AUTISM SPECTRUM DISORDER/ADD/ADHD HYPERACTIVITY DISORDER
CONFIDENTIAL PATIENT INFORMATION

Date: _____
Full Name: _____
Name of Parent or Guardian: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Telephone Number ( ) _____

1. Have any other family members been diagnosed with Autism Spectrum Disorders, ADD, ADHD, or Dyslexia?
   Yes ____ No ____ If yes, please list relationship _____
2. Have any other family members been diagnosed with a psychological condition such as depression bipolar disorder, schizophrenia OCD or other?
   Yes ____ No ____ If yes, please list relationship _____
3. Have any other family members been diagnosed with Autoimmune Disease, Rheumatoid Arthritis, Lupus, Scleroderma, MS, ALS, Thyroid Disease, Autoimmune Diabetes, Grave's, other?
   Yes ____ No ____ If yes, please list relationship _____
4. <u>Mom's Health During Pregnancy</u>
   Was mom overweight? Yes _____ No_____ If yes, weight _____
   Was mom sick? Yes _____ No_____ Name illness _____
   How many births has mother had? _____
   How many miscarriages? _____
   Did mom use fertility drugs? Yes ____ No ____
   Health of siblings _____
   Maternal stress during pregnancy: divorce?Yes___ No___; Car accident?Yes___ No___;
   Physical trauma?Yes___ No___; broken bones? Yes___ No___ other stress? if yes, explain
   _____
   Death in family?Yes___ No____; job loss? Yes___ No___
   Mom's exposure to toxins (example: mold, pesticides) Yes___ No___ if yes explain
   _____
   Known infection(s) mom had during pregnancy
   Yeast? _____; bacterial? _____; viral? _____
   Did mom drink alcohol during pregnancy? Yes___ No___; smoke? Yes____ No____;
   Drink coffee? Yes___ No___; excessive bleeding? Yes ___No___; vomiting? Yes___ No___
   Antibiotics? Yes__No __

5. <u>Birthing Process</u>
   What type of delivery? _____
   Any birth trauma? Yes___ No___ Forceps Yes ___ No ___ Vacuum extraction Yes ___ No ___
   Hypoxia Yes___ No___ Cord around babies neck Yes ___ No ___ other? if yes explain
   _____
   _____

_____
___
Birth Cont.
Was delivery induced? Yes___ No___ Natural? Yes___ No___ Epidural? Yes___ No___
APGAR score_____at one minute _____ at 5 minutes

6. Infant toxic exposure
   Mold in house? Yes___ No___; Pesticide? Yes___ No___; other _____

7. Infections
   Name all infections first two years of child's life:
   _____ Age of onset _____; _____ Age of onset _____
   _____ Age of onset _____; _____ Age of onset _____
   _____ Age of onset _____; _____ Age of onset _____
   Is child on antibiotics now? Yes____ No _____
   At what age did child first start antibiotics? _____ # of cycles of antibiotics in lifetime ____
   What age was first illness? _____

8. Please list ALL surgeries and child's age at time of surgery:
   _____
_
   _____
   _
   _____
   _

9. Motor Development
   Child's age when first held head up ____; rolled over____; sat up____; crawled ____; walked ____
   Did child display any "cute" or out of the ordinary behavior when learning to crawl or walk?
   Yes ____ No ____ if yes explain
   _____
   _____
   __
   Age potty trained: _____ age stopped wetting bed: _____ age of first words "mama", "dada" _____
   Age child spoke 2 to 3 words together _____
   Has child lost language? Yes _____ No ____; if yes, what age and how far did they regress?
   _____
   _
   How many words was your child using in a sentence before regression? _____
   Has child lost eye contact? Yes _____ No _____; if yes, at what age: _____
   How long did mother breast feed? Months _____ Never _____
   Age child started bottle-feeding?_____; formula? Yes _____ No _____; soy based? Yes ____ No ____
   Casein based? Yes ____ No ____
   Age cow's milk was introduced _____; age wheat & grains were introduced? _____

10. Vaccine

Seizures? Yes ____ No ____ When did seizures start? _____ How long did they last? _____
Bowel Symptoms? Yes ____ No ____, if yes, explain
_____
Swelling at injection site? Yes ____ No _____ Fever? Yes ___ No ____
Other reaction to vaccines:
_____
_

11. GI Tract
    How many bowel movements per day? _____ Is your child constipated? Yes _____ No _____
    Bloating? Yes _____ No _____ Dark circles under eyes? Yes ____ No ____
    Are your child's behavioral symptoms worse during ___damp; ___hot; ___misty;___moldy;____other weather?
    Does your child wake up at night laughing or giggling? Yes ____ No ____
    Does your child put pressure on stomach? Yes ____ No ____
12. Current Diet
    Does your child refuse to eat certain foods? Yes____ No ____; which foods? _____
    List all sweets that your child eats: _____
    _____
    _
    How many glasses of milk does your child drink per day? _____
    How much cheese consumption per day? _____ Slices of bread per day? _____
    How many sodas per day? _____ How many glasses of sweet tea? _____
    How many glasses of fruit juice? _____ How many sports drink per day? _____
    Does your child eat salty food or crave salty food? Yes _____ No _____
    How many food meals per day? _____ Meat intake per day? _____ ounces; What type?
    _____
    Veggies per day? _____
13. Current Diet
    What is your child eating now? Look back over past 3 days (or 3 future days) and be as accurate as possible.
    _____
    _____
    _____
    _____
    _____
    _____
    _____
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    _____

_____
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_____
_____
_____
_____

Parent's Signature _____ Date _____
Gaurdian or Spouse's Signature _____ Date _____