

**Autism Spectrum Disorder (ASD)
Intake Questionnaire**

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Patient Name: _____ Date of Birth: _____

Parent's names: _____

Today's Date: _____

Autism Treatment Checklist Score (www.ari-atec.com) _____

Child's school _____ Grade _____

Are you happy with this setting for your child?

With whom does the child live (including children)? Please list names and ages of children.

When and by whom was the diagnosis of an ASD made?

At what age did you suspect a problem and why?

Past Medical and Developmental History:

Pregnancy and early newborn history:

Was the child full-term?

Please describe any problems with the pregnancy, labor or delivery.

Did Mom receive antibiotics while in labor?

Please describe any medical problems Mom had during the pregnancy:

Did the child require antibiotics in the immediate newborn period?

Did Mom have any dental work during her pregnancy?

How many grey amalgam dental fillings does Mom have?

Did Mom receive any injections during her pregnancy? If so, what were they?

Did Mom eat fish during her pregnancy? How often?

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

If bottlefed, which formula did he/she get?

Any problems with formula? 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?

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

What surgeries has the child had 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):

Please describe and other medical history other than listed:

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, please describe what happened.

Did the 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?

Family History:

Anyone else in the family (included extended family) with an ASD? Who?

Any family history of any of the following? Who?

Early heart attack (before age 50):

Heavy bleeding (vaginal or otherwise):

Autoimmune disorders:

Current Health and Treatments:

What treatments has your child had? Please include all therapies, as well as all medications and who provided them. For medications, how did they help or hurt (ie side effects)? Use back if necessary.

Please list all current medications, vitamins or supplements and dosages.

Please describe your child's bowel movements:

Frequency:

Consistency:

Color:

Smell (foul?):

Quantity (i.e. large or small):

Is your child toilet trained? For urine? For stool?

Is your child sensitive to noise?

Does she/he put objects in her/his mouth excessively?

Please describe your child's diet:

Please describe your child's language problems.

Describes your child's sleep pattern, now and in the past.

Please describe your biggest concerns with your child now.