behaviors
0 present
1 decreasing
2 decreasing, at times not present
3 none

I HAVE COMPLETED THIS FORM FULLY AND COMPLETELY, AND CERTIFY THAT I AM THE PATIENT OR DULY AUTHORIZED GENERAL AGENT OF THE PATIENT AUTHORIZED TO FURNISH THE INFORMATION REQUESTED.

SIGNATURE: _____ DATE: _____
NAME PRINTED: _____
RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____ DATE: _____
NAME PRINTED: _____
RELATIONSHIP TO PATIENT: _____

Name: _____ Date: _____

Person Completing Form: _____

Please circle the letters to indicate how true each phrase is:

I. Speech/Language/Communication: *[N] Not true [S] Somewhat true [V] Very true*

N S V 1. Knows own name
N S V 2. Responds to 'No' or 'Stop'
N S V 3. Can follow some commands
N S V 4. Can use one word at a time (No!, Eat, Water, etc.)
N S V 5. Can use 2 words at a time (Don't want, Go home)
N S V 6. Can use 3 words at a time (Want more milk)
N S V 7. Knows 10 or more words
N S V 8. Can use sentences with 4 or more words
N S V 9. Explains what he/she wants
N S V 10. Asks meaningful questions
N S V 11. Speech tends to be meaningful/ relevant
N S V 12. Often uses several successive sentences
N S V 13. Carries on fairly good conversation
N S V 14. Has normal ability to communicate for his/her age

II. Sociability: *[N] Not descriptive [S] Somewhat descriptive [V] Very descriptive*

N S V 1. Seems to be in a shell – you cannot reach him/her
N S V 2. Ignores other people
N S V 3. Pays little or no attention when addressed
N S V 4. Uncooperative and resistant
N S V 5. No eye contact
N S V 6. Prefers to be left alone
N S V 7. Shows no affection
N S V 8. Fails to greet parents
N S V 9. Avoids contact with others
N S V 10. Does not imitate
N S V 11. Dislikes being held/cuddled
N S V 12. Does not share or show
N S V 13. Does not wave 'bye bye'
N S V 14. Disagreeable/not compliant
N S V 15. Temper tantrums
N S V 16. Lacks friends/companions
N S V 17. Rarely smiles
N S V 18. Insensitive to other's feelings
N S V 19. Indifferent to being liked
N S V 20. Indifferent if parent(s) leave

III. Sensory/Cognitive Awareness: *[N] Not descriptive [S] Somewhat descriptive [V] Very descriptive*

N S V, 1. Responds to own name
N S V 2. Responds to praise
N S V 3. Looks at people and animals
N S V 4. Looks at pictures (and T.V.)
N S V 5. Does drawing, coloring, art
N S V 6. Plays with toys appropriately
N S V 7. Appropriate facial expression
N S V 8. Understands stories on T.V.
N S V 9. Understands explanations
N S V 10. Aware of environment
N S V 11. Aware of danger
N S V 12. Shows imagination
N S V 13. Initiates activities
N S V 14. Dresses self
N S V 15. Curious, interested
N S V 16. Venturesome - explores
N S V 17. "Tuned in" — Not spacey
N S V 18. Looks where others are looking

IV. Health/Physical/Behavior: *Use this code: [N] Not a Problem [MI] Minor Problem [MO] Moderate Problem [S] Serious Problem*

N MI MO S 1. Bed-wetting
N MI MO S 2. Wets pants/diapers
N MI MO S 3. Soils pants/diapers
N MI MO S 4. Diarrhea
N MI MO S 5. Constipation
N MI MO S 6. Sleep problems
N MI MO S 7. Eats too much/too little
N MI MO S 8. Extremely limited diet
N MI MO S 9. Hyperactive
N MI MO S 10. Lethargic
N MI MO S 11. Hits or injures self
N MI MO S 12. Hits or injures others
N MI MO S 13. Destructive
N MI MO S 14. Sound-sensitive
N MI MO S 15. Anxious/fearful
N MI MO S 16. Unhappy/crying
N MI MO S 17. Seizures
N MI MO S 18. Obsessive speech
N MI MO S 19. Rigid routines
N MI MO S 20. Shouts or screams
N MI MO S 21. Demands sameness
N MI MO S 22. Often agitated
N MI MO S 23. Not sensitive to pain
N MI MO S 24. "Hooked" or fixated on certain objects/topics
N MI MO S 25. Repetitive movements (stimming, rocking, etc.)