BRAIN BIO CENTRE

PRIVATE AND CONFIDENTIAL

Patient Information for babies and children aged 0-10 years

How did you hear about the Brain Bio Centre? _____

Skype appointment required? Yes ☐ Skype ID _____ Today's Date _____

Child's First Name _____ Last Name _____ Date of Birth _____

Address _____

_____ Post Code _____

Home Tel No _____ Parent Tel No _____

Mobile _____ Contact Email of Parent _____

Gender (M/F) _____ Child's / Baby's Age _____ years _____ months Weight _____

Main reason for visit: _____

_____

GP Details

GP Name: _____

Address: _____

_____ Telephone No: _____

Is your GP aware that you are consulting a nutritional consultant? **Yes/No**

Are you happy for your GP to be kept informed on the progress of your child? **Yes/No**

Any other health professionals involved in your childs care: _____

Address: _____ Telephone No: _____

Please do let us know if you would give consent for us to contact your doctor and let them know that you are undergoing nutritional treatment at the Brain Bio Centre ☐Yes ☐No

Family Details

Mother Name: _____ Age: _____

Health problems: _____ Are you the birth mother? **Yes/No**

Father Name: _____ Age: _____

Health problems: _____ Are you the genetic father? **Yes/No**

Brothers/sisters:

Male/Female Age: Health problems: _____

Male/Female Age: Health problems: _____

Male/Female Age: Health problems: _____

Male/Female Age: Health problems: _____

Family History

Please read through the following list of medical conditions and tick the appropriate box corresponding to whether family members have a history of suffering from the listed medical conditions.

Medical History	Father	Mother	Sibling(s)	Maternal Grand mother	Maternal Grand father	Paternal Grand mother	Paternal Grand father	Other
Allergy to milk								
Allergy to wheat								
Other allergy								
Arthritis								
Asthma								
Crohn's disease								
Coeliac disease								
Diabetes								
Ear infections recurrent								
Eczema								
Other skin complaint								
Fungal infection								
Heart disease								
High blood pressure								
Hives								
Irritable bowel syndrome								
Migraines								
Malabsorption								
Phenylketonuria								
Stroke								
Anorexia								
Autism								
Asperger's syndrome								
Bulimia								
Depression								
Downs syndrome								
Dyslexia								
Hyperactivity								
Learning difficulties								
Schizophrenia								
Speech delay								
Tendency to be a loner								
Night blindness								

Home Life:

Who lives at home with your child? _____

Does your child attend? (Please tick) ☐ Day Nursery ☐ Child minder ☐ Playgroup ☐ School/Special School

Occupation of Mother _____ Occupation of Father _____

Do you have any pets at home? **Yes/No** If yes, please list: _____

Pollution Profile

Does your child live in a city or by a busy road? **Yes/No**

Does your child live in a smoky atmosphere? **Yes/No**

Does your child usually drink filtered or bottled water? **Yes/No**

Does your child eat non-organic food? **Yes/No**

Does your child have a computer or TV in their bedroom? **Yes/No**

Does your child have a mobile phone, which is used regularly? **Yes/No**

Is the main house near to: pylons, mobile phone mast, factory, petrol station, agricultural land, flight path (please underline)

Pregnancy Details

Were there any particular difficulties during the pregnancy? **Yes/No**

If yes, please list _____

Birth Details:

Was this your first labour? **Yes/No**

Duration of pregnancy (normal gestation is 40 weeks) _____

Were there any particular difficulties relating to the birth? **Yes/No**

If yes, please list _____

APGAR score _____

Did the baby suffer (please tick) ☐ jaundice ☐ oxygen deficit ☐ any other problems _____

Did the baby require special care? **Yes/No** Why/duration _____

Additional information about labour/birth: _____

Child's Health Profile

Please circle all that apply now, and underline all that previously applied

Miscellaneous symptoms

Earache	Poor Co-ordination	Obsessive Behaviour
Catarrh	Head banging/Rocking	Mood Swings
Colic	Sensitivity to Noise	Thrush
Excessive crying	Phobias	Night Terrors
Aggression	Shows no Fear	Disturbed Sleep
Constant Runny Nose	Recurrent chest infections	
Snoring	Threadworms	

Specific Disorders

Asthma	ADD/ADHD	Down's Syndrome
Eczema/Dermatitis	Autism/Autism Spectrum Disorder	Cleft Palate
Hayfever	Aspergers Syndrome	Heart Disease
Food Allergies	Epilepsy	Sickle Cell Anaemia
Dyslexia	Crohn's Disease	Diabetes
Dyspraxia	Phenylketonuria	Haemophilia
Cerebral palsy	AIDS	Cancer

Child's Personality/Behaviour

Nervous	Irritable	Contented	Popular
Plays well with others	Unhappy	A 'Holy Terror'	Very 'Good'
Easily Distracted	Sociable	Temper Tantrums	Restless
Wide-Awake	Learning Difficulties	Tip Toes	Impulsive
Tough	Tidy	'Gifted' Child	Affectionate
Excitable	Emotional	Messy	Lazy/Lethargic
Rejects Affection	Nail Biter	'All Over the Place'	Clumsy
Sleepy	Agile		

Medical History

How many courses of antibiotics has the child taken over the past 3 years? (Please tick)

☐ none ☐ 1-3 courses ☐ 4-9 courses ☐ more than 10 courses

Does/has your child take/taken any other prescribed medications? **Yes/No**

If yes, please give age, illness and treatment _____

Does your child take over the counter medications? **Yes/No**

If yes, which and what for? _____

Has your child ever been referred to a specialist? **Yes/No**

If yes, please give age, reason and type of specialist: _____

What tests has your child had done by GP, specialist, other? _____

Has your child received medical diagnosis of any condition? **Yes/No**

If yes, please expand (e.g. Asthma, Coeliac Disease, Anaemia) _____

Have you sought 'alternative health care advice for your child e.g. Homeopath, Cranial Osteopath **Yes/No**

If yes, please state which: _____

Does your child have a history of contracting any viral infections? Tick all that apply

☐ none ☐ encephalitis ☐ meningitis ☐ chicken pox ☐ measles

☐ mumps ☐ rubella ☐ unknown viral infection

☐ other, please specify _____

Does your child have a history of epilepsy or seizures? **Yes / No**

If yes, please specify type of epilepsy, date of diagnosis and date of last episode: _____

_____

Does your child have a history of bacterial or fungal infections? Tick all that apply.

☐ none ☐ oral thrush ☐ genital thrush ☐ athletes foot ☐ impetigo

☐ other, please specify _____

Does your child have any history of the following problems with their ears? Tick all that apply.

☐ none ☐ hearing loss ☐ persistent ear infection ☐ redness of ears ☐ use of grommets/tubes

☐ other, please specify _____

Does your child have any history of the following problems with their eyes? Tick all that apply.

☐ none ☐ loss of sight ☐ dark rings around the eyes ☐ squint

☐ other, please specify _____

Additional medical information? _____

List any previous major illnesses _____

_____

List any operations that the child has had _____

_____

Immunisation Programme

Has your child received the recommended standard immunisations? **Yes/No**

If no, please detail those given and those excluded and why: _____

_____

Has your child ever had an adverse reaction to any vaccine? **Yes/No**

If yes, please specify _____

Does your child suffer from frequent colds, coughs infections? **Yes/No**

Does your child have eczema, asthma, hayfever, arthritis? Please underline which

Does your child suffer from food sensitivity? **Yes/No**

Have you noticed any adverse reactions in your child after eating certain foods? **Yes/No**

If yes, state which foods and what reactions _____

Development History

Has your GP or any other medical practitioner ever expressed concern regarding your child's development? **Yes/No**

If yes, please expand e.g. speech, learning, walking etc _____

Have there been any hearing problems? **Yes/No**

Has your child's growth been 'normal' e.g. Height, Weight, Growth Centile **Yes/No**

If no, please detail _____

Digestive Profile – please circle as appropriate

Does your child chew food well? **Yes/No**

Does your child suffer from bad breath? **Yes/No**

Does your child suffer tummy upsets? **Yes/No**

Does your child suffer with an itchy bottom? **Yes/No**

Does your child have a daily bowel movement? **Yes/No**

Does your child suffer from diarrhoea? **Yes/No**

Does your child suffer from constipation? **Yes/No**

Does your child suffer from bloating/excessive wind **Yes/No**

Are the stools normal, pale, offensive, floating (please underline which)

Does your child have a history of bowel problems?

☐ no ☐ yes ☐ don't know

Is your child fully bowel continent (i.e. not using a nappy at all during the day or night)?

☐ no ☐ yes ☐ don't know

Type of bowel problem. Tick all that apply

☐ diarrhoea ☐ constipation ☐ alternating diarrhoea/constipation ☐ undigested food in stools

☐ blood in stools ☐ mucus in stools ☐ loose stools

☐ other, please specify _____

How long have the bowel symptoms been present? Tick one box only.

☐ 0-3 months ☐ 4-6 months ☐ 7-12 months ☐ more than a year

How many bowel movements does your child have in the average week (over the past 3 months)? Tick one box only.

☐ none ☐ 1 bowel movement per week ☐ 2 bowel movements per week ☐ 3 bowel movements per week

☐ 4 bowel movements per week ☐ 5-15 bowel movements per week ☐ more than 1 per week

Please describe the normal consistency / type of stool your child produces from the items shown below. Tick all that apply.

