Autism Spectrum Disorder (ASD)
Intake Questionnaire

Patient Name:___________________________________Date of Birth:___________

Parent's names:____

Autism Treatment Checklist Score (www.autism.com/atec)_______Date done_________
ATEC subscores: I: II: III: IV:

Child's school:____Grade__________

School type:____

Are you happy with this setting for your child? Explain.

Current Therapies:

Are they home, school or center based?

With whom does the child live (including children)? Please list names and ages of children and if any have special needs.

When and by whom was the diagnosis of an ASD made (if applicable, if not what diagnoses have been made)?

At what age did you suspect a problem and why?

Past Medical and Developmental History:

Pregnancy, delivery and newborn history:

Where did mom grow up?

Did she live near factories, highways, farm fields or had known chemical exposures? Did she grow up in a home known to have lead, tobacco use or mold? Please describe:

Please describe any medical problems during the pregnancy, including illness. Did she take antibiotics during the pregnancy?

Any other medications taken? If so, what and when?

Where there any injections during the pregnancy and if so when and what?

How many grey dental fillings did mom have then? Any dental work during the pregnancy? If so, what?

Did mom eat fish during her pregnancy? How often and what type?

Please describe mom's diet during her pregnancy:

During the pregnancy or nursing, did mom smoke? Y N When? Did dad or other relative in the home smoke? Y N

During the pregnancy or nursing, did mom use any other drugs? Y N If so, what and when?

Mom's occupation and where worked during the pregnancy.

Please describe any problems with the pregnancy, labor or delivery. Did Mom receive antibiotics while in labor?

Was the labor induced with Pitocin? Y N

How long was the labor?

Type of delivery: Vaginal or C-section. Were forceps or vacuum used?

Was the child full-term? (between 38—41 weeks) If not, how far along?

Birth weight:_____________Apgars (if known)________________

Describe any newborn problems. Was the baby in the NICU (intensive care)? Y N

Did the child require antibiotics in the immediate newborn period (first week)? Y N

Was your child breastfed? If so, how long? Any breastfeeding problems?

If bottlefed, which formula did he/she get?
Any problems with formula? Please describe.

Did the baby have any problems with reflux, constipation or colic? If so, please describe.

Medical History:

Has the child had problems with recurrent infections of any type (more than once, excluding simple colds not requiring antibiotics)?
If so, what were they, when did they first start and end, if applicable?

Does your child get ill unusually often or is he/she unusually well? Describe:

Does it seem to take a very long time for your child to recover from illness?

Approximately, how many times over his/her lifetime has the child had antibiotics.

What surgeries has your child had? When and why?

Has the child had any dental fillings placed? If yes, are they grey?

Please list any allergy symptoms (nasal congestion, snoring, restless sleep, increased irritability during a certain season or response to food or other contact):

Is there any history of mold exposure? If so, when and where? (include school or other places your child has spent a lot of time)

Please list all current medications, vitamins or supplements and dosages.
Does your child swallow pills? Y N

Please describe any other medical history other than listed (use back of the page if needed):

Immunization History:

Please provide a copy of child's immunization record.

Were there any problems or adverse reactions to immunizations?
If so, please describe what they were and with which immunization.

Developmental History:

Did the child develop normally to a point and then regress? If so, was it after a specific event? Please describe what happened.

Was your child generally happy as an infant?

Did your child develop a good social smile in the first few months of life?

Did your child crawl? If so, how long?

At what age did he/she sit on his/her own?

At what age did the child say his/her first word?

At what age did he/she put two words together?

At what age did he/she walk?

Are there any persistent motor delays now? Is your child receiving physical therapy for these?

Please describe your child's language problems.

Please describe any educational challenges now (if applicable):

Family History:

Anyone else in the family (including extended family) with an ASD or other developmental delays? Who and what?

Any family history of any of the following? Who?

Autoimmune disorders (type):

Seasonal or food allergies:

Asthma:

Ezcema:

Thyroid problems:

Bipolar illness or schizophrenia:

Anxiety or depression:

Other family history you wish to include:

Past Therapies or Treatments:

What treatments has your child had in the past? Please include all therapies, as well as all medications and who provided them. Include any "alternative" therapies and providers, and what has been most helpful and how. For medications, how did they help or hurt (ie side effects)? Use back if necessary.

Please describe your child's sleep pattern, now and in the past. Any snoring?

Please describe your child's diet:

Is your child toilet trained? For urine? For stool? Any accidents or bedwetting? If so, describe.

Does your child struggle to have a bowel movement?

Any history of watery stools? When?

Please describe your child's bowel movements:

Frequency:
Consistency:
Color:
Smell (foul?):
Quantity (i.e. large or small):

Current symptoms:

Is your child sensitive to noise?

Is your child sensitive to light?

Is your child intolerant to heat? Cold?

Is your child sensitive to clothing?

Is your child sensitive to food textures or tastes?

Does your child put objects in her/his mouth excessively?

Does your child grind teeth?

Does your child have repetitive speech?   Movements?

Is your child very obsessive? When did this start and how severe is it?

Is your child very anxious? When?

Does your child have trouble with transitioning to one activity to another?

Does your child have mood swings?

Does your child have a hard time calming down?

Is your child aggressive or self-injurious? Please describe:

Please describe your child's overall energy level:

Please describe your biggest concerns with your child.