ORC Medical Consultation Form: Children

Consultation Type _____ Todays Date ____/_____/_____

Guardian Information

First Name _____ Last Name _____ Email _____

Patient Information

Patient First Name: _____ Patient Last Name: _____

Date of Birth: ____/_____/_____

City of Birth: _____ State of Birth: _____ Nation of Birth: _____

Gender: M ____ / F ____ Current Height: Ft. _____ In. _____ Weight at Birth: Lbs. _____ Oz. _____

Family Information:

Religion: _____ Number Among Children: _____

Number of Brothers: _____ Number of Sisters: _____

Father's Full Name: _____ Father's Age: _____

Father's Job Type/Industry: _____

Mother's Full Name: _____ Mother's Age: _____

Mother's Job Type/Industry: _____

Additional Family Information and Disease History:

Fathers Disease History (Including His Parents)

☐ ADHD	☐ ASD	☐ Diabetes	☐ Hypertension	☐ MS
☐ Celiac	☐ Heart Disease	☐ Stroke	☐ ALS	☐ Asthma
☐ Cancer	☐ Depression	☐ Cholesterol	☐ Miscarriage	☐ Birth Defects

Fathers Other Diseases:

_____

_____

_____

_____

_____

_____

ORC Medical Consultation Form: Children

Mother's Disease History (Including His Parents)

☐ ADHD ☐ ASD ☐ Diabetes ☐ Hypertension ☐ MS ☐ Celiac ☐ Heart Disease

☐ Stroke ☐ ALS ☐ Asthma ☐ Cancer ☐ Depression ☐ Cholesterol ☐ Miscarriage

☐ Birth Defects

Mother's Other Diseases:

_____

_____

_____

_____

_____

_____

Has the Mother had any abortions? _____

ORC Medical Consultation Form: Children

Pregnancy Questions

Pregnancy Sugar Test ☐ Yes / ☐ No / ☐ NA

Vaccines in Pregnancy: ☐ Diphtheria ☐ Pertussis ☐ Tetanus ☐ Influenza ☐ None ☐ Unsure

Child Birth Type:

☐ Natural Full-Term ☐ Natural Late-Term ☐ C-Section Emergency ☐ Foceps ☐ Epidural

☐ Natural Early Term ☐ C-Section Scheduled ☐ Midwife at Home ☐ Vacuum ☐ Local Anesthesia

☐ Induction

Pregnancy Feeding

☐ Breast ☐ Formula ☐ Breast and Formula

Pregnancy Details

_____

_____

_____

_____

_____

_____

Color at Birth: ☐ Dark Red ☐ Red ☐ Purple ☐ Blue ☐ Yellowish ☐ Pink

APGAR Score: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Resuscitation: ☐ Y ☐ N Malformation: ☐ Y ☐ N Jaundice: ☐ Y ☐ N Insta-Cry? ☐ Y ☐ N Trauma: ☐ Y ☐ N

Additional Info about Birth to 1 year old:

_____

_____

_____

_____

_____

_____

ORC Medical Consultation Form: Children

Developmental Questions

What age did the child:

Sitting Age? _____ Crawling Age? ____ Walking Age? ____ Smiling Age? ____ Babbling Age? ____

Clapping Age? ____ Sight Age? ____ Hearing Age? ____ Social Age? ____ Speech Age? ____

Number of words at age 1? ____ Number of words at age 2? ____

Child has a Diagnosis?

____ ADHD ____ PDD ____ CP ____ ASD

____ Speech Delay ____ Developmental Delay ____ Epilepsy ____ Other

Other Info?

_____
_____
_____
_____
_____
_____

ORC Medical Consultation Form: Children

Prescribed Medications/Supplements: (Enter Name, Dosage, & Frequency)

Prescribed Medications/Supplements: _____
Prescribed Medications/Supplements: _____
Prescribed Medications/Supplements: _____
Prescribed Medications/Supplements: _____
Prescribed Medications/Supplements: _____
Prescribed Medications/Supplements: _____
Prescribed Medications/Supplements: _____
Prescribed Medications/Supplements: _____
Additional Meds/Ect. _____
_____
_____
_____
_____
_____
_____

Medical/Surgical/Disease (List Disease, Age, and Treatment/Medication Used)

Medical/Surgical/Disease: _____
Medical/Surgical/Disease: _____
Medical/Surgical/Disease: _____
Medical/Surgical/Disease: _____
Medical/Surgical/Disease: _____
Medical/Surgical/Disease: _____
Medical/Surgical/Disease: _____
Additional Info: _____
_____
_____
_____
_____
_____
_____

Child's Medical Tests Completed:

☐ Allergy ☐ Genetics ☐ Gut Biome ☐ Stool ☐ Parasites ☐ Amino Acids

☐ OAT ☐ NutrEval ☐ Cunningham Panel ☐ Heavy Metal Hair ☐ Heavy Metal Blood ☐ Lyme

☐ MRI ☐ Neurohormone ☐ V Panel IgG/IvG ☐ CAT Scan ☐ EEG 24/48 hour ☐ Neurohormone

