NASH INTEGRATIVE MEDICINE, INC.

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PHONE: (937) 877-1222 FAX: (937) 877-1254

Autism Spectrum Disorder
Patient History Information

Child's Name: _____

Child's Age: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female

Age of Autism 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 other developmental issues does your child currently exhibit if different from above?

Other Health Issues

Does your child have any of the following issues? [check all that apply]

- ☐ Allergies
- ☐ Asthma
- ☐ Constipation
- ☐ Diarrhea
- ☐ Eczema
- ☐ Kidney Problems
- ☐ Lung Disease
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Heart Disease
- ☐ Seizures
- ☐ Repeated Infections
- ☐ Other, please explain: _____

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 your child have periodic loose stools/diarrhea? Yes ☐ No ☐

Offensive gas? ☐ Yes ☐ No

Undigested foodstuffs in stool? ☐ Yes ☐ No

Is your child potty trained? ☐ Yes ☐ No

Does your child have reflux/heartburn? ☐ Yes ☐ No

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Is your child currently taking an acid-blocking medication? ☐ Yes ☐ No

Did occurrence of digestive problems occur following a particular vaccine? ☐ Yes ☐ No ☐ Unsure

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 a lifetime (approximately)?

☐ 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):_____

Was your child ever treated for a yeast infection following antibiotic use? ☐ Yes ☐ No

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 ☐ tile ☐ hardwood

Do you have carpeting in the bathrooms? ☐ Yes ☐ No

Has there ever been any exposure in the home to molds? ☐ Yes ☐ No If yes, 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 the 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? [check all that apply]

☐ High blood pressure

☐ Seizures

☐ Diabetes

☐ Other (please explain):_____

☐ Viral infections (e.g., Flu, Mono)

☐ Infections that required antibiotic treatment

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Does mom know her Rh status? ☐ Yes ☐ No If yes, ☐ pos(+) ☐ neg(-) Blood type:_____

Did mom receive Rhogam during pregnancy? ☐ Yes ☐ No

Did mom receive any vaccinations during pregnancy? ☐ Yes ☐ No

If yes, which ones?_____

Did mom receive any vaccinations after pregnancy while breastfeeding? ☐ Yes ☐ No

If yes, which ones?_____

Was your child delivered ☐ vaginally or ☐ via C-section?

Were forceps and/or suction devices used? ☐ Yes ☐ No

Was there any concern for birth trauma? ☐ Yes ☐ No

If yes, please explain:_____

Mother's Medical History

Check all that apply:

- ☐ Low Thyroid
- ☐ Nightblindness
- ☐ Thyroid Cancer
- ☐ Mercury fillings in mouth
- ☐ Parathyroid problems
- ☐ Dental work that contains Nickel
- ☐ Autoimmune disorders (Lupus, Connective Tissue, Rheumatoid Arthritis, Autoimmune Thyroid)
- ☐ Other, please explain:_____

Did mom have any dental work done during pregnancy? ☐ Yes ☐ No

Did mom have any mercury fillings removed while breastfeeding child? ☐ Yes ☐ No

Family History

Is there a family history of Developmental Disorders, i.e., Autism, PDD, etc.? Please explain:

Is there a family history of Neurological Disorders, i.e., Multiple sclerosis, etc.? Please explain:

Is there a family history of Asthma, Allergies, or Autoimmune Disorders (Lupus, Arthritis)? Please explain:

Is there a family history of Clotting or Blood Disorders, Strokes, Hemophilia, Platelet Disorders? Please explain:

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Is there a family history of Psychotic Disorders, i.e., Depression, Schizophrenia, etc.? Please explain:

Is there a family history of Genetic Disorders? Please explain:

Is there a family history of Seizures or Vaccine Reactions? Please explain:

Is there a family history of Celiac Disease or Gluten Intolerance? Please explain:

Vaccination Status

Has your child received all of the recommended vaccinations for their age? ☐ Yes ☐ No

Has your child received any of the following? [check all that apply]

☐ DTP	☐ Hep B	☐ Chicken Pox
☐ DTaP	☐ OPV	☐ Flu
☐ MMR	☐ IPV	
☐ Hib	☐ Pneumonia	

☐ Others, please explain:_____

Do you feel that your child's behavior changed after a particular vaccination? ☐ Yes ☐ No

If yes, please explain:_____

Approx. how long after the vaccination did the child become symptomatic? _____

Did your child ever receive any vaccinations when they were sick? ☐ Yes ☐ No

If yes, please explain:_____

Did your child suffer any vaccination reactions? [check all that apply]

☐ Fever	☐ Excessive lethargy	☐ Vomiting
☐ Inconsolable screaming	☐ Rashes	☐ Seizures

☐ Other, please explain:_____

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Medication Usage

Has child ever taken steroid medication? ☐ Yes ☐ No If yes, ☐ Inhaled, or ☐ Oral?

Has child taken medication for yeast/candida infection? ☐ Yes ☐ No

If yes, please list them:_____

Is child currently taking medication for yeast? ☐ Yes ☐ No

If yes, please list them:_____

Are they currently taking supplements for yeast? ☐ Yes ☐ No

If yes, please list them:_____

Please list any other medications your child is currently taking:

Please list any other supplements your child is currently taking:

Diet

Is child currently on a gluten free diet? ☐ Yes ☐ No

Is child currently on a casein free diet? ☐ Yes ☐ No

Has child ever benefited from being on a GF/CF diet in the past? ☐ Yes ☐ No

Other Therapies

Has child ever received Secretin? ☐ Yes ☐ No If yes, have they benefited? ☐ Yes ☐ No

Is child receiving Cod Liver Oil? ☐ Yes ☐ No If yes, have they benefited? ☐ Yes ☐ No

Is child receiving Bethanocol Treatment? ☐ Yes ☐ No If yes, have they benefited? ☐ Yes ☐ No

Has child received IVIG (Intravenous Immunoglobulins) ☐ Yes ☐ No Benefited? ☐ Yes ☐ No

Does child currently have Mercury/Amalgam/Silver fillings? ☐ Yes ☐ No

Has child received Mercury Chelation w/ DMSA? ☐ Yes ☐ No Benefited? ☐ Yes ☐ No

Has child ever 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, Diflucan? ☐ Yes ☐ No

Transfer Factor? Yes ☐ No ☐ Colostrum? ☐ Yes ☐ No

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Other Therapies, please list all and explain:

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. Thank you.