☐ separate hard lumps (nut-like) ☐ sausage shaped and lumpy

☐ sausage shaped with cracked surface ☐ sausage shaped or snake-like smooth and soft

☐ fluffy pieces with ragged edges and mushy ☐ soft blobs but with clear-cut edges

☐ watery with no solids ☐ frothy stools

☐ large bulky stools

☐ other, please specify _____

Does your child ever require any manual manoeuvres to help with defecation? Tick all that apply.

☐ none ☐ digital evacuation (use of hands) ☐ support of the pelvic floor

☐ other, please specify _____

Please describe the general colour of the stools produced. Tick all that apply.

☐ light brown ☐ dark brown ☐ black ☐ yellow, sand coloured ☐ green

☐ other colour, please specify _____

Does your child ever present with any of the following problems? Tick all that apply.

☐ bloating ☐ distension (pot belly) ☐ indications of pain on passing stools ☐ indications of abdominal pain

☐ flatulence (frequent passing of wind) ☐ none

Diagnosed bowel complaints/infections. Tick all that apply.

☐ Coeliac disease ☐ Crohn's disease ☐ ulcerative colitis

☐ lymphoid-nodular hyperplasia

☐ other, please specify _____

Urination

Is your child fully bladder continent (i.e. not using a nappy at all during day or night)?

☐ no ☐ yes ☐ don't know

How many times does your child go to the toilet for a wee? Tick one box only.

☐ none ☐ 1-4 times per day (24 hours) ☐ 5-8 times per day (24 hours) ☐ 9-12 times per day (24 hours)

☐ more than 12 times per day (24 hours) ☐ unknown

Skin

Does your child have a history of skin complaints?

☐ none ☐ yes ☐ don't' know

Type of skin complaint. Tick all that apply.

☐ eczema / contact dermatitis ☐ acne ☐ bumpy skin ☐ dryness ☐ urticaria / hives

☐ other, please specify _____

Respiratory

Does your child have any history of respiratory complaints?

☐ none ☐ yes ☐ don't know

Type of respiratory complaint. Tick all that apply.

☐ asthma ☐ wheeze ☐ persistent congestion ☐ runny nose

☐ other, please specify _____

Sleep

Does your child have any current problems with sleeping?

☐ none ☐ yes ☐ don't know

Type of sleeping problem. Tick all that apply.

☐ insomnia ☐ night waking ☐ excessive sweating ☐ frequent indications of nightmares

Eating

Was your child breast-fed as an infant? (for more than 4 weeks)

☐ no ☐ yes

Did your child experience any problems after feeding as a young baby? (e.g. vomiting, projectile vomiting, colic, failure to feed)

☐ none

☐ yes, please specify _____

Are there any current or previous problems with food allergy / intolerance?

☐ none ☐ don't know

☐ yes, please specify and provide details of testing used for diagnosis _____

Does your child show any of the following problems with feeding. Tick all that apply.

☐ none ☐ over-eating ☐ diagnosed anorexia ☐ diagnosed bulimia

☐ regurgitation of food / drink ☐ pica (eating of non-edible objects such as earth or sand)

Does your child have any problems with restricted eating habits based on either taste or texture?

☐ no ☐ yes ☐ don't know

If yes, which types of food / drink?

☐ milk ☐ other dairy products (yoghurts, cheese) ☐ bread

☐ pasta ☐ cereals (e.g. Weetabix)

☐ other, please specify _____

_____

Are there any foods that your child is not permitted to have in their diet?

☐ none ☐ yes (specify from options below)

☐ casein-free diet ☐ gluten-free diet ☐ vegetarian

☐ other, please specify _____

Does your child show any signs of having an excessive thirst?

☐ no

☐ yes, (specify types of drink and average amount per day) _____

Additional Information

Is there any other information relevant to the child's medical history that you feel is of relevance? e.g. contact with hazardous substances. Other events related to symptom onset.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Nutritional Information – Child's Feeding History

Did you bottle feed at all? **Yes/No** From what age? _____ Which formula? _____

Which, if any, special formula were required e.g. soya, casein free? _____

How old was your baby when your started weaning onto solids? _____

Which foods were introduced and in what order?

