Autism-Related Disorders Health Questionnaire

(Includes children without an official diagnosis who may have ADD, ADHD,
Sensory Processing Disorder, 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, i.e. poor eye contact, aggressive behavior, etc.):

What developmental issues does your child currently suffer from that is 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 list
_____
_____
_____

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 your 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 Pepcid, etc. ?___Yes ___ No
Did digestive problems occur following a particular vaccine? ___Yes ___No ___
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 their 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 slept in fire retardant clothing or bedding? ___Yes ___No
Is your child exposed to outside pesticides and fungicides? ___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, i.e. ___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 ___ Autoimmune Thyroid ___ Parathyroid problems ___ Nightblindness (difficulty seeing at night) ___Autoimmune Disorders (Lupus, Connective Tissue, Rheumatoid Arthritis)
Mercury Fillings in Mouth ___ Yes ___No, If so, how many
_____
Other diseases, 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 changed after a particular vaccination? ___Yes _____No. If yes, please indicate which vaccine(s)
_____
_____

How long after the above vaccine(s) did your 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_____ Rash _____ Welts at injection site ___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?
_____

Biomedical Therapies:
Has child received Secretin? ___Yes ___No. If yes, have they benefited?
_____
Is child receiving Cod Liver Oil? ___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?
___Yes____ No, If yes, please
explain_____
____
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_____

Has Parent 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.