

Advocates for Families – Autism Intake Form

Patient

Name:

Child's age:

Child's date of birth:

Hometown:

Travel time to clinic:

How did you hear about our clinic?

Diagnosis:

Age at diagnosis:

Previous Biomedical Care (include diets, supplements, labs, medications):

Main Concerns about your child:

Family

Father's occupation:

Mother's occupation:

Significant medical history:

Mother:

Father:

Siblings:

Relatives with neurodevelopmental issues:

Prenatal History

Maternal age:

Did the mother have problems during pregnancy? Yes No

If yes, what problems?

Did the mother have any illnesses during pregnancy? Yes No

If yes, what illnesses?

Did the mother receive any vaccines during pregnancy? Yes No

If yes, which vaccines?

Did the mother have any amalgam (silver) fillings during pregnancy? Yes No

Did the mother have any dental work done during pregnancy? Yes No

Was the mother exposed to any known environmental toxins during pregnancy? Yes No

During her youth? Yes No

Is the mother's blood type Rh+ or Rh-? Rh- Rh+

Did mother receive any Rhogam shots? Yes No

Was your child delivered full term? Yes No

If not, at how many weeks was child delivered?

Was delivery vaginal or c-section?	Vaginal	C-Section
Were there problems during delivery?	Yes	No
Is yes, what problems?		
Did your child spend extra time in the hospital after birth?	Yes	No
Did your child have any problems during their hospital stay?	Yes	No
If yes, please explain:		

Development

At what age did you first notice developmental problems?

Was your child developmentally normal up until a certain age?	Yes	No
Did your child experience any regression?	Yes	No
If yes, please describe regression and possible triggers:		

Gross motor skills (running, jumping, balance, etc.):	Normal	Advanced	Delayed
Fine motor skills (grasping, hand writing, cutting, etc.):	Normal	Advances	Delayed
Does your child toe walk?		Yes	No
Language-			
Is your child currently verbal?		Yes	No
If yes, about how many words are in their current vocabulary?			
If your child is currently nonverbal, were they verbal previous to speech loss?		Yes	No
If yes, as what age did your child lose their language skills?			
If your child is currently nonverbal, how do they communicate?		Yes	No

School Performance

Please describe your child's performance in school:

Gastrointestinal

Was your child breastfed? Yes No

If yes, up to what age?

Was your child formula fed? Yes No

If yes, up to what age?

Was your child a colicky infant? Yes No

Did your child show any signs of abdominal pain? Yes No

If yes, at what age?

Child's bowel habits (constipation, diarrhea, frequency, etc. Please be detailed) :

Past:

Current:

Is your child toilet trained? Yes No

Infectious Diseases

Has your child ever experienced any frequent and/or unusual infections? Yes No

If yes, please describe:

Has your child ever taken antibiotics? Yes No

If yes, how many courses?

When was the last time?

Has your child ever taken anti-viral medication?	Yes	No
Has your child ever taken anti-fungal medication?	Yes	No

Immunizations

Has your child received routine immunizations?	Yes	No
Has your child ever experienced a reaction to immunizations?	Yes	No

If yes, please explain:

Allergies

Does your child have seasonal allergies?	Yes	No
Does your child have a history of asthma or wheezing?	Yes	No
Does your child get dark circles under their eyes?	Yes	No
Has your child ever been on steroids in the past?	Yes	No
Does your child have a history of eczema?	Yes	No
Has your child ever had redness around the anus/diaper rash?	Yes	No

Behavior

Is your child: inattentive distractible hyper-focused none

Describe your child's activity level (please circle all that apply):

hyper-active low energy aggressive none

Does your child ever seem foggy or spaced-out?	Yes	No
Does your child act more silly/giddy than is expected for their age?	Yes	No
Does your child ever have melt-downs or tantrums?	Yes	No
Does your child have self-stimulating (stimming) behaviors?	Yes	No

If yes, please describe:

Does your child ever exhibit obsessive/repetitive behaviors?	Yes	No
Does your child have a history of strep infections?	Yes	No

Please describe things that make your child's behavior better:

Please describe things that make your child's behavior worse:

Social

Does your child have trouble getting along with others? Yes No

If yes, please describe:

Does your child ever seem anxious? Yes No

If yes, please describe:

Please describe any other social or emotional issues:

Sleep

Child's sleep habits:

Previous: sleeps well difficulty falling asleep night waking

Current: sleeps well difficulty falling asleep night waking

Other:

Does your child have funny odors and/or excessive sweating during sleep? Yes No

Neurological Sensory

Does your child have seizures? Yes No

Does your child have a history of tics? Yes No

Has your child ever had (please circle all that apply): EEG MRI Other:

Does your child have sensory issues (please circle all that apply):

Oral Touch Sound Smell

Is your child insensitive to pain? Yes No

Vision

Does your child make and maintain good eye contact? Yes No

Does your child wear glasses? Yes No

Does your child have trouble going down steps? Yes No

Does your child have trouble catching a ball? Yes No

Is your child cross-eyed or do they have a lazy eye? Yes No

Dental

Does your child have any amalgam (silver) fillings? Yes No

Does your child have problems with tooth enamel? Yes No

Does your child grind their teeth? Yes No

Does your child have any cavities? Yes No

Does your child have any problems with anesthesia? Yes No

Diet

Please describe any food sensitivities and/or allergies:

List any foods your child avoids:

List any foods your child craves:

List any special diets your child has been on/is currently on:

(Please attach a list detailing a typical 3 day meal plan)

Previous Interventions & Future Goals

Please describe interventions that have helped your child:

Please describe interventions that have made no difference:

Please describe interventions that made your child worse:

Please briefly describe your expectations for this consult:

Please list the three most urgent issues you hope to address: