Autism-Spectrum Health Questionnaire

(includes children without an official diagnosis)

Please bring this completed form with you to your initial visit with Dr. Keelyn Wu at the Portland Osteopathic Children's Clinic.

Child's Name:___________________________ Today's date_______________________

Child's Age:______ Date of Birth:__________Referred by:_________________________

Parent(s)Name(s):____Pediatrician/PCP:_____________________________List other providers (PT, OT, speech therapist, homeopaths, etc.) with phone #:_______________________________________

____

____

Sex: Male: ____ Female: ____ Weight: _____ Siblings with ASD/ADHD?___yes___no

Age of Autistic Spectrum Disorder (ASD) diagnosis:_____Official Diagnosis_____________

Is child's ASD classified as: Mild ___ 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.):____

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____

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

____

____

____

Please describe any other event, action, etc. that you think may have some bearing or relationship to your child's condition. Please be as detailed as possible._________________

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Other Health Issues:

Does your child suffer from other health problems? ___Food Allergies ___Seasonal / Environmental Allergies____Asthma ___Eczema___ Kidney Problems

___Lung Disease ___ Diabetes ___Thyroid Disease ___Heart Disease___ Seizures

___ Repeated Infections ___OCD 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:

Did your child breast feed?___Yes___No How long?_________ If formula fed, what kind? _________________________Any adverse reactions?___Yes___No

Did your child have colic as an infant?___Yes___No

When was dairy introduced?____________

Does child have periodic loose stools/diarrhea?___Yes __No Constipation?___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 or more

Main reason for antibiotic use: ___Ear Infections ___Bronchitis ___Pneumonia ___Sinusitus ____Intestinal Infection ____Other (please explain)_______________________________

Was your child ever treated for a yeast infection following antibiotic use?___Yes____No

Did your child ever receive probiotics after antibiotics?____Yes____No

Medication Allergies: ___Yes____No/Unknown (if answer is "yes", please list)_______

____

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 or tile?____

Has there ever been any exposure in the home to molds? ___Yes ___No

Has your child used or currently sleeps in fire retardant clothing or bedding? ___Yes ___No

Is child exposed to outside pesticides, fungicides, etc.? ___Yes ___No

Does your child consistently swim in a chlorinated swimming pool?___Yes___No

Please list pets:____

Social History

Is your child interested in other children?___Yes___No

Any interests or hobbies?____________________Recent changes, losses, births, deaths, divorce, remarriage or moves?____

Mother's Pregnancy and Labor:

Did Mom have any complications during pregnancy? ___High Blood Pressure___ Seizures ___ Diabetes___Infections with 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 If yes, which ones?

____

Did Mom receive any vaccinations after pregnancy while breastfeeding? ___Yes ___No

Was your child delivered vaginally?___ or C-section?___

Forceps and/or suction devices used?___Yes___No

Was there any concern for birth trauma?___Yes___No

Mother's Medical History:

___Low Thyroid ___ Thyroid Cancer ___ Parathyroid problems ___ Nightblindness (difficulty seeing at night)

___Autoimmune Disorders (Lupus, Connective Tissue, Rheumatoid Arthritis, Autoimmune Thyroid, Crohn's, Ulcerative Colitis, etc.)

Mercury Fillings in Mouth? ___Yes___No Dental work that contains Nickel? ___Yes___No

____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

Use of birth control pills?____Yes_____No How long?_________

Does mom have any digestive conditions? (GERD, IBS, chronic constipation, etc.)?____Yes ____No If "yes", what condition(s)?____

How many courses of antibiotics has mom received?___0____1-5____5-10____10 or more

Family History:

Is there a family history of Developmental Disorders, i.e. Autism, PDD?___Yes___No

Please explain:____

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

___Yes___No Please Explain:____

Is there a family history of Asthma, Allergies, Autoimmune Disorders (Lupus, Rheumatoid Arthritis, etc.)?___Yes___No Please Explain:____________________________________

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

___Yes___No

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

___Yes___No

Is there a family history of Genetic disorders?___Yes____No

Is there a family history of Seizures, Vaccine Reactions?___Yes___No

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

Any other relevant family history?____

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 changed 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

If "yes" please explain:____

Did your child suffer any vaccine reactions? ___Yes___No Please check if answer is "yes":

Fever __Inconsolable screaming__ Excessive lethargy___Rashes ___Vomiting ___

Seizures ___Other, Please explain: ____

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 or supplements for yeast? ___Yes ___No If "yes", 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 Oil, Flax, etc:____

____

____

Diet:

What does your child like to eat?____

____

Is child on a Gluten Free Diet? ___Yes ___No

Is child on a Casein Free Diet? ___Yes ___No

Is child on a Soy Free Diet?___Yes___No

Has child benefited by being on a GF/CF diet?___Yes___No

Is child on a Specific Carbohydrate Diet (SCD)?___Yes___No

Is child on a Low Oxalate Diet?___Yes___No

Other diet (please explain)____

DAN! Therapies:

Are you familiar with DAN?___Yes___No

Has your child seen a DAN! physician?__Yes___No If so, who?______________________

What biomedical testing and treatments were performed? Please explain:_______________

____

____

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?__Yes___No

Have you attended any DAN! conferences or other educational seminars?___Yes___No

Are you a member of a biomedical autism support group? ___Yes ___No

What autism-related books have you read?____

What biomedical therapies are you interested in? ___________________________________

Other Important Information:

If pertinent, please tell us more about the medical history of your child in relation to their autism

diagnosis on the back side of this page.

<u>Physician Only:</u>

Patient's history reviewed (date and initial):___________________________