Aidun Medical
Integrative Endocrinology
DR. SIMA AIDUN, N.M.D.

Dr. Sima Aidun N.M.D
Clinical Nutrigenomic Specialist

INTAKE PACKET CHECKLIST

☐ Please complete all relevant questions on the ***Intake Form.***

☐ If you have ***copies of any recent evaluations*** (psychological, developmental testing), please include them when you send us your Intake Form.

☐ If you are the child's guardian and not the birth or adoptive parent, please include copies of the ***Guardianship papers*** (court order or Power of Attorney) with your Intake Form.

☐ If your child is in a school, preschool, or daycare setting, please have his or her teacher(s) or caregiver(s) fill out the ***Secondary Caregiver Questionnaire*** and send it to us.

If you need help in filling out the Intake Form, please call **(480) 451-1602** and we will help you with your questions.

Please return all Intake materials by mail or fax to:

Aidun Medical
8134 E Cactus Road - Suite 610
Scottsdale, AZ 85260
Phone: (480) 451-1602
Fax: (480) 614-1242

We look forward to working with you and your family. If you do not hear from us 2 weeks after sending the packet to us, please call the number above to make sure we have received your packet.

Thank you,
Sima Aidun, N.M.D

Aidun Medical
Integrative Endocrinology
DR. SIMA AIDUN, N.M.D.

Dr. Sima Aidun N.M.D
Clinical Nutrigenomic Specialist

About Your Child:

Name: _____
Last First MI Nickname

Date of Birth: _____ Gender: ☐ Male ☐ Female

Address: _____
Street Apt or Unit #

_____
City State Zip Code County

Reason for Coming to Clinic:

What three specific questions about your child's development or behavior would you like to ask us?

1) _____

2) _____

3) _____

Who referred you to us?

_____
Name Organization Phone Number

_____
Primary Medical Provider (if different from above) Location Phone Number

Important Information:

What languages do you speak at home?

_____

Contact Information:

Parent/Caregiver 1:

Name: _____
Last First

Relationship to child: _____ Legal Guardian? ☐ Yes ☐ No

Address: _____
Street Apt or Unit # City State Zip Code County

Main Phone: _____ Alternate Phone: _____

E-mail Address: _____

Parent/Caregiver 2:

Name: _____
Last First

Relationship to child: _____ Legal Guardian? ☐ Yes ☐ No

Address: _____
Street Apt or Unit # City State Zip Code County

Main Phone: _____ Alternate Phone: _____

E-mail Address: _____

Legal Guardian (if different from above):

Name: _____
Last First

Relationship to child: _____

Address: _____
Street Apt or Unit # City State Zip Code County

Main Phone: _____ Alternate Phone: _____

E-mail Address: _____

Pregnancy & Birth: Check if birth history is not known.

Was your child born on time? ☐Yes ☐No Number of weeks: _____

At the time of birth, how old was: Mother: _____ Father: _____

How many times has mother been pregnant before this child? _____

How many: Miscarriages? _____ Abortions? _____ Stillbirths? ____

Any problems during pregnancy? ☐ Yes ☐ No

If yes, please explain: _____

_____

During pregnancy, did mother take:
Prescription medications? _____

Vitamins or supplements? _____

Drugs? ☐Yes ☐No If yes, list: _____

Smoke? ☐Yes ☐ No If yes, how many packs a day: _____

Drink alcohol? ☐ Yes ☐ No If yes, how much? _____

Where was baby born? _____
Name of Place City State

Was the baby born: ☐Naturally (vaginally) ☐C-section
If C-section, why? _____

Any problems during delivery? ☐Yes ☐No Apgars (if known)? ___1 min ___5 min
If yes, please explain: _____

_____

How long did baby stay in the hospital? _____ Which hospital? _____

Any medical problems while in the hospital?

