Western N.C. NATUROPATHIC MEDICINE

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AUTISM SPECTRUM INTAKE FORM
with Autism Treatment Evaluation Checklist (ATEC)

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 (ATEC)

N = Not true ever or very rarely S = Some what true, occurs once in awhile V = Very true, occurs all time

I. SPEECH/LANGUAGE/COMMUNICATION		
N S V 1. Knows own name	N S V 6. Can use 3 words at a time (Want more milk)	N S V 11. Speech tends to be relevant and meaningful
N S V 2. Responds to "No" or "Stop	N S V 7. Knows 10 words or more	N S V 12. Often uses several successive sentences
N S V 3. Can follow commands	N S V 8. Can use sentences with 4 or more words	N S V 13. Carries on fairly good conversations
N S V 4. Can use one word at a time (No, eat, water, etc).	N S V 9. Explains what he/she wants	N S V 14. Has normal ability to communicate for his/her age
N S V 5. Can use 2 words at a time (Don't want, Go home)	N S V 10. Asks meaningful questions	
II. SOCIABILITY		
N S V 1. Seems to be in a shell - you can not reach him/her	N S V 7. Shows no affection	N S V 14. Disagreeable/not compliant
N S V 2. Ignores other people	N S V 8. Fails to greet parents	N S V 15. Temper tantrums
N S V 3. Pays little or no attentions When addressed	N S V 9. Avoids contact with others	N S V 16. Lacks friends/companions
N S V 4. Uncooperative, resistant	N S V 10. Does not imitate	N S V 17. Rarely smiles
N S V 5. No eye contact	N S V 11. Dislikes being held or cuddled	N S V 18. Insensitive to others feelings
N S V 6. Prefers to be left alone	N S V 12. Does not share or show	N S V 19. Indifferent to being liked
	N S V 13. Does not wave "bye-bye"	N S V 20. Indifferent to parent(s) leaving
III. SENSORY/COGNITIVE AWARENESS		
N S V 1. Responds to own name	N S V 7. Appropriate facial express.	N S V 13. Initiates activities
N S V 2. Responds to praise	N S V 8. Understand stories on TV	N S V 14. Dresses self
N S V 3. Looks at people & animals	N S V 9. Understands explanations	N S V 15. Curious, interested
N S V 4. Looks at pics, TV, screens	N S V 10. Aware of environment	N S V 16. Venturesome, explores
N S V 5. Draws, colors, does art	N S V 11. Aware of danger	N S V 17. "Tuned-in" – not spacey
N S V 6. Plays with toys & games appropriately	N S V 12. Shows imagination	N S V 18. Looks where others looking
IV. HEALTH/PHYSICAL/BEHAVIOR: N = Not a problem, MI = Minor problem, MO = Moderate problem, S = Serious problem		
N MI MO S 1. Bed-wetting	N MI MO S 10. Lethargic	N MI MO S 19. Rigid routines
N MI MO S 2. Wets pants/diapers	N MI MO S 11. Hits or injures self	N MI MO S 20. Shouts our screams
N MI MO S 3. Soils pant/diapers	N MI MO S 12. Hits or injures others	N MI MO S 21. Demands sameness
N MI MO S 4. Diarrhea	N MI MO S 13. Destructive	N MI MO S 22. Often agitated
N MI MO S 5. Constipation	N MI MO S 14. Sound-sensitive	N MI MO S 23. Not sensitive to pain
N MI MO S 6. Sleep problems	N MI MO S 15. Anxious/fearful	N MI MO S 24. "Hooked" or fixated on certain objects/topics
N MI MO S 7. Eats too much/ little	N MI MO S 16. Unhappy/crying	
N MI MO S 8. Extremely limited diet	N MI MO S 17. Seizures	N MI MO S 25. Repetitive movements – stimming, rocking, etc.
N MI MO S 9. Hyperactive	N MI MO S 18. Obsessive speech	

NOW PAST	**NOW PAST**	**NOW PAST**
Daily Living Skills:		
_____ _____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	_____ _____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 issues

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	

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

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
- ☐ 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

- ☐ Diabetes
- ☐ Emotional disturbance/mental illness
- ☐ Food allergies
- ☐ Heart disease
- ☐ Hemophilia
- ☐ High blood pressure
- ☐ 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.