

Asheville Integrative Medicine
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Patient Name: _____ Date: _____

DOB: _____ Sex: _____ SS #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ E-mail: _____

What are your main concerns about your child?

Has your child been diagnosed with autism? _____

If yes, how was he/she diagnosed? _____

What degree of autism was he/she diagnosed with? _____

What autistic behaviors is he showing?

- Decreased eye contact
- Decreased interest/interaction with peers or adults
- Loss of previously acquired words
- Delayed receptive language
- Delayed expressive language
- Echolalia (repetitive speech) or odd speech
- Repetitive behaviors/movements (such as hand-flapping, rocking)
- Immature or inappropriate play
- Lack of pretend play
- Sensory issues: sensitivity to noise/light/smells/touch/taste
- Self-injurious behaviors
- Difficulty transitioning/resistance to change
- Other: please describe

Pregnancy and Birth History:

Did you have any problems during your pregnancy?

- High blood pressure
- Diabetes
- Other complications
- Infections
- Bleeding
- Premature contractions

Did you have to take any medication? _____

Did you receive any vaccines or get a Rhogam shot? _____

Did you eat fish during your pregnancy? If yes, how often? _____

Were you exposed to any chemicals/toxic substances/radiation? _____

Was your child born full term or premature? Were there any complications during the delivery? What type of delivery did you have? _____

What were the baby's Apgar scores? _____

Was the baby breast fed? If yes, for how long? _____

Immunizations

Did your child receive all childhood vaccinations? _____

Growth and Development:

When did your child (to the best of your recall):

Sit up? _____

Crawl? _____

Walk? _____

Talk? _____

Did he/she have any difficulty with feeding as an infant? _____

Has there been any loss of acquired skills, such as language? _____

Is he/she toilet trained? _____

Has your child been growing normally, or have there been problems with his/her growth? _____

What specialists have you seen? _____

What treatments have you tried? Have they been effective? _____

Has your child been seen by a Geneticist? _____

What lab tests have been done? _____

Have any imaging studies been done? (e.g. CT scan or MRI) _____

Does your child have any drug allergies? _____

Does your child have any chemical/ environmental sensitivities? _____

Please list current medications: _____

Please list current supplements: _____

Please list past medical history: (major illnesses, hospitalizations, surgeries)

Social History:

Who does your child live with? Who are all the members of your family?

Ages of siblings, if any _____

Do you have a specific religion or spiritual practice that you follow? _____

Family Medical History:

Family Member	Age (also, if deceased, at what age)	Learning problems, ADHD, speech difficulties, vision or hearing problems, neurological disorders such as seizures, genetic conditions, cancer, diabetes, heart disease, autoimmune diseases
Mother		
Father		
Sibling 1		
Sibling 2		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		

Review of Systems: General:

Sleep

Does your child have:

- Difficulty falling asleep?
- Difficulty staying asleep? (wakes up at night)
- Snoring?
- Teeth Grinding?
- Restlessness? (tossing and turning?)
- Wake up tired?
- Wake up rested?

Comments: _____

Energy

How would you describe your child's energy?

- Normal energy level
- Easily fatigued
- Tends to sit around the house
- Hyperactive
- Moving around all the time

Comments: _____

Mood, behavior, learning

Does your child:

- Appear anxious or fearful?
- Appear sad?
- Have frequent temper tantrums? If yes, is he difficult to console?
- Show obsessive compulsive behaviors?
- Have a short attention span? Is he easily distractible? Impulsive?
- Appear forgetful; have a poor memory?
- Have brain fog? Appear to be spaced out or vacant?
- Difficulty processing information?
- Have learning disabilities?
- Difficulty in class/learning environments

Comments: _____

Does anyone smoke in the home? _____

Have you ever lived in a home with any of the following? :

- Lead paint
- Mold
- New construction or remodeling
- Other toxic exposures in home or close to home

Have you traveled with your child to other countries? If yes, how long was your visit? _____

HEENT:

Are there any problems with your child's vision? _____

Are there any problems with his/her eyes? (rubbing, watering, redness, eye infections, etc)? _____

Do you think he/she hears well? _____

Has he/she had frequent ear infections? If yes, has he/she had ear tubes inserted? _____

Does your child have sinus infections? Enlarged adenoids or tonsils?

Does your child have frequent strep infections? _____

Does your child have any allergies?

- Seasonal
- Indoors
- Outdoors

Please describe: _____

Has your child had allergy testing? If yes, was it a skin or a blood test? _____

Allergy shots? _____

Other allergy medication or supplements? _____

Has your child had dental work done?

- Root canals
- Amalgam fillings
- Other metal fillings

Comments: _____

Does he/she tend to get any of the following?

- Herpes Blisters/ Cold sores
- Sores within the mouth
- Teeth clenching or grinding

Lungs:

Has your child ever had:

- wheezing episodes?
- bronchiolitis or
- pneumonia
- been diagnosed with asthma
- shortness of breath
- chronic cough

Comments: _____

Heart:

Does he/she have a heart murmur or other heart problem? If yes, does he get short of breath or sweat easily? _____

Has he/she ever fainted? _____

Gastrointestinal:

How is your child's appetite? _____

Is he/she a picky eater? _____

Can he/she chew food and swallow well? Does he gag often? _____

How often does he have a bowel movement? _____

Does he/she have food allergies? _____

Does he/she have any:

- Constipation
- Diarrhea
- Blood or mucus in stool
- Undigested food present in stool
- Bloating
- Excess gas
- Acid reflux
- Vomiting
- Stomach-ache

Comments: _____

Genitourinary:

Does he/she have :

- Any problems with the kidneys or bladder?
- Frequent urination
- Frequent kidney or bladder infections
- Bed wetting or daytime wetting
- Unusual urine color or odor

Comments: _____

Does he have normal genital development? _____

Does he/she have any of the following?

- Excessive body hair growth or loss
- Excessive genital rubbing
- Early signs of puberty

Comments: _____

Musculoskeletal:

Are there any problems with your child's gait or legs and feet? _____

Does your child get joint pains or swelling? _____

Does he/she complain of weak or sore muscles? _____

Skin:

Does your child have any of the following:

- Recurrent or chronic skin rashes
- Unusual or multiple birthmarks

Neurological:

Does your child have any of the following:

- Seizures, tremors or staring spells
- High (tight) or low (floppy) muscle tone
- Problems with the tone around his mouth
- Toe walking
- Numbness/tingling/burning/lack of sensation in any limb

Lifestyle:

Please describe type and frequency of exercise. _____

Please describe television and/or video game frequency and use. _____

Is your child on a special diet?

- Gluten-free
- Casein-free
- Specific Carbohydrate diet
- Other

Comments: _____

Does he/she eat: (Check all that apply)

- Organic foods
- Processed foods
- Preservative free
- Sugar
- Hydrogenated fats

Quantity: _____

Does he/she have food cravings? Describe: _____

Comments: _____

Does your child drink:

- Soda
- Diet soda
- Juice
- Water
- Milk

Please describe quantity _____

Thank you

