Western N.C. NATUROPATHIC MEDICINE

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AUTISM SPECTRUM INTAKE FORM

Thank you for taking the time to fill out this form as completely as possible before your or your child's visit.

Client's name: ____Date: ________________

Address:____

City: _____________________________________ State:_____________ Zip: _____________

Email: ____________________________________

Telephone (Home):_____________________________ (Cell):_____________________________

Age: ___________________ Date of birth: ___________________ Gender: F M

Diagnosis: ________________________Current height: _____Ft. _____Inches Weight: _______Lbs.

Occupation: _______________Highest level of education: _________Ethnic/Culture: ________________

* *

Mom's Name: ____

Daytime telephone: ______________________Cell Phone: ____________________________________

Occupation: __________________________Email: ____

Age: ______________Highest level of education: ________________Ethnic/Culture: _________________

Dad's Name: ____

Daytime telephone: ______________________Cell Phone: ____________________________________

Occupation: __________________________Email: ____

Age: ______________Highest level of education: ________________Ethnic/Culture: _________________

Parents are: Married _____# of years ______ Divorced _____ Separated _____ Single _____

Parents, how would you prefer to be contacted? home work email

May we leave a message? home work email

If you are an adult, do you have a significant partner? Name: ____

Daytime telephone: ______________________Cell Phone: ____________________________________

Occupation: __________________________Email: ____

Age: ______________Highest level of education: ____________________Ethnic/Culture: _____________

With whom do you or your child live with? ____

Were you or is your child adopted? Yes No

Child's school/daycare: ______________________________

Siblings and ages: ______________________________

Circle those that live in the same household with you or your child.

Any other occupants in household? Names and ages: ______________________________

Emergency contact:______________________________Relationship: ______________________________

Phone: ______________________________Email: ______________________________

* *

Name of current Medical Provider: ______________________________

Ok to contact? ___Yes ___ No Email: ______________________________Phone: ______________________________

Address? ______________________________

When was your or your child's last visit to the doctor's office? ____________What was the reason? ____________

Tell me about yourself or your child…

Strengths:______________________________

What are your or your child's most important health concerns?

1)______________________________

2)______________________________

3)______________________________

4)______________________________

When did you first notice your or your child's problems? ______________________________

What did you notice first?______________________________

Was the onset? _____ sudden _____ gradual

Any event or action that you think might have contributed to your or your child's symptoms?

____

What are your goals pertaining to your or your child's health?

Long term: ______________________________

Short term:

1. ______________________________

2. ______________________________

3. ______________________________

CLIENT'S SIGNS and SYMPTOMS *Please check all that apply.*

Daily Living Skills:

NOW	PAST		NOW	PAST		NOW	PAST	
_____	_____	sleep problems	_____	_____	sleeps in parents' bed	_____	_____	nightmares
_____	_____	wets the bed	_____	_____	poor dressing skills	_____	_____	appetite: low high
_____	_____	picky eater	_____	_____	eats things that aren't food	_____	_____	food texture issues
_____	_____	grinds teeth	_____	_____	reflux	_____	_____	nausea & vomiting
_____	_____	poor swallowing	_____	_____	drools	_____	_____	gags
_____	_____	puts objects in mouth	_____	_____	licks objects	_____	_____	won't take baths
_____	_____	not toilet trained bowel	_____	_____	not toilet trained bladder	_____	_____	bad breath

Motor Skills: Hand dominance: Right Left

_____	_____	clumsy	_____	_____	uncoordinated	_____	_____	gross motor delays
_____	_____	fine motor delays	_____	_____	poor handwriting	_____	_____	excess falls/bumps
_____	_____	poor balance	_____	_____	dizzy	_____	_____	poor muscle tone
_____	_____	hyperactive	_____	_____	impulsive	_____	_____	lethargic
_____	_____	toe walker						

Sensory Skills:

_____	_____	poor visual acuity	_____	_____	poor eye contact	_____	_____	light sensitive
_____	_____	stares vacantly	_____	_____	looks out of corners of eyes	_____	_____	likes to stare
_____	_____	excessive blinking	_____	_____	dark circles under eyes	_____	_____	turns lights on/off
_____	_____	poor hearing	_____	_____	hyper-sensitive to sounds	_____	_____	covers ears
_____	_____	aggravated by music	_____	_____	craves vibration	_____	_____	strong body odor
_____	_____	white spots on nails	_____	_____	nail biter	_____	_____	skin picker
_____	_____	sensitive to light touch	_____	_____	sensitive to heavy touch	_____	_____	irritated by clothes/sheets/tags
_____	_____	sensory processing challenges						