☐Breathing problems ☐Heart problems ☐Brain problems ☐Eye problems
☐Feeding problems ☐ Infections ☐Stomach problems ☐Skin problems

If any problems, please explain: _____

_____

Was baby: ☐Breastfed ☐Bottle fed If breastfed, for how long? _____

Your Child's Development:

How old was your child when you first became worried about his/her development? _____

What worried you at that time? _____

Did your child ever stop doing any skills that he/she had learned? ☐Yes ☐No

If yes, please explain: _____

Are you worried about your child's social or play skills? ☐Yes ☐No

If yes, please explain: _____

_____

Please tell us what your child is good at doing. What are his/her strengths? _____

_____

Please tell us what your child likes to do for fun or play with: _____

Your Child's Behavior:

Early Childhood Screening Assessment

Circle the number that best describes your child at his/her current age, compared to other children the same age. For each item, please also circle the + if you are concerned.

Behavior	Rarely/ Not True	Sometimes/ Sort of	Almost Always/ Very True	Concerned?
1. Seems sad, cries a lot	0	1	2	+
2. Is difficult to comfort when hurt or distressed	0	1	2	+
3. Loses temper too much	0	1	2	+
4. Avoids situations that remind of scary events	0	1	2	+
5. Is easily distracted	0	1	2	+
6. Hurts others on purpose (biting, hitting, kicking)	0	1	2	+
7. Doesn't seem to listen to adults talking to him/her	0	1	2	+
8. Battles over food and eating	0	1	2	+
9. Is irritable, easily annoyed	0	1	2	+
10. Argues with adults	0	1	2	+
11. Breaks things during tantrums	0	1	2	+
12. Is easily startled or scared	0	1	2	+
13. Tries to annoy people	0	1	2	+
14. Has trouble interacting with other children	0	1	2	+
15. Fidgets, can't sit quietly	0	1	2	+
16. Is clingy, doesn't want to separate from parent	0	1	2	+
17. Is very scared of certain things (needles, insects)	0	1	2	+
18. Seems nervous or worries a lot	0	1	2	+
19. Blames others people for mistakes	0	1	2	+
20. Sometimes freezes or looks very still when scared	0	1	2	+
21. Avoids foods that have specific feelings or tastes	0	1	2	+
22. Is too interested in sexual play or body parts	0	1	2	+
23. Runs around in settings when should sit still (school, worship)	0	1	2	+
24. Has a hard time paying attention to tasks or activities	0	1	2	+
25. Interrupts frequently	0	1	2	+
26. Is always "on the go"	0	1	2	+
27. Reacts too emotionally to small things	0	1	2	+
28. Is very disobedient	0	1	2	+
29. Has more picky eating than usual	0	1	2	+
30. Has unusual repetitive behaviors (rocking, flapping)	0	1	2	+
31. Might wander off if not supervised	0	1	2	+
32. Has a hard time falling asleep or staying asleep	0	1	2	+
33. Doesn't seem to have too much fun	0	1	2	+
34. Is too friendly with strangers	0	1	2	+
35. Has more trouble talking or learning to talk than others	0	1	2	+
36. Is learning or developing more slowly than other children	0	1	2	+
37. I feel too stressed to enjoy my child	0	1	2	+
38. I get more frustrated than I want to with Id's behavior	0	1	2	+
39. I feel down, depressed, or hopeless	0	1	2	+
40. I feel little interest or pleasure in doing things	0	1	2	+
Office Use Only	**Total (1-40): _____**		**(>=20)**	

Your Child's School:

Does your child receive services outside of school? ☐Yes ☐No

If yes, please list all services and where: _____

_____

How does your child do with schoolwork? _____

How does your child get along with other children at school? _____

How is your child's behavior at school? _____

Is there any other information that you would like us to know about how your child does at school?

_____

_____

Has your child had any previous evaluations for concerns about development, behavior, or school?

