ASD Patient Questionnaire

Please be as complete as possible and add extra sheets if space is insufficient if detail is required. Also, please bring/attach a fairly recent picture of your child that we may keep plus a baby photo if available. Thank you.

Darren J Sassall ND
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PERSONAL INFORMATION			
Date Questionnaire Received: ____ / ____ / ____		Date of Initial Consultation: ____ / ____ /____	
Child's Name: First:		Last:	Middle Initial:
Parent(s) Name(s):			
Address:			
State:	Postcode:	Phone: ( )	Mobile:
EMAIL :		Fax: ( )	
Child's birth date:		Child's Sex : Male / Female	
Primary Care Physician: Contact Details:			
Referred by:			
Siblings Name (s):		Birth Date (s):	
Parent's occupation(s):			

Diagnoses or explanation given to you about your child (Date of diagnoses: _____/_____/_____):
Describe your child, including his/her history. Please be as detailed as possible.
When did you first notice your child's problem?
What did you first notice?
Was the onset of your child's problem sudden or gradual?
Was there any event or illness that you or others think brought on your child's symptoms?

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Please make notation of any other event, action, etc. that you think may have some bearing/relationship to your child's condition.

CHILD'S MEDICAL HISTORY
THERAPIST(S)
Speech - Occupational - Physical – Other
Specialist(s)
Naturopath(s)/Homeopath(s)
Nutritionist
Other

PRENATAL HISTORY
Maternal age at delivery: _____ years
Illnesses during pregnancy:
Medication during pregnancy:
Other complications during pregnancy:
Complications during labor and delivery:
If vaginal delivery, did you have forceps/vacuum?
Medication(s) during labor and delivery?
Full term/premature? (Circle one) How many weeks? _____ weeks
Complications after delivery?
Medications given to child during hospital stay?
Breast-fed? Yes/No (Circle One): If yes, how long?
Bottle-fed? Brand of formula? Begun at what age? For how long?
Foods? Begun at what age? _____ First foods?

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Whole milk? Yes/No (Circle One) If yes, begun at what age?
Known allergies to food? (Please list):
Suspected sensitivities to foods? (Please list):
Food cravings? (Please list):

DIETARY/NUTRITIONAL HISTORY

Check the most appropriate description below of your child's diet:
Mostly baby foods

- ☐ Mostly carbohydrates (bread, pasta, etc.)
- ☐ Mostly dairy (milk, cheese, etc.)
- ☐ Mostly meat
- ☐ Mostly vegetarian (vegetables, fruits, grains, etc.)
- ☐ Other – Describe:

Please describe a typical days diet: Breakfast Morning Tea Lunch Afternoon Tea Dinner Desert
Please describe your child's stool pattern (Examples: daily, foul, large, mushy, etc.):

FAMILY HISTORY
List any allergies, major illnesses, genetic diseases or problems for each of the following family members of your child:
Mother:
Father:
Siblings:
Maternal Grandparents:
Paternal Grandparents:
Others:

SOCIAL HISTORY
Who lives in the home with your child:
Are any children in your family adopted?
Pets in the house:
Caregivers besides parents:
List the people most important in your child's life:
Recent changes, losses, births, deaths, divorce, remarriage or moves:
Recent travel:
Child's response to these changes:
Is your child involved in any sports, music or other activities? Please describe:
How does your child interact with other children?
How does your child interact with adults:
What makes your child happy?
Sad?
Angry?
Stressed?
How do you as a parent deal with these emotions in your child?

ENVIRONMENTAL HISTORY
Do you, your child, or any family members practice any relaxation/stress management techniques? Please describe:
Mark the appropriate answers to the following questions:
Location of home: City/Suburban/Wooded/Farm Other (describe):
Water: City/well Purification system: Yes/No If yes, please describe:
Type of heat: Electric/gas/oil/other If other, please describe:
Do you live near: Power lines/woods/industrial areas/water?
If you live near water, list type: Swamp/river/ocean/other If other, please describe:
Does your home have a lot of: Dust/mould/down or feather items (pillows, upholstery, stuffed animals?) If, so, please give details:
Describe your child's bedroom
Bedding: Synthetic/down/feather? Mattress cover: Yes/No Crib/Junior Bed/Adult Bed?
Flooring: Carpet: Wall-to-wall or area rug? Wood? Glued down? Synthetic pad?
Window treatment: Shades/blinds/thin curtain/heavy curtain/valance/other? If other, describe:
Other items in room including furniture, toys, stuffed animals:
Flooring in other rooms:
Child's bathroom?
Living room?
Family room/play room?