Cognitive/Language:

_____	_____	inattentive/poor focus	_____	_____	preoccupied	_____	_____	perseverates
_____	_____	non-verbal	_____	_____	language difficulties	_____	_____	has "own" language
_____	_____	monotone voice	_____	_____	unusual pitch to voice	_____	_____	only speaks if spoken to
_____	_____	ignores directions/conversations	_____	_____	afraid of certain sounds/words			
_____	_____	repeats words/phrases over and over	_____	_____	easily distracted			

Behaviors/Temperament:

_____	_____	nervous	_____	_____	depressed	_____	_____	anxious
_____	_____	argumentative	_____	_____	aggressive	_____	_____	self-injuries
_____	_____	hits	_____	_____	bites	_____	_____	temper tantrums
_____	_____	pulls out own hair	_____	_____	cruel to animals	_____	_____	overreacts to pain
_____	_____	under reacts to pain	_____	_____	repetitious actions	_____	_____	disruptive
_____	_____	inappropriate sexual behavior	_____	_____	self-stimulatory behaviors: rocking, spinning, flapping hands, etc			
_____	_____	cries for no apparent reason	_____	_____	little response to external activities			
_____	_____	laughs/smiles inappropriately	_____	_____	quickly changes moods			
_____	_____	blank expression on face	_____	_____	poor self-esteem			

Social Skills:

_____	_____	"in own world"	_____	_____	not cuddly as baby	_____	_____	does not recognize parent
_____	_____	prefers solitary play	_____	_____	fearful of strangers	_____	_____	does not like hugs
_____	_____	prefers older or younger children	_____	_____	few friends	_____	_____	difficulty engaging c. others
_____	_____	self-centered						

1. Have you or your child ever lost skills, which at one time were able to perform? No Yes
   If yes, please explain:_____

2. Most challenging behavior? _____

3. What triggers the challenging behaviors? _____

4. Which tools are most effective to increase desired behaviors?
☐ Physical contact ☐ Rewards ☐ Verbal praise ☐ Explanations ☐ Other:

5. Which tools are most effective to decrease unwanted behaviors?
☐ Quiet time ☐ Loss of privileges ☐ Ignoring ☐ Grounding ☐ Other:

ENERGY
How would you rate your or your child's focus/attention on a scale of 1-10? (0=least, 10=most): _____
How would you rate your or your child's activity level on a scale of 1-10? (0=none, 10=constant):_____
How would you rate your or your child's energy level during the day? (0=no energy, 10=overenergized): _____
List any problems that you think affect your or your child's energy: _____

SLEEP
Sleep: Average # hours/night? _____How long to fall asleep?_____
Waking during the night? ___Yes ___No How often? _____
Waking rested? _____
Do you have to be waken or do you wake your child in the morning? ___Yes ___No
Do you or your child snore? _____Yes ____No Do you or your child use any sleeping aids? ____Yes ____No

DIET
Allergies: _____
Food Cravings: _____
Special Diet: _____

Breakfast:

Lunch:

Dinner:

Snacks:

Fluids:

Alcohol: Yes No How much?

EXERCISE

Exercise Activity	*Frequency/Week*	*Duration in minutes*
Bike riding		
Swimming		
Dance		
Sports		
Martial Arts		
Other		

Hobbies/interests:_____
_____

CURRENT TREATMENTS/THERAPIES

Type of Treatment	Service Provider or Clinician And Contact Information	How many hours per week is this treatment provided?	Start Date	Do you feel that this treatment is beneficial? Please explain.
Special Education				
Speech Therapy				
Occupational Therapy				
Physical Therapy				
ABA Program				
Counseling				
Social Skills Training				
Neurofeedback/ Biofeedback				
Bodywork				
Yoga				
Meditation				
Hyperbaric Therapy				
IV Therapy				
Other:				