1._____ Any Reactions _____ Age _____

2. _____ Any Reactions _____ Age _____

3. _____ Any Reactions _____ Age _____

Current Eating Habits

Would you describe our child's appetite as: (please tick) ☐ good ☐ medium ☐ poor

Is your child a fussy eater? **Yes/No**

Is your child currently following a specific dietary regime e.g. gluten free? Please describe _____

_____

Are there any foods that your child craves? Please describe _____

Are there any foods that your child dislikes intensely? Please describe _____

Do you go out of your way to avoid giving foods containing preservatives and additives? **Yes/No**

Do you avoid giving foods that contain sugar? **Yes/No**

How many cans of fizzy drinks does your child drink in a week? _____

How many times a week does your child have meals containing fried or fast foods (e.g. fish fingers, McDonalds) _____

How many portions daily of fruit and vegetables does your child have? _____

How many slices of bread or rolls does your child eat in a week? _____

Do you normally eat white or wholemeal rice, pasta and flour? _____

Does your child eat at nursery or at school? **Yes/No**

If yes, please describe this food/drink _____

Does your child take a 'lunch box' to school **Yes/No**

What nutritional supplements does your child take on a daily basis? _____

Food Diary

Write down the daily food and drink consumption of the child for 2 representative days. Give as much detail as possible including description of the foods, drinks, quantities eaten and brand names.

Day 1	**Day 2**
Breakfast	Breakfast
Lunch	Lunch
Evening Meal	Evening Meal
Snacks and Drinks	Snacks and Drinks

Activity Profile:

How much time per day does your child watch TV? _____

How much time per day does your child use a computer (including school and home)? _____

How much exercise does your child have in a week? _____

What sport does your child play? _____

Any activities, hobbies or clubs (e.g. dancing) _____

TERMS AND CONDITIONS

1. Payment

1.1 Payment for consultations will be payable no later than the day of appointment.

1.2 Payment for tests must be made at the time of purchasing/ordering the test kits.

1.3 A current schedule of all fees can be found in 'Fee Schedule'.

2. Cancellations and Refunds

2.1 Cancellations of all booked appointments must be made no later than 2 working days before the appointment.

2.2 Cancellations made within 2 working days of scheduled appointment or no shows will be subject to a cancellation charge of the full consultation fee.

2.3. Tests and complete packages that have been arranged and paid for may be cancelled within 14 days. To cancel, give written notice and return the test kits which must be unopened. Money will be refunded in full, less 15% administration charge. We reserve the right to change our fees.

2.4. Any biochemical or nutritional tests once purchased from the Brain Bio Centre, should be completed within 3 months.

Your Right to Cancel

Pursuant to the Consumer Protection (Distance Selling) Regulations 2000. This notice fulfils the requirement set out in Regulation 7:

1) The supplier of the services is Brain Bio Centre, 11A Chartfield Avenue, Putney, London, SW15 6DT, Tel: 020 8332 9600. email: info@brainbiocentre.com
2) This is a contract for the booking, administration and provision of assessment and remediation services for mental health conditions.
3) Delivery or postage may be charged.
4) Payment arrangements are set out in the 'Fee Schedule'. You may pay by cheque, cash, or major credit card. We do not accept American Express.
5) You have the right to cancel this agreement within 7 working days after the day on which you receive the information. To cancel, you must contact us in writing at our address as set out in (1).
6) If you have any complaints please contact us in writing, at our address as set out in 1).
7) In addition to your statutory right to cancel as set out above, you have the contractual right to terminate the contract at any time. But you will remain liable to pay any outstanding fees (including fees for sessions booked but not attended unless they were cancelled giving the notice required as outlined in our terms and conditions and returning any unused tests kits).

Data Protection

Information about the patient will be stored by the Brain Bio Centre for the purposes of monitoring the progress of his/her programme. Such information includes personal data relating to the patient's health record and brief details of their family unit. Brain Bio Centre has taken measures to keep such information secure and our policy is not to disclose it to a third party other than those professionals directly involved in the programme. We use other (non-medical) personal information provided by patients and their parents or guardians for the purposes of administration, including collection of money due, for which purpose the information may be disclosed to debt collection and tracing agencies. Returning the Patient Information form signed by the patient, or by a parent or guardian if the patient is under 18 years old, constitutes the patient's express written consent to the processing of such data. Any queries regarding the processing of personal data may be directed to the Brain Bio Centre Clinic Manager at the Brain Bio Centre who is responsible for data protection matters.

Evaluation and research

Anonymised patient information and test results may be used in the evaluation of Brain Bio Centre treatment protocols to contribute to the continual improvement of the effectiveness of our treatment programmes.

PATIENT TO SIGN HERE

I have read and agree to the terms and conditions outlined above.

Signed.....

Date.....

If patient is under 18 years of age, this form must be signed by the legal guardian.

☐ If you do not wish to receive information from Food for the Brain (the non-profit educational charity), including monthly newsletters, please tick the box.

PLEASE RETURN THIS FORM TO:

Brain Bio Centre
11A Chartfield Avenue
Putney, London, SW15 6DT
or email: info@brainbiocentre.com