Is your child sensitive to or bothered by any of the following? Please check where appropriate and list specific products if possible:

- ☐ Perfumes/cosmetics? Mould?
- ☐ Cleaning products? Pollens/grasses?
- ☐ Soaps? Animals (dander)?
- ☐ Detergents? Gasoline?
- ☐ Dust? Paint?
- ☐ Other?

Please list known allergies:

DEVELOPMENTAL HISTORY

Please list **AGE** when following skills were mastered and any problems associated with these skills:

First words:

Phrases or sentences:

Pulling to stand:

Walking:

Sitting up:

Crawling:

Running:

Walking up/down steps without help:

Jumping:

Learned to pedal:

Rode 2-wheel bicycle:

Put on clothing:

MEDICAL HISTORY

Please indicate which tests have been done and provide date and copy of results:

Evaluation/Test Date Results (normal, abnormal or unsure)	Organic Acids—fungal/bacteria
24 Hour Amino Acids	Organic Acids—Metabolism
Amino Acid Screen	PET Scan
Blood Chemistry Screen	Pinworm Prep
Blood Count (CBC)	Plasma Amino Acids
Blood Test—Fatty Acid	Plasma or Serum Zinc
Blood Test—Food Allergies	RBC Elements
CT Scan (specify area)	Serum Ferritin (Iron stores)
Colonoscopy	Serum Methylmalonic Acid
DMSA Loading Study	Serum Vitamin A
EEG	Small Bowel Biopsy
Folic Acid	Stool Culture
Fragile X Chromosome Study	Stool Parasites
Hair Elements	Thyroid Profile
Hearing Test	Uric Acid (blood or urine)
Immune Profile	Urinary Peptides
Intestinal Permeability	Urine Elements
Liver Detox Profile	Urine Kryptopyrrole
MRI (specify area)	X-Rays (specify)
	Other:

SURGERY DATE(S) RESULTS

Major surgeries - Please describe and give dates:

INJURY DATE(S) RESULTS

Major injuries - Please describe and give dates:

ILLNESS DATE(S) COMPLICATIONS
Ear infections
Sinus infections
Bronchitis
Pneumonia
Thrush
Chicken Pox
Seizures
Other: (Please list):

Illnesses - Please list appropriate dates and any complications:

Immunizations
Please indicate date and any reactions to immunizations that your child has received (If exact date isn't known, please approximate).

MEDICATION Please circle substances taken now or in the past:

Clozaril (clozapine)
Haldol
Prolixin
Risperdal
Seroquel
Stelazine
Thorazine
Zyprexa
Clonidine
Cogentin
Deanol (deaner, DMAE)
Dextromethorphan
Lithium
Naltrexone
St. John's Wort
Anafranil
Depakene for behaviour
Depakene for seizures
Depakote for behaviour
Depakote for seizures
Dilantin
Felbatol
Gabitril
Keppra
Klonopin
Lamictal
Luvox
Mysoline
GABA
Glutamine
SAMe (SAM, Samyr)
TMG
Taurine
Tryptophan
Tyrosine
Calcium
Magnesium
Manganese
Selenium
Zinc
Human Growth Factor
IV Immune globulin
Kutapressin
Oral Immune globulin
Secretin (IV)

Neurontin
Paxil
Phenobarbital
Straterra
Tegretol
Topamax
Trileptal
Valium
Zarotin
Zonegran
Adderall
Prozac
Zoloft
Amphetamine
Cylert
Dexedrine, dextroamphetamine
Fenfluramine
Focalin
Ritalin
Buspar
Chloral hydrate
Valium
Desipramine
Mallaril
Tofranil
Klonapin