☐ Comp. Urine Element ☐ Heavy Metal Urine

ORC Medical Consultation Form: Children

Child's Allergy (List Allergy, Reaction, and any medication to treat you have used)

Child's Allergy: _____
Child's Allergy: _____
Child's Allergy: _____
Child's Allergy: _____
Child's Allergy: _____
Child's Allergy: _____
Child's Allergy: _____
Child's Allergy: _____
Additional Info_____
_____
_____
_____
_____
_____
_____

Child Details: _____
_____
_____
_____
_____
_____
_____

Child's Current Condition: _____
_____
_____
_____
_____
_____
_____

ORC Medical Consultation Form: Children

Behavior Questions:

Child's Stimming Today:

☐ Flaps Hands/Arms ☐ Spins Body ☐ Finger Licking ☐ Verbal Stims

Child's Eye Contact:

☐ Good ☐ Poor ☐ Improved

Child's Mood/OCD Today?

☐ Line Stacks Toys ☐ Moody ☐ Frustrated Easily ☐ Stressed Easily ☐ Anxiety ☐ Spins Objects

Child's Attention Today?

☐ Good ☐ Poor ☐ Moderate ☐ Associated with Hyperactivity

Child's Self Injury Today?

☐ Self Hitting ☐ Self Biting ☐ Bangs Head ☐ Aggression ☐ Other

Child's Muscle Tone Today?

☐ Good ☐ Poor ☐ Hypotonic ☐ Easily Fatigued

Child's Verbal Skills Today?

☐ Good ☐ Poor ☐ Echo ☐ Mumbles ☐ Gotten Worse

Child's Gross Motor Skills Today?

☐ Jumping ☐ Running ☐ Stairs ☐ Bike ☐ Good ☐ Poor

Child's Education/Therapy(s)

☐ Normal School ☐ Special EDU Program ☐ Private Center ☐ ABA (In-Home/Center)
☐ Speech Therapy ☐ Occupational Therapies ☐ Physical Therapies ☐ Other

Education/Therapy Comments: _____

_____

_____

_____

_____

Child's Sleep:

☐ Good Overall ☐ Bad Overall ☐ Night Awakenings ☐ Cry During Sleep

☐ Laughs During Sleep ☐ Falls Off Bed ☐ Moves a Lot in Sleep ☐ Nightmares

ORC Medical Consultation Form: Children

Vaccination Questions

Child's Vaccines:

☐ On Time ☐ Delayed ☐ Missing Vaccines ☐ Extra Vaccines

Vaccine Comments: _____

Additional Information:

Final Comments: _____

FOOD, MOOD, POOP JOURNAL

OXFORD RECOVERY CENTER

Instructions:

In the space below please ***record all the food and beverages you take over a period of 5 days*** *along with your mood and the quality of your stool. This will give us insight into their digestive function as well as their nutritional status.*

When filling this out, please ***do not alter your intake in any way****. It's important to be as honest as possible about what is typical for you.*

Be as detailed as you can when recording the food in terms of type and amount. *For example, instead of saying "cereal", saying "1/2 cup of raisin bran with 1/2 cup whole milk" is much more helpful.*

Don't forget to write down all the little ***extras*** *- added butter on potatoes, mayonnaise on sandwiches, milk with cereal etc.*

Eyeballing amounts is fine... don't worry too much about being exact.

This should not be burdensome or stressful. It will help guide our recommendations. The more detail you can provide the better analysis we can offer.

Words for poop	Words for mood	Sleep
Soft	Grumpy	Weird
Runny	Hyper	Couldn't calm down
Brown	Tantrums	Kept waking up
Green	Clingy	Lethargic
Yellow	Whiney	Exhausted
Hard	Angry	Aggressive at night
Pebble-y	Aggressive	Rising at 4-5am
Food in it	Anxious	Nightmares
Mucous-y	Careless/clumsy	Bed wetting

Name:_____

Date:_____ M T W TH F

(Cirlce one)

Time	Food/Drink	Mood	Poop
Morning			
Mid morning			
Lunch			
Mid afternoon			
Dinner			
Evening			
Sleep			

Record total of daily water intake: _____

Name:_____

Date:_____ M T W TH F

(Cirlce one)

Time	Food/Drink	Mood	Poop
Morning			
Mid morning			
Lunch			
Mid afternoon			
Dinner			
Evening			
Sleep			

Record total of daily water intake: _____

Name:_____

Date:_____ M T W TH F

(Cirlce one)

Time	Food/Drink	Mood	Poop
Morning			
Mid morning			
Lunch			
Mid afternoon			
Dinner			
Evening			
Sleep			

Record total of daily water intake: _____

Name:_____

Date:_____ M T W TH F

(Cirlce one)

Time	Food/Drink	Mood	Poop
Morning			
Mid morning			
Lunch			
Mid afternoon			
Dinner			
Evening			
Sleep			

Record total of daily water intake: _____

Name:_____

Date:_____ M T W TH F

(Cirlce one)

Time	Food/Drink	Mood	Poop
Morning			
Mid morning			
Lunch			
Mid afternoon			
Dinner			
Evening			
Sleep			

Record total of daily water intake: _____