PRENATAL/PREGNANCY

Mother's age at conception: _____
Did the mother have previous pregnancies? ☐ No ☐ Yes--how many, including miscarriages? _____
Did mother receive prenatal care during this pregnancy? ☐ No ☐ Yes, beginning at month? _____
Were there any unusual changes in the baby's activity level during pregnancy? ☐ No ☐ Yes

Did the biological mother have any of the following immediately before/after or during pregnancy?
☐ Maternal injury. Describe:
☐ Hospitalization during pregnancy. Reason:

☐ Emotional problems	☐ Rashes	☐ Excessive swelling	☐ Excessive nausea/vomiting
☐ Kidney disease	☐ Rh incompatibility	☐ Urinary problems	☐ Headaches
☐ Bed-rest	☐ Anemia	☐ Vaginal bleeding	☐ Strep throat
☐ Flu	☐ Infections	☐ Other virus	☐ Measles/German measles
☐ Severe cold	☐ Premature Labor	☐ Toxemia	☐ High blood pressure
☐ Eclampsia	☐ Threatened miscarriage	☐ Gained more than 35 pounds	☐ Other:

☐ Special diet, describe: _____

☐ Meds: _____

DELIVERY

Was infant born full-term? ☐ Yes ☐ No Birth weight:_____Birth length: _____
If premature, how early? _____If overdue, how late? _____

Check all of the following that applied to the delivery:
☐ Spontaneous ☐ Breech ☐ Forceps
☐ Head first ☐ Multiple births ☐ Cord around neck ☐Induced; Reason: _____
☐ Cesarean - Reason: _____
Describe any other complications: _____

Which of the following applied to the infant? (check all that apply)

☐ Breathing problems	☐ Jaundice (Were Bilirubin lights used?	☐ Feeding problems
☐ Rash	☐ Unusual appearance, describe: _____	☐ Bleeding into the brain

Apgars: at 1 minute _____ at 5 minutes _____
Did the infant require: ☐ X-Rays ☐ CT scans ☐ Blood transfusions ☐ Placement in the NICU (How long? _____)

DEVELOPMENTAL HISTORY

Early Childhood History: *During first three years, were any special problems noted in the following areas?*

☐ Required oxygen	☐ Required incubator - How long? _____		
☐ Sleeping problems	☐ Infection	☐ Excessive crying	☐ Seizures/convulsions
☐ Twitching	☐ Difficulty sleeping	☐ Failure to thrive	☐ Poor eye contact
☐ Eating problems	☐ Temper tantrums	☐ Withdrawn behavior	☐ Destructive behavior
☐ Irritability	☐ Unable to separate from parent		☐ Early learning problems

☐ Other _____

Milestones: *Indicate age when child*:

_____ rolled over	_____ at unaided	_____ crawled	_____ walked
_____ gave up bottle	_____ started solid foods	_____ fed self with spoon	
_____ bladder trained-day	_____ bladder trained-night	_____ bowel trained	
_____ babbled	_____ used single words	_____ used phrases/short sentences	
_____ ran	_____ rode tricycle	_____ rode two-wheel bike	

SCHOOL

Current grade in school _____Type of class: ☐ Regular Ed ☐ Special Ed ☐ Resource Room ____

#Teachers ____ #Aides ____ Does your child have a 1:1 Aide? Yes No

1. School schedule? _____
2. Any know learning disabilities? _____
3. Do you or your child enjoy school? _____Yes _____No
4. Strengths? _____
5. Weaknesses? _____
6. Any issues at school? _____
7. Any extracurricular activities? List: _____

