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?  
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: