CENTERS FOR ADVANCED MEDICINE
MAKING THE CHANGE, THE WORLD IS WAITING FOR...
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Autism Intake Form

Select the appropriate option and/or provide an answer to each of the items below:	
OVERVIEW OF HISTORY	
Patient's Name & Current Date	
Parent or Guardian Name	
Patient is from (city, state, country)	
Patient's Age & DOB (exact years and months)	________ years ________ months __________ Birthdate
Patient Marital Status	Married Separated Divorced Widowed Single Partner
Patient's Gender	Male Female Intersex / Hermaphrodite Transgender
Patient's Ethnicity	Caucasian African American Native American Asian Hispanic Hawaiian/Pacific Islander Other (please specify)
Is patient a biological or adopted child?	Biological Adopted
How did you hear about our clinic?	
DIAGNOSIS HISTORY	
Date diagnosed	
Primary Diagnosis (select only one)	Autism Spectrum Delay (ASD) Aspergers ADD / ADHD Pervasive Developmental Disorders (PDD) Developmental Delay Other (please specify) Is Primary Diagnosis a concern? Yes No
Secondary Diagnosis (select only one)	Autism Spectrum Delay (ASD) Aspergers ADD / ADHD Pervasive Developmental Disorders (PDD) Developmental Delay Other (please specify) Is Secondary Diagnosis a concern? Yes No
Who made the diagnosis?	
MOTHER'S HISTORY	
Number of times mom has been pregnant (Gravida)	
Number of times mom has had live births (Para)	
Miscarriage History	
Did mom have dental work during gestation?	Yes No If "Yes", what type of dental work?
Did mom have dental work before gestation?	Yes No If "Yes", what type of dental work?
Did mom have vaccinations before gestation?	Yes No If "Yes", which vaccines?
Did mom have vaccinations during gestation?	Yes No If "Yes", which vaccines?
Did mom get RhoGAM while pregnant with patient?	Yes No
Does mom have high seafood diet?	Yes No
Has mom had industrial exposure to mercury?	Yes No

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Select the appropriate option and/or provide an answer to each of the items below:	
How many amalgam fillings at delivery?	
Complications during gestation	
Was delivery Vaginal or by C-section?	Vaginal C-section
Complication at delivery (suction, forceps, etc)	
Complications after deliver (meconium)	
Apgar scores were	________ and ________
Did patient require neonatal ICU?	Yes No
Discharged from hospital after (# of days)	________ days
Born before, at or after due date	_____ days before due date On due date _____ days after due date
FAMILY HISTORY	
Neurological history - Mother	Alzheimer's Autism Parkinson Other (please specify)
Neurological history - Father	Alzheimer's Autism Parkinson Other (please specify)
Neurological history – Maternal Grandparents	Alzheimer's Autism Parkinson Other (please specify)
Neurological history – Paternal Grandparents	Alzheimer's Autism Parkinson Other (please specify)
CHILD'S HISTORY	
Number of vaccines from birth to symptoms	
Was initial development normal or abnormal	Normal Abnormal
Until what age were milestones hit?	________ months
Who noticed symptoms first? (mom, grandpa, etc)	
How old was patient when symptoms first noted?	________ months
Number of antibiotics from birth till diagnosis	
Any amalgams (mercury fillings) removed?	Yes No If yes, how many?
Number of words prior to onset of symptoms	
What type of doctor initially evaluated the patient?	
Initially evaluated at what age?	________ months
Did doctor who initially evaluated the patient agree, disagree, or reassure you regarding your evaluation?	Agreed Disagreed Reassured
Referred/NOT referred for more evaluation?	Referred Not referred
If referred, to what type of doctor were you referred?	
First treatment was initiated by what type of doctor?	
What did the Initial treatment consist of?	

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Select the appropriate option and/or provide an answer to each of the items below:	
INITIAL SYMPTOMS BEFORE DIAGNOSIS	
Constitutional symptoms prior to diagnosis	Vomiting Diarrhea Appetite change Sleep issues Other (please specify)
Height when initial symptoms began	Below At Above - Standard Growth Chart
Weight when initial symptoms began	Below At Above - Standard Growth Chart
Appetite when initial symptoms began	Excellent Good Poor No Appetite
When initial symptoms began, how many bowel movements did the child have daily?	1 2 3 4+
PRECIPITATING SYMPTOMS	
Precipitating cause (what parents feel initiated the change in their child)	
What symptoms was the child experiencing?	
CHILD'S CURRENT STATUS	
What order does the child fall in the family?	only child 2nd child 3rd child 4th child 5th child ______ child
Current vocabulary is how many words?	
How many words are used spontaneously?	
Expressive language (able to express thoughts with words or actions)	Excellent Good Understandable Limited Minimal None
Receptive language (ability to understand language heard or read)	Excellent Good Understandable Limited Minimal None
Child's attitude towards other children	Affectionate Tolerant Indifferent Cooperative Aggressive Violent
Parents consider Child to be	Affectionate Cooperative Indifferent Frustrated Aggressive Violent Friendly Emotional Scared Shy
How many bowel movements each day?	1 2 3 4+
Stool is normally	Loose Diarrhea Constipated Alternates Normal
Is patient potty trained?	Yes No Partially
Current medications taken? (type and dose)	
Current supplements taken? (type and dose)	
How many amalgams does patient currently have?	
Constitutional symptoms as of today	Vomiting Diarrhea Appetite change Sleep issues Other (please specify)
Current weight	Below At Above - Standard Growth Chart

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Select the appropriate option and/or provide an answer to each of the items below:	
Current appetite	Excellent Good Poor No Appetite
Experiencing any pain?	Yes No If Yes, where?
Any other information you feel is pertinent for the provider to know?	
PAST TREATMENT HISTORY	
Has child had any of the following: (check all which apply)	Speech therapy Occupational Therapy Sensory integration therapy ABA therapy Nutritional interventions Secretin DMSA Alpha Lipoic Acid Glutathione IV Glutathione TD Hyperbaric Oxygen Caesin free, gluten free diet Specific carbohydrate diet Rotating food allergy diet IV immunoglobulins Stem cell treatments DMPS IV DMPS oral EDTA IV Other attempts to reduce metal toxicity Anti fungal prescriptions TTFD Di Methyl Glycine Methyl B12 injections Cranio-sacral treatments
PARENTS AWARENESS STATUS	
Are parents aware of DMPS?	Not aware Somewhat aware Fully aware
Are parents aware of the extensive testing done at our clinic?	Not aware Somewhat aware Fully aware
Are parents aware of "non-excretor status"?	Not aware Somewhat aware Fully aware
Are parents aware patient may worsen before improving?	Not aware Somewhat aware Fully aware
Parents wish to	Start protocol immediately Schedule to begin protocol at later date Only have this consultation

PLEASE PROVIDE ANY INFORMATION WE SHOULD BE AWARE OF WHILE PROVIDING FOR THE MEDICAL NEEDS OF YOUR CHILD

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Initial Intake Synopsis

If you feel all your pertinent medical history may need further explanation or you think the provider should be aware of any additional information, please provide us with a synopsis of this information in chronological order (i.e. health timeline, diagnoses, treatments undergone, type of practitioners seen, and etc.) **See "Initial Intake Synopsis Example" on next page as reference.**

Date: ______________ Patient Name: ____________________________________