CLIENT'S MEDICAL HISTORY

NOW	PAST		NOW	PAST	
_____	_____	Acne	_____	_____	Heart murmur
_____	_____	Anal itching	_____	_____	Heat intolerance
_____	_____	Allergies	_____	_____	High fever
_____	_____	Anemia	_____	_____	Hives
_____	_____	Asthma	_____	_____	Insomnia
_____	_____	Birth defects	_____	_____	Jaundice
_____	_____	Bleeding gums	_____	_____	Joint pains
_____	_____	Blood in stools	_____	_____	Measles
_____	_____	Calf cramps	_____	_____	Mononucleosis
_____	_____	Chicken pox	_____	_____	Mumps
_____	_____	Chronic rashes	_____	_____	Nightmares
_____	_____	Colic	_____	_____	Nosebleeds
_____	_____	Cold hands/feet	_____	_____	Numbness in arms/legs
_____	_____	Congestion	_____	_____	Oily skin
_____	_____	Cough	_____	_____	Pneuomonia
_____	_____	Cradle cap	_____	_____	Rashes
_____	_____	Diarrhea	_____	_____	Rheumatic fever
_____	_____	Dry skin	_____	_____	Ringing in ears
_____	_____	Earaches	_____	_____	Rough skin
_____	_____	Ear infections	_____	_____	Rubella
_____	_____	Easy bruising	_____	_____	Scarlet fever
_____	_____	Eczema	_____	_____	Seizures
_____	_____	Epilepsy	_____	_____	Sore throats
_____	_____	Fatigue	_____	_____	Stomachaches
_____	_____	Flat feet	_____	_____	Strep throat
_____	_____	Frequent colds	_____	_____	Stuffy nose
_____	_____	Frequent fevers	_____	_____	Thrush
_____	_____	Frequent headaches	_____	_____	Tonsillitis
_____	_____	Frequent urination	_____	_____	Tremors
_____	_____	Hair loss	_____	_____	Urinary tract infections
_____	_____	Headaches	_____	_____	Wheezing
_____	_____	Head injury	_____	_____	Whoooping cough

Other: _____

FAMILY MEDICAL HISTORY *Please check all that apply.*

Have any members of the biological mother's or biological father's families had any of the following problems or disorders?

- ☐ Alcohol/drug abuse
- ☐ Anxiety
- ☐ Autism/PDD
- ☐ Alzheimer's disease
- ☐ Bipolar/manic-depressive disorder
- ☐ Birth Defect
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Childhood behavior disorder
- ☐ Chromosomal/genetic disorder
- ☐ Depression
- ☐ Developmental disability
- ☐ Diabetes
- ☐ Emotional disturbance/mental illness
- ☐ Food allergies
- ☐ Heart disease
- ☐ Hemophilia
- ☐ High blood pressure
- ☐ Huntington's chorea
- ☐ Intellectual impairment
- ☐ Kidney disease
- ☐ Migraine headaches
- ☐ Nervousness
- ☐ Multiple Sclerosis
- ☐ Obsessive Compulsive Disorder
- ☐ Parkinson's disease
- ☐ Physical handicap
- ☐ Physical/sexual abuse
- ☐ Schizophrenia
- ☐ Scleroderma
- ☐ Severe head injury
- ☐ Seizures/epilepsy
- ☐ Sickle-cell anemia
- ☐ Speech/language delay
- ☐ Stroke
- ☐ Tics/Tourette's syndrome
- ☐ Tuberous Sclerosis
- ☐ Other:

MEDICAL TEAM

	Address	Email	Phone	Date Last Visit & Reason
Primary Care Doctor:				
Pediatrician:				
Neurologist:				
Psychiatrist:				
Geneticist:				
Gastroenterologist:				
Endocrinologist:				
Other:				

Hospitalizations/surgeries/special tests:

Please list any surgical procedures, hospitalizations, X-Rays, CT scans, MRIs, EKGs, EEGs, hearing tests, vision tests, speech/language tests, or psychological evaluations that you or your child has had done in the past couple years.

Test	*Date*	*Result*

Any blood/urine/stool tests done? _____Yes _____ No **(Please bring in copies of results)**

MEDICATIONS / SUPPLEMENTS

***Current Medications**:*

Medication	Dose	Frequency	Start Date (month/year)	Reason for Use

***Supplements** (Vitamins, Minerals, Herbs, Homeopathy, Other)*

Supplement/Brand	Dose	Frequency	Start Date (Month/year)	Reason for Use

Have medications or supplements ever caused side effects or problems? _____Yes _____ No
Describe: _____

Allergies

Are you or your child allergic or hypersensitive to any medications, supplements or environmental or chemical agents?

Describe: _____

Immunizations

MMR _____	DPT _____	Chicken pox _____	Small pox _____
Measles _____	Diphtheria _____	H. influenza _____	Hepatitis B _____
Mumps _____	Rubella _____	Tetanus _____	Polio _____
Pertussis_____	Other _____		

Adverse reactions? ___Yes ___No Describe:_____

Please include any other information about you or your child that you would like to share:

_____
_____
_____
_____

Thanks for taking the time to share this valuable information.
Dr. Janet Opila-Lehman, ND, OTL