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PERSONAL INFORMATION

Date Questionnaire Received : ___ /__ / Date of Initial Consultation: ___ / ___ / 2026

[The above line is for office use only]

Child's Name: First: Jeremy Last: Lor Middle Initial: K

Parent(s) Name(s): Mother : Nenita Yang

Father : Yia Lor

Address: Street: 30264 E 83rd st S

State/Country: OK/US City: Broken Arrow Phone: (479-799-8594)

Work Phone: ( ) Cell: (479-799-7685)

E-MAIL: yeahlauj@gmail.com Fax: ( )

Child's birth date: Month: 03 Day: 13 Year: 2018 Child's Sex (Circle One)-: Female Male

Social Security Number (Optional): Child's weight : 21 kg height: 121.3 cm

Primary Care Physician: Name: City:

State: Zip: Phone #: ( ) Cell #:( )

Health insurance: ID No.:

Referred by:

Siblings: 2 Name: Sophie N. Lor, Liam C. Lor Sex: (Circle One)

Male. Female Month: 03 Day: 13 Year: 2018

Male. Female Month: 01 Day: 08 Year: 2021

Male. Female Month: Day: Year:

Parent's occupation(s):

Mother: Registered Nurse

Father: IT Analyst

Note: Please bring a fairly recent picture of your child that we may keep plus a baby picture that we may look at and return.

Diagnoses or explanation given to you about your child (Date of diagnoses)

Autism Lvl 2

Other problems to be addressed:

PERSONAL INFORMATION (Continued)

Describe your child to me, including his her history. Please be as detailed as possible.

Jeremy was conceived through IVF. He is a twin born via cesarean section. He was born at 36 weeks and had respiratory distress. He was admitted to the NICU and stayed for 10 days. Jeremy was breastfed and formula fed. As a baby, he met all his milestones on time.

- **When did you first notice your child's problem?**

We noticed his problem around 15 months old.

- **What did you first notice?**

Lack of eye contact and not responding to his name.

- **Was the onset of your child's problem sudden or gradual?**

Sudden

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

He did not have any illnesses around that time.

Please make notation of any other event, action, etc. that you think may have some bearing/ relationship to your child's condition. Again, be as 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 problem(s):

CHILD'S MEDICAL HISTORY

PRIMARY DOCTOR (S)

Name	Phone Numbers	City

THERAPIST(S)

Speech - Occupational - Physical -Other

Name	Type of Therapist	Phone	City		Hours Week
	ABA				
	Speech				
	Occupational				

Other Care-Givers

Name	Phone	City	Date of Evaluation
Specialist (s)			
Naturopath (s) Homeopath (s)			
Nutritionist			
Other			

PRENATAL HISTORY

Maternal age at delivery; 29 yrs old
Illnesses during pregnancy: none
Medication during pregnancy: Prenatal Vitamin

Other complications during pregnancy;
none
Complications during labor and delivery: none
Mode of delivery: C-section vaginal? If C-section, explain why:
C-Section, large discordance weight between the twins.
If vaginal delivery, did you have forceps/vacuum?
Medication(s) during labor and delivery?
Full term premature? premature How many weeks? 36 weeks
Complications after delivery? Respiratory distress
Medications given to child dining hospital stay?

DIETARY/NUTRITIONAL HISTORY

Breast-fed? : Yes If yes, how long? 3 months **Bottle-fed? Brand of formula? Enfamil and Similac_____ Begun at what age? Birth** **For how long? 12 months** **Foods? Begun at what age? 6 months First foods?** Baby Food in jar
Whole milk? Yes **If yes, begun at what age? 12 Months** **Known allergies to food? (Please list): None**
Suspected sensitivities to foods? (Please list): None

Food cravings? (Please list): Salty

Foods my child eats: (Place √ in appropriate column)

Food	Daily	3-5 times/ week	1-3times/ week	Never or almost never	Used to eat a lot hut no longer does
Cookies:				√	
Candy:			√		
Sweet foods:				√	
Caffeine (soda, tea, etc.):			√		
Chocolate:				√	
Milk: Whole:					
2%:					
1%:					
Skim:					
Cheese:					
Ice Cream:					
Salty Foods:					
Meat:					
Pasta:					
Bread: White:					
Wheat:					
Other: integral				√	

DIETARY/NUTRITIONAL HISTORY (Continued)

Check (√) the most appropriate description below of your child's diet;

- **Mostly baby foods**
- **Mostly carbohydrates (bread, pasta, etc.) √**
- **Mostly dairy (milk, cheese, etc.)**
- **Mostly meat √**
- **Mostly vegetarian (vegetables, fruits, grains, etc.)**
- **Other. Describe: Pasta, milk, chocolate, stews, soups, pizzas, fruit.**

Please describe your child's stool pattern (Examples; daily, foul, large, mushy, etc.);
Daily-soft, formed
Please list the foods and beverages normally consumed by your child for three typical days:
DAY 1
Breakfast;
Morning snack(s): potato chips, bread
Lunch: chicken nuggets
Afternoon snack(s): potato chips
Dinner: white rice, meat
DAY 2
Breakfast:
Morning snack(s): potato chips, bread
Lunch: corn dog
Afternoon snack(s): potato chips
Dinner: white rice, meat
Other:
DAY 3
Breakfast:
Morning snack(s): potato chips, bread
Lunch: chicken nuggets
Afternoon snack(s): potato chips
Dinner: white rice, meat

FAMILY HISTORY

List any allergies, major illnesses, genetic diseases or problems (diabetis, astma, cancer, high blood pressure, heart disease, neurologic disease ?) for each of the following family members of your child:
Mother: none
Father: none
Siblings: none

Maternal Grandparents: high blood pressure (maternal grandma)

Paternal Grandparents: high blood pressure (paternal grandpa)

Others: None.

SOCIAL HISTORY

Who lives in the home with your child: Mother, Father, twin sister, younger brother

Are any children in your family adopted? none

Pets in the house: dog, fish

Caregivers besides parents: none

List the people most important in your child's life: mother, father, siblings, great aunt/great uncle

Recent changes, losses, births, deaths, divorce, remarriage or moves: none

Recent travel: none

Child's response to these changes:

Is your child involved in any sports, music or other activities? Please describe: none

How does your child interact with other children? Prefers to play by himself

- **With adults: likes to sit and snuggle with select adults**
- **What makes your child happy? Being outdoors, music, videos, tv shows**
- **Sad? When he is not allowed to do what he wants**
- **Angry? When other kids get into his space**
- **Stressed? Not being able to communicate needs**
- **How do you as a parent deal with these emotions in your child? Hug him, distractions, talk to him**

ENVIRONMENTAL HISTORY

Do you, your child, or any family members practice any relaxation/stress management techniques? Please describe;

Deep breathing exercises

CIRCLE THE APPROPRIATE ANSWERS TO THE FOLLOWING QUESTIONS:

Location of home: Suburban Other (describe): Suburban
Water: City Purification system: No If yes, please describe:
Type of heat: Electric If other, please describe:
Do you live near: Power lines Avoids/industrial areas/Water? no
If you live near water, list type: Swamp/river/ocean/other If other, please describe:
Does your home have a lot of: pillows, upholstery, stuffed animals If, so, please give details:
Describe your child's bedroom (Circle appropriate response):
Bedding: Synthetic/down/feather? Mattress cover: Yes/No Crib/Junior Bed /Adult Bed
Flooring: Caipet: Wall-to-wall or area rug? Wood? Glued down? Synthetic pad?
Window treatment: Shades/blinds/thin curtain/heavy curtain/valance/other? If other, describe:
Other items in room including furniture, toys, stuffed animals: wooden drawer, tv, stuff animals
Flooring in other rooms:
Child's bathroom? tiles
Living room? Vinyl wood flooring
Family room/play room? Vinyl wood flooring
Is your child sensitive to or bothered by any of the following? Please check where appropriate and list specific products if possible:
Perfumes/cosmetics? Mold?
Cleaning products? Pollens grasses?
Soaps? Animals (dander)?
Detergents? Gasoline?
Dust? Paint?
Other?
Please list known allergies: none

DEVELOPMENTAL HISTORY

Please list age when following skills were mastered and any problems associated with these skills:

First words: (Age:) 1 year
Phrases or sentences: (Age:) 4 years old
Pulling to stand: (Age:) 9 months
Walking: (Age:) 11 months
Sitting up: (Age:) 6 months
Crawling: (Age:) 9 months
Running: (Age:) 14 months
Walking up/down steps without help: (Age:) 16 months
Jumping: (Age:) months
Learned to pedal: (Age:) 5 years old
Rode 2-wheel bicycle: (Age:)
Put on clothing: (Age:) 7 years old

MEDICAL HISTORY
Please mark which tests have been done and provide date and results

Evaluation Test	Date	
24 Hour Amino Acids		
Amino Acid Screen		
Blood Chemistry Screen		
Blood Count (CBC)		
Blood Test—Fatty Acid		
Blood Test—Food Allergies		
CT Scan (specify area)		
Colonoscopy		
DMSA Loading Study		
EEG		
Folic Acid		
Fragile X Chromosome Study		
Hair Elements		
Hearing Test		
Immune Profile		
Intestinal Permeability		
Liver Detox Profile		
MRI (specify area)		
Organic Acids—fungal bacteria		
Organic Acids—Metabolism		
Brain SPECT Scan		
MEDICAL HISTORY		
Please mark which tests have been done and provide date and results		

Evaluation Test	Date	Results (normal, abnormal or unsure)
Pinworm Prep		
Plasma Amino Acids		
Plasma or Serum Zinc		
RBC Elements		
Serum Ferritin (Iron stores)		
Serum Methylmalonic Acid		
Serum Vitamin A		
Small Bowel Biopsy		
Stool Culture		
Stool Parasites		
Thyroid Profile		
Uric Acid (blood or urine)		
Urinary Peptides		
Urine Elements		
Urine KryptopyiTole		
X-Rays (specify)		
Zink (blood)		
Lithium (blood)		
Ammonia (blood)		
Other:		

MEDICAL HISTORY (Continued)

Major surgeries - Please describe and give dates:

SURGERY	DATE(S)	RESULTS
Major injuries - Please describe and give dates:		
INJURY	**DATE(S)**	**RESULTS**
Illnesses - Please list appropriate dates and any complications:		
ILLNESS	**DATE(S)**	**COMPLICATIONS**
Ear infections		
Sinus infectious		
Bronchitis		
Pneumonia		
Thrush		
Chicken Pox		
Seizures		
Mono		
Other: (Please list):		

Immunizations

Please indicate date and any reactions for those immunizations that your child has received. If exact date isn't known, please approximate. "Bowel" refers to any bowel symptom such as diarrhea. "Swelling" refers to the site of the injection.

Diptkei in Pertussis Tetanus	Date	Bowel	Swelling	Crying	Seizure	Irritable	Fever	Other

DPT 1								
DPT 2								
DPT 3								
DPT 4								
DPT 5								
Adult DiptherkTetanus								
Peadiatric Diptheris/Tetanus								
H Influenza Type B	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**Other**
Hibl								
Hib 2								
Hib 3								
Hib 4								
Polio (circle oral or Injection.)	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**Other**
OPV 1 Iuiection 1								
OPV 2/Injection 2								
OPV 3/Injection 3								
OPV 4/ Injection 4								
OPV 5/ **Injection** 5								
Measle s/JVIumps/Rubella	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**Other**
mmr1								
mmr:								
Hepatitis b V accine	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**Other**
HBV1								
HBV2								
HBV3								
Prevnar (pnemococcal)								
Miscellaneous	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**Other**
Varivax (chicken Pox)								
Troe Test								
Flu Vaccine	**02/17/**							
Other								

Medication or Supplements

Please check (√) substances takeu now or iu the past and mark the appropriate reaction

now	past	Medication or Supplement	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments
		Clozaril (clozapine)							
		Haldol							
		Prohxni							
		Risperdal							
		Seroquel							
		Stelazine							

		Thorazine							
		Zyprexa							
		Clonidine							
		Cogentin							
		Deanol (deaner, DMAE)							
		Dextromethorphan							
		Lithium							
		Naltrexone							
		Anafianil							
		Depakene for behavior							
		Depakene for seizures							
		Depakote for behavior							
		Depakote for seizures							
		Dilantin							
		Felbatol							
		Gabitril							
		Keppra							
		Klonopin							
		Lamictal							
		Luvox							
		Mysoline							

Medication or Supplements

Please check (√) substances taken now or in the past and mark the appropriate reaction

now	past	Medication or Supplement	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments
		Neurontin							
		Paxil							
		Phenobarbital							
		Stratena							
		Tegretol							
		Topamax							
		Trileptal							
		Valium							
		Zarotin							
		Zonegran							

		Adderall							
		Prozac							
		Zoloft							
		Amphetamine							
		Cylert							
		Dexedrme, dextroamphetamine							
		Fenfluramine							
		Focalir.							
		Ritalin							
		Buspar							
		Chloral hydrate							
		Valium							
		Desipramine							
		Mallaril							
		Tofranil							
		Klonapin							

Medication or Supplements

Please check (√) substances taken now or in the past and mark the appropriate reaction

now	past	Medication or Supplement	Very Good	Good	None	Bad	Very Bud	Bad then Good	Comments
		Benadryl		√					
		Clantin							
		Singulair							
	√	**Zyrtec**		√					
		Digestive Flora							
		Bactrim (septra)							
		Diflucan							
		Humatin							
		Lamisil							
		Nizoral							
		Nystatin							
		Saccharomyces, boulardii							
		Sporonax							
		Transfer Factor (oral). Colostrum							
		Yodoxin							
		Digestion							

		Bethenecol							
		Digestive enzymes							
		Pepsid							
		Peptidase enzymes							
		Probiotics							
		DMPS							
		DMSA							
		Reduced glutathione (TTFD)							
		Reduced glutathione (IV)							
		Reduced glutathione (oral)							
		Folic Acid							
		Melatonin							

Medication or Supplements

Please check (√) substances taken now or in the past and mark the appropriate reaction

now	past	Medication or Supplement	Very Good	Good	None	Bad	Very Bad	Bad theu Good	Comments
		Multivitamin (Specifiy)							
		Vitamin A							
		Vitamin C							
		Vitamin B3 (Niacin)							
		Vitamin B6							
		5 HTP							
		Alpha Keto Glutarate (AKG)							
		Amino Acid Mix							
		Deanol							
		Dimethylglycine (DMG)							
		GABA							
		Glutamine							
		SAMe (SAM, Samyr)							
		TMG							
		Taurine							
		Tryptophan							

		Tyrosine							
		Calcium							
		Magnesium							
		Manganese							
		Selenium							
		Zinc							
		Human Growth Factor							
		IV Immune globulin							
		Kutapressin							

Medication or Supplements

Please check (√) substances taken now or in the past and mark the appropriate reaction

now	past	Medication or Supplement	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments
		Oral Immune globulin							
		Secretin (IV)							
		Secretin (transdermal sublingual)							
		Steroids (oral)							
		Steroids (topical)							
		DHA rich oils							
		EPA rich oils							
		Omega 6 rich oils							
		Cod liver oil							
		Flax oil							
		Other							
		Activated Charcoal							
		AlkaGold							
		Carbatrol							
		Tranxene							
		Famvir							
		Valtrex							
		Zovirax							
		OTHER:							

Therapies and Diets

Please indicate therapies and diets you have used and/or are using.

now	past	Therapies	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments
		Acupuncture							
		Auditory Training							
		Craniosacral							
		Energy Therapy (Specify)							
		Homeopathy							
		Lovaas (ABA)							
		Naturopathy							
		Neural Therapy							
		Occupational Therapy							
		Osteopathy							
		Physical Therapy							
		Sensory Diet							
		Speech Therapy							
		Hyperbaric Oxygen Theraphy							Number of sessions:
		Genetic By-pass							
		Biofilm treatment							
		Other:							
		Diets							
		Gluten Free							
		Casern Free							
		Yeast Free							
		High Protein/ Low Carb							
		Salicylate Free							
		Low Phenolics							
		IgG reactive food avoidance							
		Specific Carbohydrate Diet							
		Other:							

SIGNS AND SYMPTOMS

Please check (√) any signs/symptoms your child may demonstrate and note duration and details if appropriate:

No.	Description	Mild	Moderate	Severe	Duration	Unique details

1	Stimming (repetitive actions or movements)					
2	Rocking					
3	Head banging					
4	Self-mutilation					
5	Nail biting					
6	Hand/arm biting					
7	Nail/skin picking					
S	Aggressiveness (hitting, kicking, biting others)					
9	Mood swings					
10	Irritability/tantrums					
11	Fears/anxieties					
12	Hyperactivity					
13	Inability to concentrate/focus					
14	Always fidgety in his/her seat					
15	Impulsive					
16	Breath holding					
17	Dizziness					
18	Seizures					
19	Poor coordination					
20	Problems with buttons, ties, snaps or zippers					
21	Processing problems - visual, motor, language, etc.					
22	Problems with social interactions					
23	Sensitive to crowds					
24	Trouble remembering					
25	Low self-esteem					
26	Fatigue					
27	Cold hands/feet					

SIGNS AND SYMPTOMS (Continued)

Please check (√) any signs/symptoms your child may demonstrate and note duration and details if appropriate:

No.	Description	Mild	Moderate	Severe	Duration	Unique details
28	Cold intolerance					
29	Heat intolerance					
30	Recurrent/chronic fever					

31	Flushing					
32	Difficulty falling to sleep					
33	Night waking					
34	Nightmares					
35	Difficult)' waking					
36	Bed wetting, soiling					
37	Day time wetting/soiling					
38	Numbness/tingling in hands/feet					
39	Headache					
40	Blinking					
41	Tics					
41	Eye discharge					
43	Dark circles'puffuiess under eyes					
44	Night-blindness in child/family					
45	Congestion					
46	Dripping nose					
47	Sensitivity to bright lights					
48	Earaches					
49	Ringing in ears					
50	Sensitive to sounds/noise					
51	Bad breath					
52	Nose bleeds					
53	Acute sense of smell					
54	Sore throats					
55	Hoarseness					
56	Cough					

SIGNS AND SYMPTOMS (Continued)

Please check (√) any signs/symptoms your child may demonstrate and note duration and details if appropriate:

No.	Description	Mild	Moderate	Severe	Duration	Unique details
57	Wheezing					
58	Geographic tongue					
59	Swollen gums					
60	Canker sores					
61	Dry lips/mouth					
62	Diarrhea					
63	Constipation					

64	Bloating					
65	Passing gas					
66	Belching					
67	Stomach ache					
68	Refusal to eat					
69	Sensitive to texture of food					
70	Difficulty swallowing					
71	Food Craving					
72	Grinding teeth					
73	Mucous/blood in stools					
74	Anal itching					
75	Calf cramps					
76	Other muscle cramps/spasms					
77	Tremors					
78	Weakness					
79	Stiffness					
80	Eczema					
81	Psoriasis					
82	Hives					
83	Acne					
84	Seborrhea (cradle cap)					
85	Other rashes					

SIGNS AND SYMPTOMS (Continued)

No.	Description	Mild	Moderate	Severe	Duration	Unique Details
86	Easy bruising					
87	Itchy scalp					
88	Dry skin					
89	Oily skin					
90	Pale skin					
91	Sensitivity to insect bites					
92	Sensitive to texture of clothes					
93	Cracking/peeling Lauds					
94	Cracking peeling feet					

95	**Strong body odor**					
96	**Strong urine odor**					
97	**Strong stool odor**					
98	**Soft nails**					
99	**Thickening of nails**					
100	**Ridges/pitting of nails**					
101	**White spots/lines on nails**					
102	**Brittle nails**					
103	**Any OCD (obsessive com-pulsive) behaviors**					
104	**Strategies to put pressure On abdomen**					
105	**Reflux**					
106	**Persistent colic**					
107	**Toe walking**					

SIGNS AND SYMPTOMS (Continued)
Describe any other symptoms you would like me to know about your child:
List any other history, pertinent thoughts or questions that you want to address:

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