_____

_____

Your Child's Medical History:

Please tell us whether your child has problems **now or in the past** with:

				If Yes, Please Explain & Include Age
Eyes, Vision	☐YES	☐NO	☐DON'T KNOW	
Ear, Nose, Throat	☐YES	☐NO	☐DON'T KNOW	
Hearing	☐YES	☐NO	☐DON'T KNOW	
Stomach/Intestines/Bowels	☐YES	☐NO	☐DON'T KNOW	
Heart problems	☐YES	☐NO	☐DON'T KNOW	
Heart rhythm problems	☐YES	☐NO	☐DON'T KNOW	
Lung/Breathing problems	☐YES	☐NO	☐DON'T KNOW	
Blood problems (anemia, leukemia)	☐YES	☐NO	☐DON'T KNOW	
Brain/Neurologic problems	☐YES	☐NO	☐DON'T KNOW	
Muscle or movement problems	☐YES	☐NO	☐DON'T KNOW	
Skin problems	☐YES	☐NO	☐DON'T KNOW	
Thyroid problems	☐YES	☐NO	☐DON'T KNOW	
Diabetes	☐YES	☐NO	☐DON'T KNOW	
Other endocrine/hormone problems	☐YES	☐NO	☐DON'T KNOW	
Joint or bone problems	☐YES	☐NO	☐DON'T KNOW	
Kidney problems	☐YES	☐NO	☐DON'T KNOW	
Genetic or hereditary problems	☐YES	☐NO	☐DON'T KNOW	
Accidents or injuries	☐YES	☐NO	☐DON'T KNOW	
Mental health/emotional problems	☐YES	☐NO	☐DON'T KNOW	
Leaning problems (dyslexia, etc.)	☐YES	☐NO	☐DON'T KNOW	
Intellectual Disability/Mental Retardation	☐YES	☐NO	☐DON'T KNOW	
Autism spectrum	☐YES	☐NO	☐DON'T KNOW	
Attention Deficit (ADHD, ADD)	☐YES	☐NO	☐DON'T KNOW	

List surgeries or operations your child has had below: ☐None

Surgery Type	Which Hospital	Date of Surgery

Please list times your child had to stay in the hospital overnight: ☐None

Hospital Name	Why?	Dates of Hospital Stay

Are your child's immunizations up to date? ☐Yes ☐No (explain):_____

Has your child ever had:

MRI or CT scan? ☐Yes ☐No (If yes, explain): _____

Genetic testing? ☐Yes ☐No (If yes, explain): _____

Hearing test by a specialist? ☐Yes ☐No (If yes, explain):_____

Other medical procedures/tests? ☐Yes ☐No (If yes, explain):_____

Your Child's Medications and Allergies:

Please list all **medications** your child takes ***now***:

Name	Dose	How Often?	Date Started	Who prescribes?	Does it help?
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No

If you need more room, please write on a new sheet of paper.

Please list all **medications** your child has taken ***in the past***:

Name	Dose	How Often?	Date Taken	Who prescribed?	Does it help?
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No

If you need more room, please write on a new sheet of paper.

Please write any **vitamins, herbals, or supplements** your child takes below:

_____

_____

Please list all **allergies**, including your child's reaction (hives, trouble breathing, etc.), below:

Food: _____

Medicines/Drugs: _____

Environmental/Seasonal: _____

Does your child eat a special **diet**? ☐Yes ☐No (If yes, explain): _____

_____

Please tell us other information about your child's medical history that you think we should know:

_____

_____

_____

About the Family:

What is your child's living/custody arrangement (check all that apply)?

☐Birth Mother ☐Birth Father ☐Guardianship ☐Foster Care ☐Adoptive Family
☐Other (explain):_____

If child is in foster care or in an adoptive family, how old was the child when he/she came into your home? _____

How often does your child get to see the other family members whom live elsewhere?

_____

Is there anything about your family's religion, traditions, culture, or practices of your family that you would like us to know?

_____

_____

Family Medical History:

Please tell us whether any of the child's biological family members has any of the following.
Biological family members (related to the child by blood) include mother, father, grandparents, brothers, sisters, aunts, uncles, and first cousins.

Condition	Mother's Side Who? What problem	Fathers Side Who? What problem
Autism/Asperger's/PDD		
Developmental Delay		
Learning Problems		
Intellectual Disability (formerly mental retardation)		
ADHD or ADD		
Speech or language problems		
Tics or other movements		
Seizures/Brain problems		
Severe emotional problems (Depression, Bipolar, etc.)		
Anxiety		
Schizophrenia or Psyhosis		
Alcohol/drug problems		
Still births		
Birth defects		
Heart problems		
Heart rhythm problems		
Sudden, unexplained death		
Diabetes		
Thyroid problems		
Hearing loss/problems		
Eye problems		
Genetic/Hereditary problems		
Other:		

Thank You!