Secretin (transdermal/sublingual)
Steroids (oral)
Steroids (topical)
DHA rich oils
EPA rich oils
Omega 6 rich oils
Cod liver oil
Flax oil
Activated Charcoal
Alka Gold
Carbatrol
Tranxene
Famvir
Valtrex
Zovirax
Other:

Antihistamines
Benadryl
Claritin
Singulair
Zyrtec
Digestive Flora/Probiotics

Antibiotics (specify type and number of times)
Bactrim (septra)
Diflucan
Humatin
Lamisil
Nizoral
Nystatin
Saccharomyces boulardii
Sporonax
Transfer Factor (oral)/ Colostrum
Yodoxin
Digestion
Bethenecol
Digestive enzymes
Pepsid
Peptidase enzymes

Therapies
Acupuncture
Auditory Training
Craniosacral
Energy Therapy (Specify)
Homeopathy
Lovaas (ABA)
Naturopathy
Neural Therapy
Occupational Therapy
Osteopathy
Physical Therapy
Sensory Diet
Speech Therapy
Other:

Probiotics
Detoxification
DMPS
DMSA (succimer, chemet)
Reduced glutathione (TTFD)
Reduced glutathione (IV)
Reduced glutathione (oral)
Folic Acid
Melatonin

Nutrition and Metabolism
Multivitamin (Specifiy)
Vitamin A
Vitamin C
Vitamin B3 (Niacin)
Vitamin B6
5 HTP
Alpha Keto Glutarate (AKG)
Amino Acid Mix
Deanol
Dimethylglycine (DMG)

Diets
Gluten Free
Casein Free
Yeast Free
High Protein/ Low Carb
Salicylate Free
Low Phenolics
IgG reactive food avoidance
Specific Carbohydrate Diet
Other:

From the above lists please note below what works and what does not in your experience for your child:

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SIGNS AND SYMPTOMS Please circle any signs/symptoms your child may demonstrate		
Stimming (repetitive actions or movements) Rocking Head banging Self-mutilation Nail biting Hand/arm biting Nail/skin picking Aggressiveness (hitting, kicking, biting others) Mood swings Irritability/tantrums Fears/anxieties Hyperactivity Inability to concentrate/focus Always fidgety in his/her seat Impulsive Breath holding Bad breath Nose bleeds Acute sense of smell Sore throats Hoarseness Cough Wheezing Geographic tongue Swollen gums Canker sores Dry lips/mouth Diarrhoea Constipation Bloating Passing gas Belching Stomach ache Refusal to eat Sensitive to texture of food Difficulty swallowing Food Craving Grinding teeth Mucous/blood in stools Anal itching Calf cramps Other muscle	Dizziness Seizures Poor coordination Problems with buttons, ties, snaps or zippers Processing problems - visual, motor, language, etc. Problems with social interactions Sensitive to crowds Trouble remembering Low self-esteem Fatigue Cold hands/feet Cold intolerance Heat intolerance Recurrent/chronic fever Flushing Difficulty falling to sleep Night waking cramps/spasms Tremors Weakness Stiffness Eczema Psoriasis Hives Acne Seborrhoea (cradle cap) Other rashes Easy bruising Itchy scalp Dry skin Oily skin Pale skin Sensitivity to insect bites Sensitive to texture of clothes Cracking/peeling hands Cracking/peeling feet Strong body odour Strong urine odour Strong stool odour Soft nails Thickening of nails	Nightmares Difficulty waking Bed wetting/soiling Day time wetting/soiling Numbness/tingling in hands/feet Headache Blinking Tics Eye discharge Dark circles/puffiness under eyes Night-blindness in child/family Congestion Dripping nose Sensitivity to bright lights Earaches Ringing in ears Sensitive to sounds/noise Any OCD (obsessive compulsive) behaviours Strategies to put pressure On abdomen Reflux Persistent colic Toe walking Ridges/pitting of nails White spots/lines on nails Brittle nails

For any symptoms marked above please list duration and details if appropriate - Description Mild/ Moderate/ Severe/ Duration /Unique details:
Describe any other symptoms you would like me to know about your child:
List any other history, pertinent thoughts or questions that you want to address:

Please return the completed document to your practitioner prior to or on the day of your first consultation.

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