

**Autism Spectrum Disorder - New Patient Medical History Form**

Child's Name: \_\_\_\_\_ DOB \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Child's Social Security Number: \_\_\_\_\_

Primary Care Physician: (PCP) \_\_\_\_\_

Location of PCP: \_\_\_\_\_ PCP Phone Number: \_\_\_\_\_

Health Insurance Carrier: \_\_\_\_\_

Current Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Referred by: \_\_\_\_\_

Siblings: Please indicate whether Male or Female

Name: \_\_\_\_\_ DOB \_\_\_\_\_

Name: \_\_\_\_\_ DOB \_\_\_\_\_

Name: \_\_\_\_\_ DOB \_\_\_\_\_

Diagnosis given about your child: \_\_\_\_\_

Date diagnosis given: \_\_\_\_\_

Other problems to be addressed: \_\_\_\_\_

**Allergies**

	Side Effects
Medications: _____	_____
_____	_____
_____	_____
Chemicals: _____	_____
_____	_____
_____	_____
Foods: _____	_____
_____	_____
_____	_____

## Current Medications

*Please list your child's current medications, supplements, and allergies.*

Current Medications:

Medication	Frequency	Dosage	Taken Since

Current Vitamins and Nutritional Supplements

Medication	Frequency	Dosage	Taken Since

Describe your child to us, including his/her history. Please be as detailed as possible.

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When did you first notice your child's problem?

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What did you first notice?

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Was the onset of your child's problem sudden or gradual?

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Was there any event or illness that you or others think brought on your child's symptoms?

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Please make note of any other action that you think may have some bearing to your child's condition

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## Health Care Providers

### *Primary Care Doctors*

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

### *Therapists*

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

### *Other Care Givers*

*Please specify field of expertise*

Name \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ Date of Evaluation \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ Date of Evaluation \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ Date of Evaluation \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ Date of Evaluation \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ Date of Evaluation \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ Date of Evaluation \_\_\_\_\_

## Prenatal History

Maternal Age at Delivery: \_\_\_\_\_

Medication during pregnancy: \_\_\_\_\_

Illness during pregnancy: \_\_\_\_\_

Other complications during pregnancy: \_\_\_\_\_

Complications during labor and delivery: \_\_\_\_\_

Mode of delivery:                      C-Section                      Vaginal                      If C-section, explain why: \_\_\_\_\_

If vaginal delivery, did you have forceps/vacuum? \_\_\_\_\_

Medications during labor and delivery? \_\_\_\_\_

Circle One:                      Full Term                      Premature                      How many weeks? \_\_\_\_\_

Complications after delivery? \_\_\_\_\_

Medications given to child during hospital stay? \_\_\_\_\_

## Dietary/Nutritional History

Breast-Fed? Yes/No (circle one) If yes, how long? \_\_\_\_\_

Bottle Fed? Brand of formula? \_\_\_\_\_

Began at what age? \_\_\_\_\_ For how long? \_\_\_\_\_

Foods? Began at what age? \_\_\_\_\_ First Foods? \_\_\_\_\_

Whole milk? Circle one: Yes No If yes, at what age? \_\_\_\_\_

Known allergies to foods? (Please List) \_\_\_\_\_

Suspected allergies to foods? (Please List) \_\_\_\_\_

Food Cravings: (Please List) \_\_\_\_\_

Check the most appropriate description below of your child's diet:

<input type="checkbox"/>	Mostly baby foods
<input type="checkbox"/>	Mostly carbohydrates (bread, pasta, etc.)
<input type="checkbox"/>	Mostly dairy (milk, cheese)
<input type="checkbox"/>	Mostly meat
<input type="checkbox"/>	Mostly vegetarian (vegetables, fruits, grains, etc.)
<input type="checkbox"/>	Other. Describe: _____

Describe your child's food stool pattern (Daily, foul, large, mushy, etc.) \_\_\_\_\_

Please place a check mark in the appropriate column of foods your child eats.

Food	Daily	3-5x/week	1-3x/week	Never	Used to, but no longer does
Cookies					
Candy					
Sweet foods					
Caffeine					
Chocolate					
Milk: Whole					
2%					
1%					
Skim					
Cheese					
Ice cream					
Salty Foods					
Meat					
Pasta					
Bread: White					
Wheat					
Other					

Please list all of the foods and beverages normally consumed by your child for three typical days:

Day 1	
Breakfast	
Morning Snack	
Lunch	
Afternoon Snack	
Dinner	
Day 2	
Breakfast	
Morning Snack	
Lunch	
Afternoon Snack	
Dinner	
Day 3	
Breakfast	
Morning Snack	
Lunch	
Afternoon Snack	
Dinner	

## Family History

Has any relative had one or more of the following? (Please check all that apply)

MGM=Maternal Grandmother, PGM=Paternal Grandfather

PGM=Paternal Grandmother, PGF=Paternal Grandfather

Cancer and Type	<input type="checkbox"/> PGF <input type="checkbox"/> Sister	<input type="checkbox"/> PGM <input type="checkbox"/> Brother	<input type="checkbox"/> MGM <input type="checkbox"/> Aunt	<input type="checkbox"/> MGF <input type="checkbox"/> Uncle	<input type="checkbox"/> Mother <input type="checkbox"/> Father
Diabetes	<input type="checkbox"/> PGF <input type="checkbox"/> Sister	<input type="checkbox"/> PGM <input type="checkbox"/> Brother	<input type="checkbox"/> MGM <input type="checkbox"/> Aunt	<input type="checkbox"/> MGF <input type="checkbox"/> Uncle	<input type="checkbox"/> Mother <input type="checkbox"/> Father
Heart Disease	<input type="checkbox"/> PGF <input type="checkbox"/> Sister	<input type="checkbox"/> PGM <input type="checkbox"/> Brother	<input type="checkbox"/> MGM <input type="checkbox"/> Aunt	<input type="checkbox"/> MGF <input type="checkbox"/> Uncle	<input type="checkbox"/> Mother <input type="checkbox"/> Father
High Blood Pressure	<input type="checkbox"/> PGF <input type="checkbox"/> Sister	<input type="checkbox"/> PGM <input type="checkbox"/> Brother	<input type="checkbox"/> MGM <input type="checkbox"/> Aunt	<input type="checkbox"/> MGF <input type="checkbox"/> Uncle	<input type="checkbox"/> Mother <input type="checkbox"/> Father
Stroke	<input type="checkbox"/> PGF <input type="checkbox"/> Sister	<input type="checkbox"/> PGM <input type="checkbox"/> Brother	<input type="checkbox"/> MGM <input type="checkbox"/> Aunt	<input type="checkbox"/> MGF <input type="checkbox"/> Uncle	<input type="checkbox"/> Mother <input type="checkbox"/> Father
High Cholesterol	<input type="checkbox"/> PGF <input type="checkbox"/> Sister	<input type="checkbox"/> PGM <input type="checkbox"/> Brother	<input type="checkbox"/> MGM <input type="checkbox"/> Aunt	<input type="checkbox"/> MGF <input type="checkbox"/> Uncle	<input type="checkbox"/> Mother <input type="checkbox"/> Father
Bowel/Colon Disorders	<input type="checkbox"/> PGF <input type="checkbox"/> Sister	<input type="checkbox"/> PGM <input type="checkbox"/> Brother	<input type="checkbox"/> MGM <input type="checkbox"/> Aunt	<input type="checkbox"/> MGF <input type="checkbox"/> Uncle	<input type="checkbox"/> Mother <input type="checkbox"/> Father
Alcoholism	<input type="checkbox"/> PGF <input type="checkbox"/> Sister	<input type="checkbox"/> PGM <input type="checkbox"/> Brother	<input type="checkbox"/> MGM <input type="checkbox"/> Aunt	<input type="checkbox"/> MGF <input type="checkbox"/> Uncle	<input type="checkbox"/> Mother <input type="checkbox"/> Father
Lung Disease	<input type="checkbox"/> PGF <input type="checkbox"/> Sister	<input type="checkbox"/> PGM <input type="checkbox"/> Brother	<input type="checkbox"/> MGM <input type="checkbox"/> Aunt	<input type="checkbox"/> MGF <input type="checkbox"/> Uncle	<input type="checkbox"/> Mother <input type="checkbox"/> Father
Glaucoma	<input type="checkbox"/> PGF <input type="checkbox"/> Sister	<input type="checkbox"/> PGM <input type="checkbox"/> Brother	<input type="checkbox"/> MGM <input type="checkbox"/> Aunt	<input type="checkbox"/> MGF <input type="checkbox"/> Uncle	<input type="checkbox"/> Mother <input type="checkbox"/> Father

Relationship	Present Age or age at death	State of Health	Major Illnesses or Cause of Death
Paternal Grandfather	<input type="checkbox"/> Ex	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Paternal Grandmother	<input type="checkbox"/> Ex	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Maternal Grandfather	<input type="checkbox"/> Ex	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Maternal Grandmother	<input type="checkbox"/> Ex	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Father	<input type="checkbox"/> Ex	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Mother	<input type="checkbox"/> Ex	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Brothers	<input type="checkbox"/> Ex	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
	<input type="checkbox"/> Ex	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Sisters	<input type="checkbox"/> Ex	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
	<input type="checkbox"/> Ex	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
	<input type="checkbox"/> Ex	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	

