# Expanded History Form

**Name:**
**Date:**
**Type of Consult:**
**Age:**
**Weight:**
**Supplement Preference:**

**Development – 1st year**

**Development – 2nd year**

**Autism Development (early onset, gradual, sudden):**

**Digestive Problems:**

**Past Assessment (traditional):**

**Medications:**

**<u>Main Issues (current):</u>**

**-Language –**

**-Social –**

**-Behavior –**

**-Sensory/Self-Stimulatory Activities –**

**-Ritualistic/OCD –**

**-Anxiety –**

**-Other Odd Behaviors –**

**Biomedical Intervention (current and past list):**

**Most Helpful (supplements, diet, medications, etc.)**

**Makes Worse (supplements, medications, etc.)**

**Other Comments and Impressions:**

**Parents Treatment Interest List:**

**Future Treatment/Testing Consideration List:**