Autism-Spectrum Health Questionnaire

(Includes children without an official diagnosis who may have ADD, ADHD, Sensory Issues etc.) ***Please use black ink***

Child's Name_____
Child's Age_____ Date of Birth: Month_____Day_____Year_____
Sex: Male: ____ Female: ____ Weight: _____

Age of Autistic Spectrum Disorder (ASD) Diagnosis? _____ Official Diagnosis _____
Is child classified as Mild ASD ___ Moderate ___ Severe ___
Symptoms became apparent at what age? _____
What signs and symptoms first became noticeable that alarmed you as a parent? (Please list as many initial developmental problems as possible, ie. poor eye contact, aggressive behavior, etc.):

What developmental issues does child suffer with currently if different from above?

Other Health Issues:
Does your child suffer with other health problems: ___Allergies ___Asthma ___Constipation ___Diarrhea ___Eczema___ Kidney Problems ___Lung Disease ___ Diabetes ___Thyroid Disease ___Heart Disease
___ Seizures___ Repeated Infections ___Other, please explain_____
Did your child's condition change following an illness, infection and/or seizure disorder (such as a febrile seizure) ___No ___Yes, please explain_____

Digestive Health:
Does child have periodic loose stools/diarrhea___ Yes ___ No
Offensive Gas ___Yes ___No Undigested Food Stuff in Stools ___Yes ___No
Is you child potty trained ___Yes ___No Does your child suffer with reflux/heartburn ___Yes ___No
Is your child currently taking an acid-blocking medication such as Tagamet, Pepcid, etc. ___Yes ___ No
Did occurrence of digestive problems occur following a particular vaccine ___Yes ___No ___ Unsure
Does your child produce formed stools ___Yes ___ No
Have they ever produced formed stools ___Yes ___ No

Antibiotic History:
How many courses of antibiotics has your child received in lifetime (approx): ___ 0 ___ 1-5 ___5-10 ___10-15 ___15-20 ___20+
Main reason for antibiotic use: ___Ear Infections ___Bronchitis ___Pneumonia ___Sinus Infection ___Intestinal Infection ___Other (please explain)_____
Was your child ever treated for a yeast infection following antibiotic use _____

Drug Allergies: ____No/Unknown ____Yes (explain)_____

Home Environment:
How old is your current home____ Has your child lived in a home that had lead-based paint___Yes ___No
Is your flooring carpet ___ hardwood ___ tile___ Do you have carpeting in the bathrooms _____

Has there ever been any exposure in the home to molds ___Yes ___No, explain_____
Do you use commercial cleaners in the home ___Yes ___No
Has your child used or sleep in fire retardant clothing or bedding ___Yes ___No
Is child exposed to outside pesticides, fungicides, etc. ___Yes ___No
Please list pets and/or farm animals your child is exposed to _____

Mothers Pregnancy and Labor:
Did Mom have any complications during pregnancy, ie. ___High Blood Pressure___ Seizures ___ Diabetes
___Infections that antibiotic treatment ___Viral Infections (Flu, Mono) _____
Does Mom know her Rh status ___ (+ or -) Blood Type ___
Did Mom receive Rhogam during pregnancy ___Yes ___No
Did Mom receive any vaccinations during pregnancy ___Yes ___No, which ones _____
Did Mom receive any vaccinations after pregnancy while breastfeeding ___Yes ___No
Was your child delivered vaginal___ or C-section___ Labor induced with pitocin? ____Yes _____No
Forceps and/or suction devices used _____ Was there any concern for birth trauma _____

Mother's Medical History:
___Low Thyroid ___ Thyroid Cancer ___ Parathyroid problems ___ Nightblindness (difficulty seeing at night)
___Autoimmune Disorders (Lupus, Connective Tissue, Rheumatoid Arthritis, Autoimmune Thyroid)
Mercury Fillings in Mouth ___ Dental work that contains Nickel ___
Other, please explain_____
Did Mom have any dental work done during pregnancy ___Yes ___No
Did mom have mercury fillings removed while breastfeeding child ___Yes ___No

Family History:
Is there a family history of Developmental Disorders, i.e. Autism, PDD? Please explain:

Is there a family history of other Neurological Disorders, i.e. Multiple Sclerosis, etc.

Is there a family history of Asthma, Allergies, Autoimmune Disorders (Lupus, Rheumatoid Arthritis, etc.)?

Is there a family history of Clotting or Blood Disorders, Strokes, Hemophilia, Platelet Disorders?

Is there a family history of Psychiatric Disorders, i.e. Depression, Schizophrenia, etc.?

Is there a family history of Genetic disorders?

Is there a family history of Seizures, Vaccine Reactions?

Is there a family history of Celiac Disease, or Gluten Intolerance?

Vaccination Status:
Has child received all the recommended vaccinations for their age? ____ Yes ____ No
Has your child received: ___DTP ___ DTaP ___ MMR ___Hib ___Hep B ___OPV ___IPV
___Pneumonia ___Chicken Pox ___Flu ___Others (please list)_____
Do you feel your child's behavior change after a particular vaccination? ____Yes _____No. If yes, please indicate which vaccine(s) _____
How long after the above vaccine(s) did child become symptomatic? (ex:: Minutes, days, etc. _____

Did your child receive any vaccinations when they were sick ___Yes ___No, please explain_____

Did your child suffer any vaccine reactions ___Fever ___ Inconsolable screaming ___Excessive lethargy___
___Rashes ___Vomiting ___Seizures ___Other_____

Medication Usage:
Has child taken steroid medication ___Yes ___No. If Yes, which kind ___Inhaled ___oral
Has child taken medication for yeast/candida infection ___No ___Yes, please list_____

Is child currently taking medication for yeast ___Yes ___No
Are they taking supplements for yeast ___Yes ___No, please list_____
Please list other medication child is currently taking:

Supplements:
Please list all supplements child is currently taking, including nutritional oils, i.e. Cod Liver, Flax, etc:

Diet:
Is child on a Gluten Free Diet ___Yes ___No
Is child on a Casein Free Diet ___Yes ___No
Has child benefited by being on a GF/CF diet:_____
Is child on a Specific Carbohydrate Diet _____ Is child on a Low Oxalate Diet _____Other Diet_____

DAN! Therapies:
Has child received Secretin ___Yes ___No. If yes, have they benefited_____
Is child receiving Cod Liver Oil ___Yes ___No. Any benefits?_____
Is your child receiving Bethanocol Treatment ___Yes ___No. Any benefits?_____
Has child received IVIG (Intravenous Immunoglobulins) ___Yes ___No. Any benefits?_____
Is child currently receiving IVIG therapy ___Yes ___No
Does child currently have Mercury/Amalgam/Silver Fillings? ___Yes ___No
Has child received Mercury Chelation w/DMSA ___Yes ___No DMPS ___Yes ___No EDTA ___Yes ___No Any benefits from chelation therapy?_____
Has child received Chelation Therapy for other Heavy Metals besides Mercury?
_____
Has your child taken antifungals in the past, i.e. Nystatin,? ___Yes ___No Diflucan ___Yes ___No
Is child taking Transfer Factor? ___Yes ___No Colostrum ___Yes ___No
Valtrex ____Yes ____No Low Dose Naltrexone (LDN) ____ Yes ____No Actos ____ Yes ____ No

Spironolactone ____Yes ___ No
Other Biomedical Therapies_____

Attended a "Great Plains" seminar ___Yes ____ No Other biomedical Autism Conferences ___Yes ___No

Online seminars or classes ___Yes ___No Other biomedical autism support groups ___Yes ___No

What autism-related books have you read _____

Internet articles or websites _____

What biomedical therapies are you interested in? _____

Other Important Information: If pertinent, please take the time to tell us more about the medical history of your child in relation to their autism diagnosis. If more space is needed you may use the back of this document or send extra pages with the other office paperwork.