Autistic – Spectrum Disorder
Health History Information

Childs Name: _____ DOB: _____ Sex: _____

1. At what age was your child diagnosed as having Autistic Spectrum Disorder?
   _____

2. Your child is classified as mild, Moderate, or Severe ASD?
   _____

3. Your child's symptoms became apparent at what age?
   _____

4. What signs and symptoms first became noticeable that alarmed you as a parent? List as many developmental problems as possible, e.g. poor eye contact, aggressive behavior, etc.
   _____
   _____
   _____
   _____

5. What developmental issues does your child suffer with currently if different from above?
   _____
   _____
   _____
   _____
   _____

Other Health Issues:

6. Does your child suffer with other health problems?
   ____ Allergies ____ Asthmas ____Constipation ____Diarrhea ____Eczema ___ Kidney Problems ____Lung disease
   ____Diabetes ____Thyroid Disease ____ Heart Disease ____ Seizures
   ____ Ear Infections ____ Other _____

7. Did your child's condition change following an illness, infection, and or seizure disorder? Explain:
   _____
   _____
   _____

Digestive Health:

8. Does your child have periodic loose stools or diarrhea? How often and what color?
   _____

9. Does your child have offensive gas after eating a certain meal? If yes what food.
   _____

10. Does your child have undigested food in his stools?
    _____

11. Is your child potty trained and at what age?
    _____

12. Does your child suffer from heartburn or reflux?
    _____

13. Is your child currently taking and acid blocking medication such as Tagament or Pepcid, etc.?
_____
14. Did your child digestive problems occur following a particular vaccine? Which one?
_____

15. Has your child ever produce formed stools?
_____

Antibiotic History:

16. How many courses of antibiotic has your child received in his/her lifetime? Name of antibiotic if known.
_____
_____

17. Main reason for antibiotic use:
____ Ear infection ____Bronchitis ____Pneumonia ____ Sinus Infection ___Intestinal Infection
_____ other, please explain _____

18. Was your child ever treated for yeast or Candida following antibiotic use?
_____

Home Environment:

19. How old is your current home?
_____

20. Has your child lived in a home that had lead based paint?
_____

21. What kind of flooring does your home have?
___ Carpet ___ Wood floors ___Tile ____other_____

22. Do you use commercial cleaners at home? List them:
_____
_____
_____

23. Has your child ever used or currently sleeps with fire resistant clothes or bedding?
_____

24. Is your child exposed to outside pesticides, fungicides, etc.?
_____

25. Please list pets and or farm animals your child is exposed to.
_____
_____

Mother's Pregnancy and Labor:

26. Did child's mother have any complications during pregnancy? Explain.
_____
_____
_____

27. Does the child's mother know her Rh factor and blood type?
_____

28. Did the mother receive Rhogam medication during her pregnancy?
_____

29. Did mother receive any vaccinations during pregnancy? If yes which ones.
_____
_____

30. Did mother receive any vaccinations after birth when breast feeding child? If yes which ones.
_____
_____

31. During labor was your child delivered vaginally, C-Section, Forceps and or suction devices? Was there a concern for trauma?
_____
_____

Parent's Medical History:

32. Does the child parents suffer from any of the following medical conditions:
____ Low Thyroid ____ Thyroid Cancer ____ Parathyroid Problems ____ Night Blindness
____ Autoimmune Disorders ____ Lupus ____ Connective Tissue ____ Rheumatoid Arthritis
____ Cancer ____ High Blood Pressure _____ other _____

33. Did mother have any dental work done while pregnant? Explain:
_____

34. Is there a family history of Developmental Disorders, i.e. autism, PDD, etc? Explain
_____
_____

35. Is there a family history of Neurological disorders, i.e. multiple sclerosis, etc.? Explain
_____
_____

36. Is there a history of Asthma, Allergies, Autoimmune Disorders, i.e. Lupus, Rheumatoid Arthritis, etc.? Explain:
_____
_____

37. Is there a family history of blood disorders, i.e. clots, Stokes, Hemophilia, or Platelet Disorders? Explain
_____
_____

38. Is there a family history of Psychiatric disorders, i.e. depression, schizophrenia, etc.? Explain
_____
_____

39. Is there a history of genetic disorders? Explain
_____
_____

40. Is there a history of seizures or vaccine reactions? Explain
_____
_____
_____

41. Is there a family history of celiac disease or gluten intolerance? Explain:
_____
_____

Vaccination History:

42. Has your child received all the recommended vaccination for his age?
    _____

43. Has your child received any of the following vaccination:
    ____ DTP ____ DTap ____ MMR ____ Hib ____ Hep B ____ OVP ____ IVP ____ Pneumonia
    ____ Chicken Pox ____ Flu ____ other, list_____

44. Do you feel your child's behavior changed after receiving a particular vaccine? Which one and explain behavior.
    _____
    _____

45. How long after the above vaccine did your child become sympathetic? Explain
    _____
    _____

46. Did your child receive any vaccinations when they were sick? If yes explain
    _____
    _____

47. Did your child suffer from any vaccine reactions listed below:
    ___ Fever_____ degrees ____ Inconsolable Screams ____ excessive lethargy ____ Rashes___ Hives ____
    vomiting ____ Seizures _____ other _____

Medication Usage:

48. Is your child allergic to any medication? List
    _____
    _____

49. Has your child taken any steroid medication that is inhaled, oral use or injections? Explain
    _____
    _____

50. Has your child taken any medication for yeast or Candida infections?
    _____

51. Please list all medication and supplements your child is currently taking.
    _____
    _____
    _____
    _____
    _____
    _____
    _____

Child's Diet:

52. Is your child on a gluten or casein free diet? Which one?
    _____
    _____

53. Has your child benefited by being on a Gluten /Casein free diet?
    _____
    _____

DAN Therapies:

54. Has your child ever received Secretin? If yes have they benefited?

55. Is your child taking Cod Liver Oil?

56. Has your child ever received IVIG (Intravenous Immunoglobulin)? Benefits seen.

57. Does your child currently have Mercury, Amalgam, or Silver fillings? How many?

58. Has child ever received Mercury Chelation with DMSA? Did you notice any benefits?

59. Has your child ever received any Chelation Therapies for Heavy metals besides mercury?

60. Has your child ever taken antifungal medication in the past, i.e. Nystatin, Diflucan?

61. Is your child taking Transfer Factor Colostrum?

62. Please list and explain any other DAN therapies your child has received.

63. Any other information you would like Dr. West to know: