Welcome to Sletten Wellness Medical Center. We are honored and excited to be partnering with you in your medical care. For optimal time efficiency and productivity, it is imperative that you complete the New Patient Intake Form before your initial visit. Upon receiving the Intake Form, we will call you to schedule an appointment. You may send the form via mail, fax or personal delivery.

We also strongly recommend that every effort be made for both parents and/or primary care givers of your child to be present at the initial visit. Many interventions that affect the entire household will be discussed, and good communication and cooperation are essential for success and peace at home.

If you have not already tried the Casein-free (dairy-free) and/or Gluten-free (wheat, barley, rye, oat) diets, then we highly recommend that you try this diligently before your first visit. It is one of the earliest and simplest steps in the DAN! Approach. However, you will not be turned away if you have not yet done so.

Also, please bring to your appointment the following:

- ☐ All Laboratory Tests with Results
- ☐ Any Special Imaging Study (e.g., X-Ray, MRI)
- ☐ All Medical Consultation Reports (e.g., Neurologist)
- ☐ All Developmental Assessments
- ☐ Complete Immunization Records
- ☐ Patient Insurance Card (for Laboratory Billings)

In order to have longer and higher quality interactions with our patients, Sletten Wellness is a fee-for-service practice. You will be expected to pay your bill in full at the time that you receive services. We accept Visa, MasterCard, check or cash.

We will provide you with an accurate superbill with a correct service level and diagnosis coding. You may submit this to your insurance company for reimbursement. If your insurance company requests, we will provide you with any clinical documentation at no charge so that your reimbursement is fair and appropriate. We will make every effort to assist you in this process.

Your initial time investment in compiling these records will greatly enhance the value of our time together and lead to a clearer strategy for treatment. Thank you for your diligence and commitment for greater health and we look forward to seeing you at Sletten Wellness Medical Center.

"The journey of a thousand miles begins with one step."

64 N. Brent St., Suite A · Ventura, CA 93003
Phone: (805) 643-7902 · Fax: (805) 643-7863 · Email: info@slettenwellness.com

Sletten Wellness
INTEGRATIVE AND SPORTS MEDICINE

NEW PATIENT QUESTIONNAIRE - Pediatric - ASD

Date:________________ Email address(es): ________________________________
Child's Full Name:________________________________ Sex: Male ☐ Female ☐
Nick name:_______________________________ Birth date: ___________________

Primary Address:
Street Address:____
City:__________________________ State:________________ Zip:_______________

Parent(s):
Name:_______________________________ Age:________ Birth date:___________
Name:_______________________________ Age:________ Birth date:___________

Telephone:
Home:___________________ Mobile:_________________ Office:________________

Sibling(s):
Name: _____________________________ Age:________ Birth date:___________
Name: _____________________________ Age:________ Birth date:___________
Name: _____________________________ Age:________ Birth date:___________
Others living in home: ____
Pets: ____
Religion: ____
List 3 most important sources of support: (e.g., family, friends, neighbors, etc.):
____

Primary Care Physician:
Name: ____
Address:____
Phone:________________________________ Fax:______________________________
Who should we contact in case of emergency?
Name:_______________________________ Phone:______________________________
Relationship: ____
How did you learn about us?____
____

Insurance Information:
Company Name:____
Address:____
Phone:______________________ Group or policy number: ___________________
Insured's name:____

Sletten Wellness
INTEGRATIVE AND SPORTS MEDICINE

MOTHER'S INFORMATION:

First name:____

Occupation:________________________ Years of Education:______________

Hobbies:____

Cigarettes (Number or packs/day):____________________________

Alcohol intake (What type and how much/day):______________________

Recreational drugs (Type and frequency):________________________

Allergies:____

Health problems: History of Allergy ☐, Asthma ☐, Auto-immune disorder ☐, Chronic Fatigue Syndrome/Fibromialgia ☐, Eating Disorder ☐, Herpes ☐, Lyme Disease ☐, MS ☐, Other ☐

If so, give date of diagnosis and treatments:

Medications:

Supplements:

Hospitalizations/Surgeries (Provide dates):

____

Amalgam Fillings: How many?__________________ When placed?____________

Dental work during pregnancy?__________________________________

Psychiatric Conditions:

Depression ☐, Psychosis ☐, Bipolar ☐, Anxiety ☐, Personality Disorder ☐, Learning Disabilities ☐, Obsessive Compulsive Disorder ☐

If so, give date of diagnosis and treatments:________________________

____

MATERNAL FAMILY HISTORY:

Allergy ☐, ADHD ☐, Asthma ☐, Alcoholism or other Addictions ☐, Autism ☐, Auto-immune/Rheumatologic Disorders ☐, Cancer ☐, Emotional or Psychiatric Disorders ☐, Genetic Diseases ☐, Heart Disease ☐, Learning disabilities ☐, Other ☐

If so, state relationship to child:________________________________

____

Sletten Wellness
INTEGRATIVE AND SPORTS MEDICINE

PRENATAL HISTORY: Maternal Age at delivery:___________________________
Vaccinations during or 2 years before pregnancy?___________________________
Medications and supplements during pregnancy?___________________________
Rh Neg ☐, Pos ☐, Rho-gam ☐
Complications during pregnancy?____
Mode of delivery: Vaginal ☐ or C-section ☐
If C-section, explain:____
If vaginal delivery, did you have forceps/vacuum/breech, shoulder distocia?
____
Medication(s) during delivery, including epidural:
____
Full term ☐ or premature ☐ If premature, how many weeks?________________
Complications after delivery:____
Medications/Vaccinations given to child after delivery:_________________________
Breast feeding:
Less than 1 month ☐, 1-6 months ☐, 6-18 months ☐, 1 ½ to 3 yrs ☐, >3 yrs ☐
Problems with breast feeding:____
Describe fish consumption/painting/construction/pesticide exposure during pregnancy and breast feeding:

FATHER'S INFORMATION:
Name:____
Occupation:___________________________ Years of Education:________________
Hobbies:____
Cigarettes (Number or packs/day):____
Alcohol intake (What type and how much/day):______________________________
Recreational drugs (Type and frequency): __________________________________
Allergies: ____
Health problems: History of Allergy ☐, Asthma ☐, Auto-immune disorder ☐, Chronic Fatigue Syndrome/Fibromialgia ☐, Eating Disorder ☐, Herpes ☐, Lyme Disease ☐, MS ☐, Other ☐
If so, give date of diagnosis and treatments:

Sletten Wellness
INTEGRATIVE AND SPORTS MEDICINE

FATHER'S INFORMATION - Continued:

Medications:

Supplements:

Hospitalizations/Surgeries (Provide dates):

____

Amalgam Fillings: How many?____________ When placed?_________________

Psychiatric Conditions:

Anxiety ☐, Bipolar ☐, Depression ☐, Learning Disabilities ☐,
Obsessive Compulsive Disorder ☐, Personality Disorder ☐, Psychosis ☐,
If so, give date of diagnosis and treatments:

____

PATERNAL FAMILY HISTORY: Autism ☐, ADHD ☐, Asthma ☐, Allergy ☐, Cancer ☐, Heart Disease ☐, Auto-immune/Rheumatologic Disorders ☐, Learning disabilities ☐, Genetic Diseases ☐, Emotional or Psychiatric Disorders ☐, Alcoholism ☐ or other Addictions ☐, Other ☐.
If so, state relationship to child (e.g., Cousin, Uncle or other):

____

INFORMATION About Your Child

What diagnoses has your child been given and at what age?

Who gave you the diagnosis? ______________________________

Describe your child to me and tell his/her story. Be as detailed as possible.

Sletten Wellness
INTEGRATIVE AND SPORTS MEDICINE

INFORMATION About Your Child – Continued**:**

At what age did you first notice neurodevelopmental problems with your child?

____

What did you notice?____

____

Did you notice a decline in function following a vaccination (MMR, DTaP, Polio, Chicken Pox, etc.)? ____

____

Colic? ☐ Describe:____

Did your child lose spoken words? Describe:_________________________

____

Did your child lose social and/or motor skills? Describe:_______________

____

____

Was the onset gradual or sudden? _______________________________

____

Was there any illness or event that preceded the problem? Do not hesitate to mention anything, no matter how insignificant it seems._______________

____

____

Has your child had antibiotics? What age 1st time, diagnosis, number of courses in lifetime, etc:____

____

____

Known Allergies? ☐ Medicines ☐, Foods ☐, Environment ☐

How diagnosed?____

____

____

Asthma? ☐ Describe symptoms, date of onset, treatments.______________

____

Milk intolerance or craving? ☐ Describe:____________________________

Have you started or tried any dietary interventions? Please list:

____

Does your child have any sensory issues (Light, sound, tactile, deep pressure, oral, etc)?____

Does your child have sleep problems? ☐ Describe sleep patterns and any treatments: ____

Sletten Wellness
INTEGRATIVE AND SPORTS MEDICINE

INFORMATION About Your Child – Continued:

How does your child interact with:

Family?____

Peers?____

Caregivers?____

Pets?____

What is his/her closest personal bond? Favorite object? Favorite activity? Greatest fear?____

____

____

Any unusual fears, phobias, attachments?____

Does your child initiate play?____

How would you describe his/her:

Imagination:____

Affection: ____

Alertness: ____

Sense of humor:____

Please check (√) any behaviors that may apply:

- ☐ Inappropriate Giggle
- ☐ Spacey/Foggy
- ☐ Night Waking
- ☐ Hyperactive
- ☐ Toe Walking
- ☐ Hand Flapping
- ☐ Sugar Craving
- ☐ Anus Red Ring
- ☐ Ring Worm
- ☐ Cradle Cap
- ☐ Bedwetting
- ☐ Fatigue
- ☐ Irritability
- ☐ Loose Stools
- ☐ Headache
- ☐ Head Banging
- ☐ Fatigue
- ☐ Aggressive
- ☐ Violent
- ☐ Foul Smelling Stools
- ☐ Hypoactive
- ☐ Recurrent Strep Infection
- ☐ OCD
- ☐ Verbal Stimming
- ☐ Echolalia
- ☐ ADD/ADHD
- ☐ Tics
- ☐ Mood Changes
- ☐ Tantrums
- ☐ Poor Eye Contact
- ☐ Poor Muscle Tone
- ☐ Seizures
- ☐ Cold Sores
- ☐ Warts
- ☐ Socially Inappropriate
- ☐ Other
- ☐ Itchy Buttocks
- ☐ Fecal Smearing
- ☐ Teeth Grinding
- ☐ PICA
- ☐ Insatiable Appetite
- ☐ Picking
- ☐ Biting
- ☐ Bloated Belly

What makes your child:

Happy? ____

Sad? ____

Angry?____

Stressed?____

INFORMATION About Your Child – Continued:

How do you as parents and the family deal with the emotions of your child?
____
____

How is his/her eye contact?______________________________

Does your child enjoy vigorous physical activity? Describe frequency, duration, and intensity: ______________________________
____

Does your child require special help with activities of daily living? (Dressing, feeding, bathing, etc)?______________________________

Describe any special school programs that your child is in:______________
____

Academic performance? ______________________________
____

Learning disorders or delays? ______________________________
____

Disruptive or antisocial behavior in public?______________________
____

Is your child potty trained: Yes ☐, NO ☐

Describe bowel movements: ______________________________

Frequency?______________________________

Texture? (hard ☐, mushy ☐, sticky ☐, runny ☐) ______________

Color? (Light ☐, dark ☐) ______________________

Odor? (Normal ☐, pungent ☐)______________________

Is there abdominal pain/discomfort or does the abdomen seem bloated?
NO ☐, YES ☐ Describe:______________________________

Any problems with vomiting or reflux? NO ☐, YES ☐ Describe:
____

Any skin problems? (Eczema, diaper rashes, etc.) NO ☐, YES ☐ Describe:
____

Ear, nose and throat problems? (Thrush ☐, cavities ☐, tonsillitis ☐, colds ☐, ear infections ☐, etc.) Describe:______________________________
____

Has hearing been tested? NO ☐, YES ☐ Results:______________________

Has your child had respiratory infections in the past? (Bronchitis ☐, Pneumonia ☐). Describe:______________________________
____

Sletten Wellness
INTEGRATIVE AND SPORTS MEDICINE

INFORMATION About Your Child - Continued

Has your child had any infectious diseases? (Chicken pox ☐, Meningitis ☐, Mono ☐, Herpes ☐, etc). Describe:______________________________________

____

Has your child ever had a seizure? NO ☐, YES ☐ If so, when was the 1st and most recent episode: ____

Does your child have any bone, joint or orthopedic problems? NO ☐, YES ☐
If so, list date and treatments:____

Has your child had any major injuries or surgeries? NO ☐, YES ☐ Date:_______

Does your child have any other medical problems?

List all medication that your child is currently taking. Dosage and Frequency.

List medications in the past: Improvement or Decline:

List all supplements that your child is taking. Dosage and Frequency.

DIETARY/NUTRITIONAL HISTORY

Breast-fed? NO ☐, YES ☐: If yes, how long?___________________________

Bottle-fed? NO ☐, YES ☐: If yes, brand of formula.______________________

Begun at what age?___________________For how long? _________________

Foods: Begun at what age?___________________

First foods: (Please list):

Milk? NO ☐, YES ☐: If yes, begun at what age? _________________________

Known allergies to food (Please list):

Suspected sensitivities to foods (Please list):

Food cravings (Please list):

DIETARY/NUTRITIONAL HISTORY - Continued

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

Food	Daily	3-5 times/ week	1-3 times/ week	Never or almost never	Used to eat a lot but no longer does
Cookies:	☐	☐	☐	☐	☐
Candy:	☐	☐	☐	☐	☐
Sweet foods:	☐	☐	☐	☐	☐
Caffeine (soda, tea, etc.):	☐	☐	☐	☐	☐
Chocolate:	☐	☐	☐	☐	☐
Milk: Type:__________	☐	☐	☐	☐	☐
Cheese:	☐	☐	☐	☐	☐
Ice Cream:	☐	☐	☐	☐	☐
Salty Foods:	☐	☐	☐	☐	☐
Meat:	☐	☐	☐	☐	☐
Pasta: Type:__________	☐	☐	☐	☐	☐
Bread: Type:__________	☐	☐	☐	☐	☐
Rice	☐	☐	☐	☐	☐
Potato	☐	☐	☐	☐	☐
Soy	☐	☐	☐	☐	☐
Corn	☐	☐	☐	☐	☐
Eggs	☐	☐	☐	☐	☐
Peanuts	☐	☐	☐	☐	☐

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:______________________________________

DIETARY/NUTRITIONAL HISTORY - Continued

Please list the foods and beverages normally consumed by your child for three typical days:

DAY 1	
Breakfast:	
Morning snack(s):	
Lunch:	
Afternoon snack(s):	
Dinner:	
Other:	
DAY 2	
Breakfast:	
Morning snack(s):	
Lunch:	
Afternoon snack(s):	
Dinner:	
Other:	
DAY 3	
Breakfast:	
Morning snack(s):	
Lunch:	
Afternoon snack(s):	
Dinner:	
Other:	

ENVIRONMENTAL HISTORY

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

____

____

CHECK "√" THE APPROPRIATE ANSWERS TO THE FOLLOWING QUESTIONS:

Location of home: City ☐, Suburban ☐, Wooded ☐, Farm ☐

Water: City ☐, Well ☐, Bottled ☐, Purification system: No ☐, Yes ☐ If yes, please describe:____

Type of heat: Electric ☐, Gas ☐, Oil ☐, Other ☐. If other, please describe:

____

Sletten Wellness
INTEGRATIVE AND SPORTS MEDICINE

ENVIRONMENTAL HISTORY - Continued

Do you live near: Power lines ☐, Woods ☐, Industrial areas ☐, Water ☐
Do you live near or down wind of agriculture fields?________________________
If you live near water, list type: Swamp ☐, River ☐, Ocean ☐, Other ☐
If other, please describe:____
Does your home have a lot of: Dust ☐, Mold ☐, Down ☐, Other feather items (pillows, upholstery, stuffed animals?) ☐. If yes, please describe:

____

Describe your child's bedroom (check the appropriate response(s):

Bedding:	Synthetic ☐, Down ☐, Feather ☐, Cotton ☐, Organic ☐
Mattress cover:	No ☐, Yes ☐
Type:	Crib ☐, Junior bed ☐, Adult bed ☐
Flooring:	Carpet wall-to-wall ☐, Area rug ☐, Wood ☐, Glued down ☐, Synthetic padding ☐
Window treatment:	Shades ☐, Blinds ☐, Thin curtain ☐, Heavy curtain ☐, Valance ☐, Other ☐. Describe: ________________________
Other items in the room:	Describe furniture , toys , stuffed animals , etc.
Flooring in other rooms:	

Is your child sensitive to or bothered by any of the following?
Please check where appropriate:

Perfumes/cosmetics ☐	Mold ☐
Cleaning products ☐	Pollens/grasses ☐
Soaps ☐	Animals (dander) ☐
Detergents ☐	Gasoline ☐
Dust ☐	Paint ☐
Other ________________________	

Please list known environmental allergies:

Sletten Wellness
INTEGRATIVE AND SPORTS MEDICINE

DEVELOPMENTAL HISTORY

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

First words / Age:	Walking / Age:
Sitting up / Age:	Running / Age:
Crawling / Age:	Jumping / Age:
Phrases or sentences / Age:	Putting on clothes / Age:
Pulling to stand / Age:	Pedaling bicycle / Age:

Do you have any other developmental concerns?

Sletten Wellness
INTEGRATIVE AND SPORTS MEDICINE

LABORTORY TESTING

Please provide date for tests that have been completed. Results section will be filled out by Dr. Sletten upon review.

Evaluation/Test:	**Date:**	**Results** (Save results section for Doctor visit):
24 Hour Amino Acids	______________	
Organic Acids – fungal/ bacterial	______________	
Organic Acids – Metabolism	______________	
Urinary Peptides	______________	
Urine Toxic Elements	______________	
Urine Kryptopyrrole	______________	
Urine Porphyrins/ Neopterin	______________	
Amino Acid Screen	______________	
Blood Chemistry Screen	______________	
Blood Count (CBC)	______________	
Fatty Acids	______________	
Food Allergy/Sensitivity	______________	
Folic Acid	______________	
Fragile X Chromosome Study	______________	
ASO/Anti DNAse B Ab (PANDAS)	______________	
SED RATE (ESR)	______________	
Cytokine Profile	______________	

Sletten Wellness
INTEGRATIVE AND SPORTS MEDICINE

LABORTORY TESTING - Continued

Evaluation/Test:	**Date:**	**Results** (Save results for Doctor visit):
CR Reactive Protein	______________	
Myelin Basic Protein	______________	
Neurofilaments	______________	
Lyme Disease Panel	______________	
Virus Panel	______________	
Magnesium/Calcium	______________	
Lactate	______________	
Carnitine	______________	
Immune Profile	______________	
Intestinal Permability	______________	
Liver Detox Profile	______________	
Zinc/Copper	______________	
RBC Elements	______________	
Ferritin (Iron Stores)	______________	
Methylmalonic Acid	______________	
Vitamin A/D/B_{12}	______________	
Thyroid Profile	______________	

Sletten Wellness
INTEGRATIVE AND SPORTS MEDICINE

LABORTORY TESTING - Continued

Evaluation/Test:	**Date:**	**Results** (Save results for Doctor visit):
Uric Acid (blood or urine)	______________	
Pinworm Prep	______________	
Stool Culture	______________	
Stool Parasites	______________	
Reducing Substances	______________	
Alpha-1-Antitrypsin	______________	
Comprehensive Stool Analysis	______________	
X-Rays (specify)	______________	
CT Scan (specify area)	______________	
Colonoscopy	______________	
EEG	______________	
Hair Toxic Elements	______________	
Hearing Test	______________	
MRI (specify area)	______________	
PET Scan/SPECT	______________	
Small Bowel Biopsy	______________	
Other: ______________	______________	

Sletten Wellness
INTEGRATIVE AND SPORTS MEDICINE

IMMUNIZATIONS

Age	Vaccinations Given (Pleae list)	Vaccinations given while child was sick?	Bowel Stool Change	Crying	Seizure	Irritable	Fever	Rash	Poor sleep	Other Observation
0–2 months	☐	☐	☐	☐	☐	☐	☐	☐	☐	
2-4 months		☐	☐	☐	☐	☐	☐	☐	☐	
4-6 months		☐	☐	☐	☐	☐	☐	☐	☐	
6-9 months		☐	☐	☐	☐	☐	☐	☐	☐	
9-12 months		☐	☐	☐	☐	☐	☐	☐	☐	
12-15 months		☐	☐	☐	☐	☐	☐	☐	☐	
15-18 months		☐	☐	☐	☐	☐	☐	☐	☐	
18-24 months		☐	☐	☐	☐	☐	☐	☐	☐	
Other		☐	☐	☐	☐	☐	☐	☐	☐	

Do you have any other questions or concerns about immunizations?

Sletten Wellness
INTEGRATIVE AND SPORTS MEDICINE

MEDICATIONS 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
		Central Nervous System							
☐	☐	Clozaril (clozapine)	☐	☐	☐	☐	☐	☐	____
☐	☐	Haldol	☐	☐	☐	☐	☐	☐	____
☐	☐	Prolixin	☐	☐	☐	☐	☐	☐	____
☐	☐	Risperdal	☐	☐	☐	☐	☐	☐	____
☐	☐	Seroquel	☐	☐	☐	☐	☐	☐	____
☐	☐	Stelazine	☐	☐	☐	☐	☐	☐	____
☐	☐	Thorazine	☐	☐	☐	☐	☐	☐	____
☐	☐	Zyprexa	☐	☐	☐	☐	☐	☐	____
☐	☐	Clonidine	☐	☐	☐	☐	☐	☐	____
☐	☐	Cogentin	☐	☐	☐	☐	☐	☐	____
☐	☐	Deanol (deaner, DMAE)	☐	☐	☐	☐	☐	☐	____
☐	☐	Dextromethorphan	☐	☐	☐	☐	☐	☐	____
☐	☐	Lithium	☐	☐	☐	☐	☐	☐	____
☐	☐	Naltrexone	☐	☐	☐	☐	☐	☐	____
☐	☐	St. John's Wort	☐	☐	☐	☐	☐	☐	____
☐	☐	Anafranil	☐	☐	☐	☐	☐	☐	____
☐	☐	Depakene for behavior	☐	☐	☐	☐	☐	☐	____
☐	☐	Depakene for seizures	☐	☐	☐	☐	☐	☐	____
☐	☐	Depakote for behavior	☐	☐	☐	☐	☐	☐	____
☐	☐	Depakote for seizures	☐	☐	☐	☐	☐	☐	____
☐	☐	Dilantin	☐	☐	☐	☐	☐	☐	____
☐	☐	Felbatol	☐	☐	☐	☐	☐	☐	____
☐	☐	Gabitril	☐	☐	☐	☐	☐	☐	____
☐	☐	Keppra	☐	☐	☐	☐	☐	☐	____
☐	☐	Klonopin	☐	☐	☐	☐	☐	☐	____
☐	☐	Lamictal	☐	☐	☐	☐	☐	☐	____
☐	☐	Luvox	☐	☐	☐	☐	☐	☐	____
☐	☐	Mysoline	☐	☐	☐	☐	☐	☐	____
☐	☐	Neurontin	☐	☐	☐	☐	☐	☐	____
☐	☐	Paxil	☐	☐	☐	☐	☐	☐	____
☐	☐	Phenobarbital	☐	☐	☐	☐	☐	☐	____
☐	☐	Straterra	☐	☐	☐	☐	☐	☐	____
☐	☐	Tegretol	☐	☐	☐	☐	☐	☐	____
☐	☐	Topamax	☐	☐	☐	☐	☐	☐	____
☐	☐	Trileptal	☐	☐	☐	☐	☐	☐	____
☐	☐	Zarotin	☐	☐	☐	☐	☐	☐	____
☐	☐	Zonegran	☐	☐	☐	☐	☐	☐	____

Sletten Wellness
INTEGRATIVE AND SPORTS MEDICINE

Now	Past	Medication or Supplement	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments
		Central Nervous System - Continued							
☐	☐	Adderall	☐	☐	☐	☐	☐	☐	________
☐	☐	Prozac	☐	☐	☐	☐	☐	☐	________
☐	☐	Zoloft	☐	☐	☐	☐	☐	☐	________
☐	☐	Amphetamine	☐	☐	☐	☐	☐	☐	________
☐	☐	Cylert	☐	☐	☐	☐	☐	☐	________
☐	☐	Dexedrine, dextroamphetamine	☐	☐	☐	☐	☐	☐	________
☐	☐	Fenfluramine	☐	☐	☐	☐	☐	☐	________
☐	☐	Focalin	☐	☐	☐	☐	☐	☐	________
☐	☐	Ritalin	☐	☐	☐	☐	☐	☐	________
☐	☐	Buspar	☐	☐	☐	☐	☐	☐	________
☐	☐	Chloral hydrate	☐	☐	☐	☐	☐	☐	________
☐	☐	Valium	☐	☐	☐	☐	☐	☐	________
☐	☐	Spironolactone	☐	☐	☐	☐	☐	☐	________
☐	☐	Desipramine	☐	☐	☐	☐	☐	☐	________
☐	☐	Mallaril	☐	☐	☐	☐	☐	☐	________
☐	☐	Tofranil	☐	☐	☐	☐	☐	☐	________
☐	☐	Klonapin	☐	☐	☐	☐	☐	☐	________
		Antihistamines							
☐	☐	Benadryl	☐	☐	☐	☐	☐	☐	________
☐	☐	Claritin	☐	☐	☐	☐	☐	☐	________
☐	☐	Singulair	☐	☐	☐	☐	☐	☐	________
☐	☐	Zyrtec	☐	☐	☐	☐	☐	☐	________
		Antimicrobials							
☐	☐	Antibiotics (specify type and number of times)	☐	☐	☐	☐	☐	☐	________
☐	☐	Vancomycin	☐	☐	☐	☐	☐	☐	________
☐	☐	Amphoterinin-B	☐	☐	☐	☐	☐	☐	________
☐	☐	Metronidazole (Flagyl)	☐	☐	☐	☐	☐	☐	________
☐	☐	Bactrim (Septra)	☐	☐	☐	☐	☐	☐	________
☐	☐	Diflucan	☐	☐	☐	☐	☐	☐	________
☐	☐	Humatin	☐	☐	☐	☐	☐	☐	________
☐	☐	Lamisil	☐	☐	☐	☐	☐	☐	________
☐	☐	Nizoral	☐	☐	☐	☐	☐	☐	________
☐	☐	Nystatin	☐	☐	☐	☐	☐	☐	________
☐	☐	Saccharomyces boulardii	☐	☐	☐	☐	☐	☐	________
☐	☐	Sporonax	☐	☐	☐	☐	☐	☐	________
☐	☐	Yodoxin	☐	☐	☐	☐	☐	☐	________
☐	☐	Famvir	☐	☐	☐	☐	☐	☐	________
☐	☐	Valtrex	☐	☐	☐	☐	☐	☐	________
☐	☐	Zovirax	☐	☐	☐	☐	☐	☐	________

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

Sletten Wellness
INTEGRATIVE AND SPORTS MEDICINE

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
		Digestion							
☐	☐	Transfer Factor (oral)/ Colostrum	☐	☐	☐	☐	☐	☐	____
☐	☐	Bethenecol	☐	☐	☐	☐	☐	☐	____
☐	☐	Digestive enzymes	☐	☐	☐	☐	☐	☐	____
☐	☐	Pepsid	☐	☐	☐	☐	☐	☐	____
☐	☐	Probiotics	☐	☐	☐	☐	☐	☐	____
		Detoxification							
☐	☐	DMPS	☐	☐	☐	☐	☐	☐	____
☐	☐	DMSA	☐	☐	☐	☐	☐	☐	____
☐	☐	Ca-EDTA	☐	☐	☐	☐	☐	☐	____
☐	☐	Epsom Salt Baths	☐	☐	☐	☐	☐	☐	____
☐	☐	Succimer, Chemet	☐	☐	☐	☐	☐	☐	____
☐	☐	(TTFD)	☐	☐	☐	☐	☐	☐	____
☐	☐	Reduced glutathione (IV)	☐	☐	☐	☐	☐	☐	____
☐	☐	Reduced glutathione (oral)	☐	☐	☐	☐	☐	☐	____
☐	☐	Glutathione (transdermal)	☐	☐	☐	☐	☐	☐	____
☐	☐	Folic Acid	☐	☐	☐	☐	☐	☐	____
☐	☐	Melatonin	☐	☐	☐	☐	☐	☐	____
		Nutrition/Metabolism/							
☐	☐	Multivitamin (Specify) ____ ____	☐	☐	☐	☐	☐	☐	____
☐	☐	Vitamin A	☐	☐	☐	☐	☐	☐	____
☐	☐	Vitamin C	☐	☐	☐	☐	☐	☐	____
☐	☐	Vitamin B3 (Niacin)	☐	☐	☐	☐	☐	☐	____
☐	☐	Vitamin B6	☐	☐	☐	☐	☐	☐	____
☐	☐	5 HTP	☐	☐	☐	☐	☐	☐	____
☐	☐	Alpha Keto Glutarate (AKG)	☐	☐	☐	☐	☐	☐	____
☐	☐	Amino Acid Mix	☐	☐	☐	☐	☐	☐	____
☐	☐	Deanol	☐	☐	☐	☐	☐	☐	____
☐	☐	Dimethylglycine (DMG)	☐	☐	☐	☐	☐	☐	____
☐	☐	Trimethylglycine (TMG)	☐	☐	☐	☐	☐	☐	____
☐	☐	GABA	☐	☐	☐	☐	☐	☐	____
☐	☐	Glutamine	☐	☐	☐	☐	☐	☐	____
☐	☐	SAMe (SAM, Samyr)	☐	☐	☐	☐	☐	☐	____
☐	☐	Taurine	☐	☐	☐	☐	☐	☐	____

Sletten Wellness
INTEGRATIVE AND SPORTS MEDICINE

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
		Nutrition/Metabolism/Immune therapy - Continued							
☐	☐	Tryptophan	☐	☐	☐	☐	☐	☐	____
☐	☐	Tyrosine	☐	☐	☐	☐	☐	☐	____
☐	☐	Calcium	☐	☐	☐	☐	☐	☐	____
☐	☐	Magnesium	☐	☐	☐	☐	☐	☐	____
☐	☐	Manganese	☐	☐	☐	☐	☐	☐	____
☐	☐	Selenium	☐	☐	☐	☐	☐	☐	____
☐	☐	Zinc	☐	☐	☐	☐	☐	☐	____
☐	☐	Human Growth Factor	☐	☐	☐	☐	☐	☐	____
☐	☐	IV Immune globulin	☐	☐	☐	☐	☐	☐	____
☐	☐	Kutapressin	☐	☐	☐	☐	☐	☐	____
☐	☐	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	☐	☐	☐	☐	☐	☐	____
☐	☐	Alka Gold	☐	☐	☐	☐	☐	☐	____
☐	☐	Carbatrol	☐	☐	☐	☐	☐	☐	____
☐	☐	Tranxene	☐	☐	☐	☐	☐	☐	____
		Other (please list):							
☐	☐	____	☐	☐	☐	☐	☐	☐	____
☐	☐	____	☐	☐	☐	☐	☐	☐	____
☐	☐	____	☐	☐	☐	☐	☐	☐	____

Additional Comments (please refer to page number and question):

Sletten Wellness
INTEGRATIVE AND SPORTS MEDICINE

THERAPIES AND DIETS

Please check (√) 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	☐	☐	☐	☐	☐	☐	____________
☐	☐	RDI	☐	☐	☐	☐	☐	☐	____________
☐	☐	Other:	☐	☐	☐	☐	☐	☐	____________
☐	☐	Other:	☐	☐	☐	☐	☐	☐	____________
		Diets							
☐	☐	Gluten Free	☐	☐	☐	☐	☐	☐	____________
☐	☐	Casein Free	☐	☐	☐	☐	☐	☐	____________
☐	☐	Yeast Free	☐	☐	☐	☐	☐	☐	____________
☐	☐	High Protein/Low Carb	☐	☐	☐	☐	☐	☐	____________
☐	☐	Salicylate Free	☐	☐	☐	☐	☐	☐	____________
☐	☐	Low Phenolics	☐	☐	☐	☐	☐	☐	____________
☐	☐	IgG reactive food avoidance	☐	☐	☐	☐	☐	☐	____________
☐	☐	Specific Carbohydrate Diet (SCD)	☐	☐	☐	☐	☐	☐	____________
☐	☐	Sugar Free	☐	☐	☐	☐	☐	☐	____________
☐	☐	Soy Free	☐	☐	☐	☐	☐	☐	____________
☐	☐	Corn Free	☐	☐	☐	☐	☐	☐	____________
☐	☐	Egg Free	☐	☐	☐	☐	☐	☐	____________
☐	☐	Other:	☐	☐	☐	☐	☐	☐	____________
☐	☐	Other:	☐	☐	☐	☐	☐	☐	____________
☐	☐	Other:	☐	☐	☐	☐	☐	☐	____________

Additional Comments (please refer to page number and question):

What do you think is/are the major cause(s) of your child's condition?

What are your hopes for your child?

Tell us about your child's strengths.

What are your expectations for these treatments?

List, in order of importance, what your feel are the top five issues for your child (e.g., medical, behavioral, cognitive, social, etc.):

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Is there anything else you would like to discuss with Dr. Sletten?

Would you like Dr. Sletten to pray for your child and your family at the end of your consultation? No ☐, Yes ☐. Comments:

Remember: "This race is not a sprint; it is a marathon."

Sletten Wellness
INTEGRATIVE AND SPORTS MEDICINE

HEALTH CARE PROVIDER TEAM

PRIMARY DOCTOR:
Name:____________________
Phone:____________________ Email:____________________
Address:____________________

DAN PHYSICIAN:
Name:____________________
Phone:____________________ Email:____________________
Address:____________________

THERAPIST(S):
Name:____________________
Phone:____________________ Email:____________________
Address:____________________
Duration:__________ Hours/week:__________ Helpfulness:__________
Type: Speech ☐, Occupational ☐, Physical ☐, Social ☐, Behavioral ☐,
Other ☐ ____________________

THERAPIST(S):
Name:____________________
Phone:____________________ Email:____________________
Address:____________________
Duration:__________ Hours/week:__________ Helpfulness:__________
Type: Speech ☐, Occupational ☐, Physical ☐, Social ☐, Behavioral ☐,
Other ☐ ____________________

SPECIALISTS:
Name:____________________
Phone:____________________ Email:____________________
Address:____________________
Date of Evaluation:____________________

NATUROPATH/HOMOEPATH:
Name:____________________
Phone:____________________ Email:____________________
Address:____________________
Date of Evaluation:____________________

NUTRITIONIST:
Name:____________________
Phone:____________________ Email:____________________
Address:____________________
Date of Evaluation:____________________

OTHER:
Name:____________________
Phone:____________________ Email:____________________
Address:____________________
Date of Evaluation:____________________