## Social History

Who lives in the home with your child: \_\_\_\_\_

Are any children in your family adopted? \_\_\_\_\_

Pets in the house? How many? What kind? \_\_\_\_\_

Caregivers besides parents: \_\_\_\_\_

List the people most important in your child's life: \_\_\_\_\_

Recent changes, losses, births, deaths, divorce, remarriage or moves? \_\_\_\_\_

Recent Travel: \_\_\_\_\_

Child's response to these changes: \_\_\_\_\_

Is your child involved in any sports, music, or other activities? Please describe: \_\_\_\_\_

How does your child interact with other children? \_\_\_\_\_

With adults: \_\_\_\_\_

What makes your child happy? \_\_\_\_\_

Sad? \_\_\_\_\_

Angry? \_\_\_\_\_

Stressed? \_\_\_\_\_

How do you as a parent deal with these emotions in your child? \_\_\_\_\_

## Environmental History

Do you, your child, or any family members practice any relaxation/stress management techniques?

*Circle the appropriate answers to the following questions:*

Location of home:      City                      Suburban                      Wooded area                      Farm

Water:                      City                      Well                      Purification system?                      Y/N

Type of Heat:              Electric              Gas              Oil              Other: \_\_\_\_\_

Do you live near:      Power lines                      Woods                      Industrial area                      Water

Do you live near water:              Swamp              River              Ocean              Other: \_\_\_\_\_

Does your home have a lot of:              Dust              Mold              Down or feather items

Describe your child's bedroom:

Bedding:                      Synthetic                      Down                      Feather

Flooring:                      Carpet                      Wood                      Synthetic                      Glued down?

Mattress Cover:              Yes                      No

Bed:                      Adult bed                      Crib                      Junior bed

Window Treatment:              Shades                      Blinds                      Valance                      Curtains

Other items in room including furniture, toys, stuffed animals: \_\_\_\_\_

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Describe the flooring in other rooms of the house:

Child's Bathroom: \_\_\_\_\_

Living Room: \_\_\_\_\_

Family/Play room: \_\_\_\_\_

Is your child sensitive to or bothered by any of the following?

- |                                  |                                  |                                     |  |
|----------------------------------|----------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Perfume | <input type="checkbox"/> Paint   | <input type="checkbox"/> Animals    | <input type="checkbox"/> Cleaning Products |
| <input type="checkbox"/> Soaps   | <input type="checkbox"/> Mold    | <input type="checkbox"/> Grass      | <input type="checkbox"/> Gasoline          |
| <input type="checkbox"/> Dust    | <input type="checkbox"/> Pollens | <input type="checkbox"/> Detergents |  |

## Developmental History

*Please list the age when the following skills were mastered and any problems associated with these skills.*

First Words: (Age: _____ )
Phrases or sentences: (Age: _____ )
Pulling to Stand: (Age: _____ )
Walking: (Age: _____ )
Sitting Up: (Age: _____ )
Crawling: (Age: _____ )
Running: (Age: _____ )
Walking up/down steps without help: (Age: _____ )
Jumping: (Age: _____ )
Learned to pedal: (Age: _____ )
Rode 2-wheel bicycle: (Age: _____ )
Put on clothing: (Age: _____ )

## Medical History

*Please mark which tests have been done and provide date and results.*

<b>Evaluation/Test</b>	<b>Date</b>	<b>Results</b>
24 Hour Amino Acids		
Amino Acid Screen		
Blood Chemistry Screen		
Blood Count (CBC)		
Blood Test-Fatty Acid		
Blood Test-Food Allergies		
CT Scan		
Colonoscopy		
DMSA Loading Study		
EEG		
Folic Acid		
Fragile X Chromosome Study		
Hair Elements		
Hearing Test		
Immune Profile		
MRI		
Organic Acids-fungal/bacteria		
Organic Acids-Metabolism		
PET Scan		

## Medical History

*Please mark which tests have been done and provide date and results.*

<b>Evaluation/Test</b>	<b>Date</b>	<b>Results</b>
Pinworm Prep		
Plasma Amino Acids		
Plasma or Serum Zinc		
RBC Elements		
Serum Ferritin (Iron stores)		
Serum Methylmalonic Acid		
Serum Vitamin A		
Small Bowel Biopsy		
Stool Culture		
Stool Parasites		
Thyroid Profile		
Uric Acid (blood or urine)		
Urinary Peptides		
Urine Elements		
Urine Kryptopyrrole		
X-Rays (specify)		
Other:		

## Immunizations

*Please indicate date and any reactions for those immunizations that your child has received.*

*If exact date isn't know, please approximate.*

*"Bowel" refers to any bowel symptom such as diarrhea.*

*"Swelling" refers to the site of the injection.*

<b>Immunization</b>	<b>Date</b>	<b>Bowel</b>	<b>Swelling</b>	<b>Crying</b>	<b>Seizure</b>	<b>Irritable</b>	<b>Fever</b>
<b>Diphtheria/Pertussis/ Tetanus</b>							
DPT 1							
DPT 2							
DPT 3							
DPT 4							
DPT 5							
<b>Immunization</b>	<b>Date</b>	<b>Bowel</b>	<b>Swelling</b>	<b>Crying</b>	<b>Seizure</b>	<b>Irritable</b>	<b>Fever</b>
Adult Dip/Tet							
Pediatric Dip/Tet							
<b>H Influenza Type B</b>							
HIB 1							
HIB 2							
HIB 3							
HIB 4							
<b>Polio Oral/Inject (Please circle)</b>							
OPV 1    Inject 1							
OPV 2    Inject 2							
OPV 3    Inject 3							
OPV 4    Inject 4							
OPV 5    Inject 5							
<b>Measles/Mumps Rubella</b>							
MMR 1							
MMR2							
<b>Hepatitis B</b>							
HBV 1							
HBV 2							
HBV 3							
<b>Prevnar (Pneumococcal)</b>							
<b>Miscellaneous</b>							
<b>Varivax (Chicken Pox)</b>							
<b>Tine Test</b>							
<b>Flu Vaccine</b>							
<b>Other</b>							

## Therapies and Diets

Now	Past	Therapies	Results
		Acupuncture	
		Auditory Training	
		Craniosacral	
		Energy Therapy	
		Naturopathy	
		Neural Therapy	
		Occupational Therapy	
		Osteopathy	
		Physical Therapy	
		Sensory Diet	
		Speech Therapy	
		Other	

Now	Past	Diets	Results
		Gluten Free	
		Casein Free	
		Yeast Free	
		High Protein/Low Carb	
		Salicylate Free	
		Low Phenolics	
		IgG reactive food avoidance	
		Specific Carb Diet	
		Other	

## Signs and Symptoms

*Please check any signs/symptoms your child may demonstrate  
and note duration and details if applicable.*

Description	Mild	Moderate	Severe	Duration	Details
Stimming (repetitive actions or movements)					
Rocking					
Head banging					
Self-mutilation					
Nail Biting					
Hand/arm biting					
Nail/skin picking					
Aggressiveness (Hitting, kicking, biting others)					
Mood swings					
Irritability/tantrums					
Fears/anxieties					
Hyperactivity					
Inability to concentrate					
Always fidgety in his/her seat					
Impulsive					
Breath holding					
Dizziness					
Seizures					
Poor Coordination					
Problems with buttons, ties, snaps or zippers					
Processing problems Visual, motor, etc.					
Problems with social interactions					
Sensitive to crowds					
Trouble remembering					
Low self-esteem					
Fatigue					
Cold hands/feet					
Cold intolerance					
Heat intolerance					
Recurrent/chronic fever					
Flushing					
Difficulty falling to sleep					
Night waking					
Nightmares					
Difficulty waking					
Bed Wetting/soiling					
Day time wetting/soiling					
Numbness/Tingling in hands/feet					
Headache					
Blinking					
Tics					

<b>Description</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>	<b>Duration</b>	<b>Details</b>
Eye Discharge					
Dark circles/Puffiness under eyes					
Night-blindness in child/family					
Congestion					
Dripping nose					
Sensitive to sounds/noise					
Bad breath					
Nose bleeds					
Acute sense of smell					
Sore throats					
Hoarseness					
Cough					
Wheezing					
Geographic Tongue					
Swollen gums					
Canker Sores					
Dry lips/mouth					
Diarrhea					
Constipation					
Bloating					
Passing Gas					
Belching					
Stomach Ache					
Refusal to eat					
Sensitive to texture of food					
Difficulty swallowing					
Food craving					
Grinding teeth					
Mucous/blood in stool					
Anal itching					
Calf cramps					
Other muscle cramps/spasms					
Tremors					
Weakness					
Stiffness					
Eczema					
Psoriasis					
Hives					
Acne					
Seborrhea					
Other rashes					
Easy bruising					
Itchy scalp					
Dry skin					
Oily skin					
Pale skin					
Sensitivity to insect bites					
Sensitive to texture of clothes					
Cracking/peeling hands					

<b>Description</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>	<b>Duration</b>	<b>Details</b>
Cracking/peeling feet					
Strong body odor					
Strong urine odor					
Strong stool odor					
Soft nails					
Thickening of nails					
Ridges/pitting of nails					
White spots/lines on nails					
Brittle nails					
Any OCD behaviors					
Reflux					
Persistent Colic					
Toe walking					

## Signs and Symptoms

*Please describe any other symptoms you would like us to know about your child:*

*List any other history, pertinent thoughts or questions that you want to address:*

***I certify that the above information is true and correct to the best of my knowledge. It is my responsibility to inform my health care provider if there are any changes in the information contained in this form.***

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Health Care Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_