Signature _____ Printed Name _____ Date Completed _____

Relationship to Child _____

PLEASE RETURN TO:

Aidun Medical
8134 E Cactus Road - Suite 610
Scottsdale, AZ 85260
Phone: (480) 451-1602 Fax: (480) 614-1242

Children's Health System-Authorization for Release of Information

Patient Name (First, Last, MI):_____

Address:_____

Phone Number: (_____) _____Date of Birth:_____

This Authorization applies to the following Information:

☐ *All* Information. I understand that the information may contain psychiatric/psychological, alcohol/drug abuse, and/or HIV information and I expressly consent to the release of the information.

☐ *Only* the following records or types of Information: _____

_____

Treatment Dates: from (month/day/year) _____/_____/_____ **to** (month/day/year) _____/_____/_____

The Information may be released as follows:

by **to** (Please check all that apply)

☐ ☐ **Aidun Medical, 8134 E Cactus Road, Suite 610, Scottsdale, AZ 85260 – Phone (480) 451-1602; FAX (480) 614-1242**

☐External Individual/Agency/Organization (*Please provide address & phone number*):_____

_____

Purpose of the release:

☐ Continuity of Treatment ☐Other (*Please specify*):_____

I understand the Information released will be limited to information necessary to fulfill the need or purpose for the disclosure. If I have authorized the disclosure of Information to a recipient who is not subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), then the recipient may re-disclose it and it may no longer be protected under HIPAA, a federal privacy law. This Authorization is valid for ninety (90) days from the date of signature, unless otherwise noted. This Authorization only applies to treatment occurring before the date of signature. I may decline to sign this Authorization. I understand I may revoke this authorization in writing at any time by completing a form available from Medical Information Services. If I revoke this authorization, the revocation will not apply to information that has already been released in response to this authorization. I understand the patient's health care and the payment for the patient's health care will not be affected if I do not sign this form. I understand I may see and copy the Information described on this form if I ask for it, and I may receive a copy of this form after I sign it. Before requesting medical record copies, please inquire about the copy fee by law that may apply. I represent that I have the authority to and voluntarily grant permission for the Information to be released as described above.

_____ _____

Patient/Parent/Legal Guardian Printed Name Patient/Legal Guardian Signature Date

_____ _____

Patient Signature (if 14 or older) Date Witness Signature Date

SECONDARY CAREGIVER QUESTIONNAIRE

Child and Parent Information:

Child's Name: _____ Birth Date: _____
Last First Middle
Gender: Male Female Child's Classroom/Age Level: _____
Parent's Name: _____ Relationship to child: _____

Please have child care (daycare, etc.) or school personnel fill out below and return.

Form Completed by _____ Date Completed: _____
Position/Title _____
How long have you known the child? _____
Child Care/School: _____
Address: _____
Street City State Zip County
Primary Phone: _____ Fax Number: _____
What specific questions would you like answered that would help you better meet this child's developmental and educational needs?
1) _____
2) _____
3) _____

Please describe the child's strengths:

Please describe any areas of functioning that need the most improvement:

Any other specific concerns you have about this child?

Besides English, are there any other languages used in the child's instruction?

ACADEMIC PERFORMANCE:

	Not Yet	Progressing	Proficient
A. Basic Concepts			
1. Knows colors	☐	☐	☐
2. Knows letters of the alphabet	☐	☐	☐
3. Knows numbers and counts past 10	☐	☐	☐
4. Adds and subtracts things	☐	☐	☐
5. Size concepts	☐	☐	☐
6. Location concepts	☐	☐	☐
B. Language and Communication			
1. Uses speech to communicate	☐	☐	☐
2. Explains and describes things	☐	☐	☐
3. Rhymes words and remembers poems/songs	☐	☐	☐
4. Uses uncommon words	☐	☐	☐
5. Uses long sentences	☐	☐	☐
6. Tells or retells stories or events	☐	☐	☐
7. Speaks understandably	☐	☐	☐
8. Follows oral instructions on level with peers	☐	☐	☐
9. Uses correct grammar (e.g. verb tense)	☐	☐	☐
10. Uses sign language or other communication system	☐	☐	☐
11. Follows classroom routine	☐	☐	☐
C. Emergent Literacy			
Listens to stories in books	☐	☐	☐
1. Asks questions about words	☐	☐	☐
2. Reads words on signs and labels	☐	☐	☐
3. Reads words in books	☐	☐	☐
4. Recites books from memory	☐	☐	☐
5. Reads "easy" books	☐	☐	☐
6. Writes or copies words	☐	☐	☐
7. Dictates stories	☐	☐	☐
8. Writes "little" stories	☐	☐	☐
9. Answers questions about orally read story	☐	☐	☐
D. Motor Skills			
1. Constructs puzzles or builds things	☐	☐	☐
2. Uses pencils and pens correctly	☐	☐	☐
3. Uses scissors well	☐	☐	☐
4. Copies and traces shapes	☐	☐	☐
5. Draws recognizable objects	☐	☐	☐
6. Is coordinates on outdoor recess activities	☐	☐	☐
7. Ties shoe laces	☐	☐	☐

BEHAVIOR/EMOTIONAL CONCERNS:

Circle the number that best describes your child compared to other children the same age. For each item, please circle the + if you are concerned.

Behavior	Rarely/ Not True	Sometimes/ Sort of	Almost Always/ Very True	Concerned?
1. Seems sad, cries a lot	0	1	2	+
2. Is difficult to comfort when hurt or distressed	0	1	2	+
3. Loses temper too much	0	1	2	+
4. Avoids situations that remind of scary events	0	1	2	+
5. Is easily distracted	0	1	2	+
6. Hurts others on purpose (biting, hitting, kicking)	0	1	2	+
7. Doesn't seem to listen to adults talking to him/her	0	1	2	+
8. Battles over food and eating	0	1	2	+
9. Is irritable, easily annoyed	0	1	2	+
10. Argues with adults	0	1	2	+
11. Breaks things during tantrums	0	1	2	+
12. Is easily startled or scared	0	1	2	+
13. Tries to annoy people	0	1	2	+
14. Has trouble interacting with other children	0	1	2	+
15. Fidgets, can't sit quietly	0	1	2	+
16. Is clingy, doesn't want to separate from parent	0	1	2	+
17. Is very scared of certain things (needles, insects)	0	1	2	+
18. Seems nervous or worries a lot	0	1	2	+
19. Blames others people for mistakes	0	1	2	+
20. Sometimes freezes or looks very still when scared	0	1	2	+
21. Avoids foods that have specific feelings or tastes	0	1	2	+
22. Is too interested in sexual play or body parts	0	1	2	+
23. Runs around in settings when should sit still (school, worship)	0	1	2	+
24. Has a hard time paying attention to tasks or activities	0	1	2	+
25. Interrupts frequently	0	1	2	+
26. Is always "on the go"	0	1	2	+
27. Reacts too emotionally to small things	0	1	2	+
28. Is very disobedient	0	1	2	+
29. Has more picky eating than usual	0	1	2	+
30. Has unusual repetitive behaviors (rocking, flapping)	0	1	2	+
31. Might wander off if not supervised	0	1	2	+
32. Has a hard time falling asleep or staying asleep	0	1	2	+
33. Doesn't seem to have too much fun	0	1	2	+
34. Is too friendly with strangers	0	1	2	+
35. Has more trouble talking or learning to talk than others	0	1	2	+
36. Is learning or developing more slowly than other children	0	1	2	+
Office Use Only	**Total (1-36):** _____		**(>=18)**	

Please describe the child's behavior below:

Please describe this child's social-emotional functioning, including moods and relationship/play with peers.

Please share any other information you think would be helpful for us to know.

Signature	Print Name	Date Completed

Relationship to child

Please send the completed packet back to:

Aidun Medical
8134 E Cactus Road
Suite 610
Scottsdale, Arizona 85260
Fax: (480) 614-1242