

**Autistic-Spectrum Disorder**  
**Health History Information**

Child's Name \_\_\_\_\_

Child's Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Sex: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Age of Autistic Spectrum Disorder (ASD) Diagnosis? \_\_\_\_\_

Is child classified as Mildly 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 child suffer with currently if different from above?

**Other Health Issues:**

Does your child suffer with other health problems: Allergies \_\_\_\_\_ Asthma \_\_\_\_\_  
Constipation \_\_\_\_\_ Diarrhea \_\_\_\_\_ Eczema \_\_\_\_\_ Kidney Problems \_\_\_\_\_ Lung Disease \_\_\_\_\_  
Thyroid Disease \_\_\_\_\_ Heart Disease \_\_\_\_\_ Seizures \_\_\_\_\_ Repeated Infections \_\_\_\_\_ Other  
\_\_\_\_\_, please explain \_\_\_\_\_

**Digestive Health:**

Does your 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 Tagamet, Pepcid, etc.  
Yes \_\_\_\_\_ No \_\_\_\_\_  
Did occurrence of 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 lifetime (approx): 0-5 \_\_\_\_\_  
5-10 \_\_\_\_\_ 10-15 \_\_\_\_\_ 15-20 \_\_\_\_\_ 20+ \_\_\_\_\_  
Main reason for antibiotic use: Ear Infections \_\_\_\_\_ Bronchitis \_\_\_\_\_ Pneumonia \_\_\_\_\_  
Sinus Infection \_\_\_\_\_ Intestinal Infection \_\_\_\_\_ Other (please explain)  
\_\_\_\_\_

**Home Environment:**

How old is your current home \_\_\_ Has your child lived in a home that lead-based paint

Yes \_\_\_ No \_\_\_ Is your flooring carpet \_\_\_ hardwood \_\_\_ Tile \_\_\_

Do you have carpeting in he bathrooms Yes \_\_\_ No \_\_\_

Has there ever been exposure in the home to molds Yes \_\_\_ No \_\_\_

Has your child used or sleep in fire retardant clothing or bedding Yes \_\_\_ No \_\_\_

Do you use commercial cleaners in the home Yes \_\_\_ No \_\_\_

Is child exposed to outside pesticides, fungicides, etc. Yes \_\_\_ No \_\_\_

Please list pets and/ or farm animals your child is exposed to \_\_\_\_\_

**Mother's Pregnancy and Labor:**

Did Mom have any complications during pregnancy, i.e. High Blood Pressure \_\_\_

Seizures \_\_\_ Infections tat 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 \_\_\_

Forceps and/or suction devices used \_\_\_\_\_ Was there any concern for birth

trauma \_\_\_\_\_

**Mother's Medical History:**

Low Thyroid \_\_\_ Thyroid Cancer \_\_\_ Parathyroid problems \_\_\_ Night blindness

(difficulty seeing at night) \_\_\_ Autoimmune Disorders (Lupus, Connective Tissue,

Rheumatoid Arthritis, Autoimmune Thyroid) Mercury Fillings in Mouth \_\_\_

Dental work that contains Nickel \_\_\_ Other, please explain \_\_\_\_\_

Did Mom have any dental work done during pregnancy 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 change 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 \_\_\_ please explain \_\_\_\_\_  
Did your child suffer any vaccine reactions Fever \_\_\_ Inconsolable screaming \_\_\_  
Excessive lethargy \_\_\_ Rashes \_\_\_ 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 Yes \_\_\_ No \_\_\_  
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 Casein Free Diet Yes \_\_\_ No \_\_\_  
Has child benefited by being on a GF/CF diet: \_\_\_\_\_

**Dan! Therapies:**

Has child received Secretin Yes \_\_\_ No \_\_\_ If yes, have they benefited \_\_\_\_\_

Is child receiving Cod Liver Oil Yes \_\_\_ No \_\_\_ Any benefits? \_\_\_\_\_

Is your child receiving Botanical Treatment Yes \_\_\_ No \_\_\_ Any benefits? \_\_\_\_\_

Is child currently receiving IVIG therapy Yes \_\_\_ No \_\_\_

Does child currently have Mercury/Amalgam/Silver Filling? Yes \_\_\_ No \_\_\_

Has child received Mercury Chelation w/DMSA Yes \_\_\_ No \_\_\_ Any Benefits?

\_\_\_\_\_ Has child received Chelation Therapy for other Heavy Metals besides Mercury? \_\_\_\_\_

Has your child taken antifungals in the past, i.e. Nystatin, Diflucan? Yes \_\_\_ No \_\_\_

Is child taking Transfer Factor? Yes \_\_\_ No \_\_\_ Colostrum Yes \_\_\_ No \_\_\_

Other DAN! Therapies \_\_\_\_\_

**Other Important Information:** If pertinent, please take the time to tell us more about the medical history of your child in relation their autism diagnosis. Thank you.