THE Autism CLINIC LTD

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CONFIDENTIAL PATIENT QUESTIONNAIRE

Day .... Month 2008

....

Last and first name of patient | date of birth | gender | blood group | height (cm) | weight (kg)

.... → father → mother → other: ....

Name of the person filling out this questionnaire (Mr, Ms, Mrs, Dr)

....

Address *(block letters please)*

....

Postcode | Country

....

Day phone *(country code, area code, number)* | Evening Phone *(country code, area code, number)*

....

Fax *(country code, area code, number)* | E-mail

....

Father's age | Mother's age | How many siblings? | Age(s) of sibling(s) and sex

....

Is your joint income less than £45,000/annum Yes/No
(Required for possible grant application ONLY)

Occupation | Occupation

Any siblings with Autistic Spectrum Disorders?

Please let us know more about the patient with autism:

A. Has the patient been diagnosed?

a. Yes and at what age
b. No
c. By whom:

i. Name of person ....
ii. Title ....
iii. Name of institution ....
iv. Mailing address ....
....
v. Post Code ....
vi. Country ....
vii. Telephone ....
viii. Fax ....
ix. E-mail address ....

B. **What is the diagnosis (please tick):**

a. Classical early infantile autism (Kanner's Syndrome)

b. Autism

c. Dyspraxic

d. Asperger Syndrome

e. Rett Syndrome

f. Dyslexic

g. ADD: Attention Deficit Disorder

h. ADHD: Attention Deficit Hyperactivity Disorder

i. Other:

C. **Date of age *you* suspected delayed development**

D. **What did you notice?**

E. **Was the onset of your child's problem sudden or gradual?**

F. **Does the patient speak?** Yes No

If not, does the patient make sounds? Please describe

G. **Did the patient lose spoken words? If so, describe speech regression and at what age:**

H. **Frequency and age of first ear infection(s)**

I. **Did the patient lose social and/or motor skills?** Yes No

Please describe:

J. **Did you associate a decline in the patient's health and functions after a vaccine?**

(MMR, DPT. Polio, etc). Which vaccine?

K. **Does the patient have food allergies?** i.e. milk, wheat, soy, eggs, fish etc:

Please describe:

L. List all foods most commonly consumed.

M. Potty trained? Yes No

If so at what age?

N. Describe bowel movements: (please tick)

Diarrhoea
Constipation
Foul Smelling
Light/dark in colour
Mucous present in stool
Leaky Gut

Rapid transit time
Undigested foods in stools
Parasites
Gut Dysbiosis i.e. poor levels of beneficial bacteria

O. Does the patient have auditory defensive behaviour?
i.e. tendency to be very frightened of loud noises. Yes No

P. What type of touch bothers your child? Please describe:

Q. Describe the activities of daily living you must help your child with (dressing, feeding, bathing, etc):

R. What aspects are most troubling to you? i.e. self injurious, aggressive to others etc.

S. Describe your child's sleep pattern from birth to now in simple terms
i.e. when goes to bed, when wakes in night, when wakes in morning, sweats etc:

T. List all medical treatments, especially ANTIBIOTICS the patient has received, for what and at what age:

Medication	What For	What Age	Effective (Yes/No)

List all illnesses your child experienced before 12 months

List all illnesses your child experienced after 12 months

U. **List all current EDUCATION therapies:** i.e. Lovaas, ABA etc

Which ones have been most successful?

V. **Mainstream School programs and grade level:**

W. **List all medications currently used: Including dosage.**

U2. **Has your child had any reactions to the medications prescribed?**

X. **List alternative therapies used and whether they have been effective**
i.e. Auditory Integration Therapy, Cranial Osteopathy, Reflexology, Kinesiology.

Y. **List all current nutritional supplements taken daily. Include brand names and dosage.**

Z. **List any medication and nutritional supplements that you think have helped your child:**

AA. **What has benefited your child the most?**

BB. **Is your child right or left handed?**

CC. List all vaccinations, age given and any reactions that were noted i.e. fever, red rash, inflammation, etc

TB

VITAMIN K

DTP, HIB & POLIO
(please describe separately vaccinations given at 2, 3 and 4 months)

MMR

Others

DD. Other medical problems? The age when identified and severity of problem, please describe:

a. ADENOID/SINUS PROBLEMS.

b. KNOWN ALLERGIES.

c. ASTHMA

d. SKIN RASHES OR ECZEMA

e. SWEATING ESPECIALLY AT NIGHT

f. STRONG SMELLING URINE (MAPLE SYRUP SMELL)

g. SEIZURES

h. EYE/VISUAL PROBLEMS

i. WALKING/RUNNING

j. BRONCHITIS

k. CATARRH

l. CHICKEN POX

m. CONSTIPATION

n. DIARRHEOA

o. DIABETES

p. GASTRO-ENTERITIS

q. GLANDULAR FEVER

r. HERPES

s. HIVES

t. FLU

u. SORE THROATS

v. MUSCULAR DYSTROPHY

w. GLUE EAR

x. PNEUMONIA

y. WHOOPING COUGH

z. LUPUS

EE. List all diagnostic tests performed on the patient:

FF. From the tests, what tests showed abnormalities?

PLEASE ENCLOSE COPIES OF RESULTS IF YOU HAVE THEM.

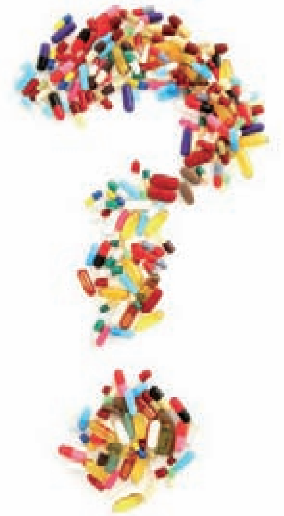
GG. In order for us to better understand the patient, please list any and all of the symptoms, presently being exhibited:

a.	Sleeplessness	Yes	No	Comments:
b.	Temper tantrums	Yes	No	Comments:
c.	Crying for no apparent reason	Yes	No	Comments:
d.	Laughing for no apparent reason	Yes	No	Comments:
e.	Hyperactive/overactive	Yes	No	Comments:
f.	Uncontrollable	Yes	No	Comments:
g.	Angry/hostile	Yes	No	Comments:
h.	Itchy/red anus	Yes	No	Comments:
i.	Jekyll/Hyde behaviour	Yes	No	Comments:
j.	Leaky gut	Yes	No	Comments:
k.	Eyes sensitive to bright lights	Yes	No	Comments:
l.	Pale complexion	Yes	No	Comments:
m.	Craves sweets	Yes	No	Comments:
n.	Shaky/irritable before meals	Yes	No	Comments:
o.	Behaviour improved after meals	Yes	No	Comments:
p.	Hyperactive/irritable after eating	Yes	No	Comments:
q.	Easily agitated	Yes	No	Comments:
r.	Defiant	Yes	No	Comments:
s.	Vomiting/spitting up	Yes	No	Comments:
t.	Colic	Yes	No	Comments:
u.	Ear infections	Yes	No	Comments:
v.	Excessive thirst	Yes	No	Comments:
w.	Dark circles under eyes	Yes	No	Comments:
x.	Congestion/runny nose	Yes	No	Comments:
y.	Coughing/wheezing	Yes	No	Comments:
z.	Bed-wetting	Yes	No	Comments:
aa.	Picky eater	Yes	No	Comments:
bb.	Seasonal allergies	Yes	No	Comments:

cc.	Hives/skin rashes/eczema	Yes	No	Comments:
dd.	Red earlobes/pink cheeks	Yes	No	Comments:
ee.	Chronic infections	Yes	No	Comments:
ff.	Constipation	Yes	No	Comments:
gg.	Diarrhoea	Yes	No	Comments:
hh.	Fatigue	Yes	No	Comments:
ii.	Learning problems	Yes	No	Comments:
jj.	Had lots or multiple antibiotics	Yes	No	Comments:
kk.	Craves certain foods	Yes	No	Comments:
ll.	Cold hands and feet	Yes	No	Comments:
mm.	Night sweats	Yes	No	Comments:
nn.	Rapid heart rate	Yes	No	Comments:
oo.	Red spots on back of arms	Yes	No	Comments:
pp.	Poor balance/clumsy	Yes	No	Comments:
qq.	Creative/artistic talent	Yes	No	Comments:
rr.	Doesn't like to read	Yes	No	Comments:
ss.	Won't try new things	Yes	No	Comments:
tt.	Can't stay on task	Yes	No	Comments:
uu.	Points to things	Yes	No	Comments:
vv.	Can hear but doesn't listen	Yes	No	Comments:
ww.	Does well in school one day and poor the next	Yes	No	Comments:
xx.	Muscle cramps	Yes	No	Comments:
yy.	White flecks on nails	Yes	No	Comments:
zz.	Stimming (repetitive actions)	Yes	No	Comments:
aaa	Rocking	Yes	No	Comments:
bbb	Head banging	Yes	No	Comments:
ccc	Self-mutilation	Yes	No	Comments:
ddd	Nail biting	Yes	No	Comments:
eee	Hand/arm biting	Yes	No	Comments:
fff	Nail / skin picking	Yes	No	Comments:
ggg	Seizures	Yes	No	Comments:
hhh	Processing problems – visual, motor, language, sensory, etc	Yes	No	Comments:
iii	Excessive sweating	Yes	No	Comments:
jjj	Difficulty falling asleep	Yes	No	Comments:
kkk	Night waking	Yes	No	Comments:
lll	Difficulty waking	Yes	No	Comments:
mmm	Bed wetting/soiling	Yes	No	Comments:
nnn	Staring	Yes	No	Comments:
ooo	Bad breath	Yes	No	Comments:
ppp	Nose Bleeds	Yes	No	Comments:
qqq	Acute sense of smell	Yes	No	Comments:
rrr	Geographic tongue	Yes	No	Comments:
sss	Swollen gums	Yes	No	Comments:
ttt	Belching	Yes	No	Comments:
uuu	Refusal to eat	Yes	No	Comments:
vvv	Sensitive to texture of food	Yes	No	Comments:
www	Grinding teeth	Yes	No	Comments:
xxx	Mucous/blood in stools	Yes	No	Comments:
	Sensitivity to insect bites	Yes	No	Comments:
zzz	Sensitive to texture of clothes	Yes	No	Comments:
	Ridges/pitting of nails	Yes	No	Comments:
	Hite spots/lines on nails	Yes	No	Comments:

NUTRIENT DEFICIENCY SYMPTOMS

Please underline the symptoms that are affecting your child NOW and highlight the ones that were previously affecting your child



A

Red, Itchy Eyes
Night Blindness
Sensitivity to bright lights
Rough or dry skin
Cold or infections esp. respiratory tract
Allergies
Acne
Dry Hair
Insomnia

B1

Irritability
Sensitivity to Noise
Anxiety and confusion
Hypothyroidism
Fear
Constipation
Fatigue
Gastrointestinal disturbances
Muscle loss
Loss of appetite

B2

Mouth and lip lesions esp. at corners
Tongue inflammation
Gritty Eyes
Red itchy eyes
Scaly skin on face
Dermatitis
Hair loss
Insomnia
Slowed mental response

B3

Eczema
Diarrhoea
Bad breath
Fatigue
Indigestion
Depression
Insomnia
Skin eruptions
Inflammation

B5

Irritability
Depression
Hypoglycaemia
Indigestion
Constipation
Ulcers
Low adrenal output

B6

Linear nail ridges. Impaired wound Healing
Inability to tan, sensitivity to sun
Cracks around lips. Impaired memory
Convulsions/tremors/seizures
Hypoglycaemia. Learning difficulties
Diabetes
Appetite loss
Allergies
Oedema (Water retention)
Flaky skin
Carpal Tunnel syndrome (mother)

B12

Abnormal gait/walking difficulties
Pernicious anaemia
Heart palpitations
Loss of co-ordination (Ataxia)
Impaired memory
Sharp mood swings
Constipation
Digestive disorders
Moodiness
Hallucinations
Ringing in ears

Biotin

Eczema and dermatitis
Lack of appetite
Muscle aches and pains
Cradle Cap (dry scaly scalp)
Inflammation
Pallor of skin
Sore tomgue

C
Common colds and infections
Allergies
Bleeding or inflamed gums
Defective teeth
Anaemia
Easy bruising
Loss of appetite
Fatigue
Anxiety
Depression
Slow wound healing
Poor digestion

Calcium
Hyperactivity
Fractures of bone
Nervousness
Muscle aches
Leg cramps
Teeth grinding
Brittle nails
Eczema
Insomnia
Pasty Complexion
Convulsions
Cold sores
Mouth blisters
Impaired growth
High lead levels
High Oxalic acid Poor fat digestion

Choline
Fatty liver
Intolerance to fats
Hypertension
Liver impairment
High homocysteine

Chromium
Fatigue
Anxiety
Hypertension
Impaired glucose metabolism
Obesity

Copper
Anaemia
Fatigue
Shortness of breath
Skin de-pigmentation
Skin sores

D
Soft Teeth/Tooth decay
Fatigue
Short sightedness
Loss of appetite
Insomnia
Visual problems
Diarrhea
Burning sensation in mouth and throat

E
Poor wound healing
Inflamed veins
Haemolytic anaemia
Menstrual problems (Mother)
Miscarriage, Infertility, Sterility (Mother)

Folic Acid
Megaloblastic anaemia
Depression
Psychosis
Epileptic fits
Lack of appetite
Sore red tongue
Digestive disturbances
Fatigue
Insomnia
Paranoia
Memory problems

Inositol
Hypertension
High cholesterol
Dermatitis
Hair Loss
Constipation
Mood swings
Skin eruptions
Obsessive Compulsive Disorder
Anxiety

Iodine
Goiter (mother/father)
Obesity
Dry hair
Heart palpitations
A cold body
Constipation
Weakness
Low resistance to colds and infections
Nervousness
Irritability

Iron
Iron deficient anaemia
Pallor
Weakness
Shortness of breath
Brittle nails and hair
Spoon shaped nails or ridges running lengthwise
Nervousness
Slowed mental reactions

K
Poor liver function
Nose bleeds
Coeliac/ Irritable Bowel Syndrome

Lead
Hyperactivity
Mental retardation
Depression
Nervousness
Frequent cold and infections
Low levels of zinc, iron and copper

Manganese
Learning problems
Low tolerance to carbohydrate
Short or long legs in proportion to body length
Loss of muscle coordination
Confusion
Convulsions
Pancreatic damage
Eye problems
Teeth grinding
High purines

Magnesium
Irregular/rapid Heart beat
Jumpy nerves
Weak/twitching muscles
Convulsions and seizures
Fatigue
Bed wetting
Irritability
Insomnia
Depression
Imbalanced pH
Premature labour (mother)
PMS (mother)

Mercury
Nervous system
Brain damage

Molybdenum
Predisposition to tooth decay
Anaemia
Mouth and gum disorders

Potassium
Cognitive Impairment
Oedema (water retention)
Hypertension
Irregular heart beat
Nervousness and Fatigue
Abnormally dry skin
Insomnia
Nausea and vomiting
Proteinuria (protein in urine)

Selenium
Sterility (mother/father)
Susceptibility to colds and infections
Fatigue
Cancer in family and heart disease
Pancreatic insufficiency

Sodium
Intestinal Gas/Flatulence
Weight loss
Muscle wasting
Fatigue
Dehydration
Abdomibnal Cramps
Hallucinations
Impaired sense of taste
Memory Impairment
Poor co-ordination
Recurrent infections
seizures

Sulphur
Dry Hair
Brittle nails
Rough skin
Pale stools
Many bacterial infections
Leaky gut
Low glutathione levels

Zinc
Slow learning
Susceptibiltiy to infections
Loss of appetite
Fatigue
Loss of taste and smell
Allergies
Acne
White spots on nails
Peeling, thin nails
Impaired night vision
Memory impairment
Skin lesions
Slow wound healing

This section to be completed by the Mother

Pregnancy information

Labor

Induced	Yes/No	Babys birth weight	................lbs ....ozs	
Forceps	Yes/No	APGAR Rating	....	
C-Section	Yes/No	Long delivery. If so, how long?	....	
Premature	Yes/No	How many weeks?	....	
Late	Yes/No	Distressed birth	....	Yes/No
If yes, how late?		Any discussion of oxygen starvation?		Yes/No
		Did the baby cry after delivery?		Yes/No

Please describe anything out of the ordinary during pregnancy?

Did you receive any medical treatment (including dental) during pregnancy? If so for what and what was the treatment given?

Did you have greater Heavy Metal Exposure during pregnancy *(increased tuna/swordfish/sea bass consumption; dental work: root canal, amalgams; fluvax; Rhogan injection?)*

Did you breast feed (Yes/No). If yes for how long?

Did/does the child experience colic or milk intolerance? (Yes/No) Please describe symptoms:

Did you use formula? (Yes/No) What brand name or type?

At what ages was your child introduced to wheat products?

Was your child significantly under or over the average weight percentile in the first year? If so,

% High

% Low

Please complete the following:

High blood pressure	Yes ☐	No ☐	Don't Know ☐
Sugar problem	Yes ☐	No ☐	Don't Know ☐
Excessive weight gain *(greater than 35 pounds)*	Yes ☐	No ☐	Don't Know ☐
Marked water retention	Yes ☐	No ☐	Don't Know ☐
Pre-ecclampsia or toxemia	Yes ☐	No ☐	Don't Know ☐
Premature labour	Yes ☐	No ☐	Don't Know ☐
Bleeding problems	Yes ☐	No ☐	Don't Know ☐
Amalgam fillings	Yes ☐	how many	No ☐

Before and after pregnancy, did you have any of the following:

Heavy menses with blood clots	Yes ☐	No ☐	Don't Know ☐
Migraine headaches	Yes ☐	No ☐	Don't Know ☐
High blood pressure	Yes ☐	No ☐	Don't Know ☐
Chronic fatigue	Yes ☐	No ☐	Don't Know ☐
Depression	Yes ☐	No ☐	Don't Know ☐
Chronically sore or painful muscles or joints	Yes ☐	No ☐	Don't Know ☐
Inflammatory bowel disease	Yes ☐	No ☐	Don't Know ☐
Chronic or common abdominal pain	Yes ☐	No ☐	Don't Know ☐
Chronic headaches	Yes ☐	No ☐	Don't Know ☐
Obsessive or compulsive problems	Yes ☐	No ☐	Don't Know ☐
Infertility problems	Yes ☐	No ☐	Don't Know ☐

The key shows useful abbreviations you can use to identify the Individual's in your family who have suffered from any of the conditions listed. Simply list these abbreviations alongside the relevant condition. For example, if both mother and Father have suffered from migraine your entry would be:

MIGRAINE M F

....

You may wish to list other relations also, ie uncles, aunts. Brothers, sisters

KEY – Relation to autistic child

M = Mother
F = Father
PM = Grandparent (mother's side)
PF = Grandparent (Fathers' side)
GPM = Great Grandparent (Mother's side)
GPF = Great Grandparent (Father's side)

BLOOD TYPE O ....

<u>INCREASED HOMOCYSTEINE</u> ....
EARLY HEART DISEASE ....
HEART ATTACKS ....
DIABETES ....
STROKES ....
ALZHEIMERS ....
NEURAL DEFECTS ....

<u>DECREASED METHYLATION</u> ....
CANCERS ....
PREMATURE AGING ....
CARDIOVASCULAR DISEASE ....
NEUROLOGICAL ISSUES ....
RETEROVIRAL TRANSMISSION ....
DOWN'S SYNDROME ....

MIGRAINE ....
IBS ....
AUTOIMMUNE ILLNESSES ....
CEREBAL PALSY ....
AUTISTIC SPECTRUM DISORDER: ....
DYSLEXIA: ....

DEPRESSION: ....
RHEUMATOID ARTHRITIS: ....

ALLERGIES TO FOODS AND ENVIRONMENT: ....
ASTHMA: ....
DERMATITIS: ....
ECZEMA: ....
HAY FEVER: ....
HIVES: ....

ATHLETES FOOT: ....
CHRONIC FATIGUE SYNDROME: ....
FIBROMYALGIA: ....
LUPUS: ....
PSORIASIS ....
CIRRHOSIS: ....

COLONIC COLITIS: ....
IRRITABLE BOWEL SYNDROME: ....
LEAKY GUT: ....
CONSTIPATION: ....
DIARRHOEA: ....
GASTRO-ENTERITIS: ....
GASTRIC AND DUODENAL ULCERS: ....
INDIGESTION: ....
LACTOSE INTOLERANT ....

PNEUMONIA: ....
PLEURISY: ....
SHINGLES: ....
SINUSITIS: ....
SORE THROATS (recurrent): ....
INFERTILITY PROBLEMS: ....
MISCARRIAGES: ....
RAYNAUDS DISEASE (cold hands and feet): ....
PALE COMPLEXION: ....
OTHERS: ....

....

....

....

....

....

....

PRESENT DIET CONSUMED

DAY 1	DAY 2
BREAKFAST	BREAKFAST
LUNCH	LUNCH
DINNER	DINNER
SNACKS AND DRINKS	SNACKS AND DRINKS

DAY 1	DAY 2
BREAKFAST	BREAKFAST
LUNCH	LUNCH
DINNER	DINNER
SNACKS AND DRINKS	SNACKS AND DRINKS

ENVIRONMENTAL HISTORY

Do you, your child, or any family members practice any relaxation, stress management techniques? Please describe:

Circle appropriate answers to the following questions and describe:

1. **Location of home:** City/ Suburban/ Wooded/ Farm/ Other (describe):
2. **Water:** City/Well **Purification system:** yes/no If yes what kind?
3. **Type of heat:** Electric/gas/ oil/ other(describe):
4. **Do you live near:** Power lines/ woods/ industrial area/ water
5. **If you live near water, what type?** Swamp/river/ocean/other(describe):
6. **Does your home have a lot of:** Dust/ mold/ down/ or feather items? If so please describe:

Describe your child's bedroom:

Bedding: synthetic/down/feather **Mattress enclosed:** Yes/ No Crib/Jr. Bed / Adult bed

Flooring: Carpet: wall-to-wall area rug/ Wood Glued down Synthetic pad

Window treatments: Shades Blinds/ Thin Curtains/ Heavy curtains/ valance Other (describe):

Other items in room including furniture, toys, stuffed animals, etc.:

Flooring in other rooms:

Child's bathroom:

Living room?

Family room/play room?

Is your child sensitive to or bothered by the following?

Perfumes/cosmetics?
Cleaning products?
Pollens/grasses?
Soaps?
Animals (dander)?

Detergents?
Gasoline?

Dust?
Paint?

Other?

PARENT RATING SCALE

Instructions: Below are a number of common problems that children with autistic spectrum disorders commonly have. Please rate each item according to your child's behaviour in the last month. For each item, ask yourself "How much of a problem has this been in the last month?", and circle the best answer for each one. If none, not at all, seldom, or very infrequently, you would circle 0. If very much true, or it occurs very often or frequently, you would circle 3. You would circle 1 or 2 for ratings in between. Please respond to all the items.

	Item				
1.	Angry and resentful	0	1	2	3
2.	Difficulty doing or completing homework	0	1	2	3
3.	Is always "on the go" or acts as if driven by a motor	0	1	2	3
4.	Timid, easily frightened	0	1	2	3
5.	Everything must be just so	0	1	2	3
6.	Has no friends	0	1	2	3
7.	Stomach aches	0	1	2	3
8.	Fights	0	1	2	3
9.	Avoids, expresses reluctance about, or has difficulties engaging in tasks that require sustained mental effort (such as schoolwork or homework)	0	1	2	3
10.	Has difficulty sustaining attention in tasks or play activities	0	1	2	3
11.	Argues with adults	0	1	2	3
12.	Fails to complete assignments	0	1	2	3
13.	Hard to control in malls or while grocery shopping	0	1	2	3
14.	Afraid of people	0	1	2	3
15.	Keeps checking things over again and again	0	1	2	3
16.	Loses friends quickly	0	1	2	3
17.	Aches and pains	0	1	2	3
18.	Restless or overactive	0	1	2	3
19.	Has trouble concentrating in class	0	1	2	3
20.	Does not seem to listen to what is being said to him/her	0	1	2	3
21.	Loses temper	0	1	2	3
22.	Needs close supervision to get through assignments	0	1	2	3
23.	Runs about or climbs excessively in situations where it is inappropriate	0	1	2	3
24.	Afraid of new situations	0	1	2	3
25.	Fussy about cleanliness	0	1	2	3
26.	Does not know how to make friends	0	1	2	3
27.	Gets aches and pains or stomach aches before school	0	1	2	3
28.	Excitable, impulsive	0	1	2	3
29.	Does not follow through on instructions and fails to finish schoolwork, chores or duties in the workplace (not due to oppositional behaviour or failure to understand instructions	0	1	2	3
30.	Has difficulty organizing tasks and activities	0	1	2	3
31.	Irritable	0	1	2	3
32.	Restless in the "squirmy sense"	0	1	2	3
33.	Afraid of being alone	0	1	2	3
34.	Things must be done the same way every time	0	1	2	3

35. Does not get invited over to friends' houses 0 1 2 3
36. Headaches 0 1 2 3
37. Fails to finish things he/she starts 0 1 2 3
38. Inattentive, easily distracted 0 1 2 3
39. Talks excessively 0 1 2 3
40. Actively defies or refuses to comply with adults' requests 0 1 2 3
41. Fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities 0 1 2 3
42. Has difficulty waiting in lines or awaiting turn in games or group situations 0 1 2 3
43. Has a lot of fears 0 1 2 3
44. Has rituals that he/she must go through 0 1 2 3
45. Distractibility or attention span a problem 0 1 2 3
46. Complains about being sick even when nothing is wrong 0 1 2 3
47. Temper outbursts 0 1 2 3
48. Gets distracted when given instructions to do something 0 1 2 3
49. Interrupts or intrudes on others (e.g. butts into others conversations or games) 0 1 2 3
50. Forgetful in daily activities 0 1 2 3
51. Cannot grasp arithmatic 0 1 2 3
52. Will run around between mouthfuls at meals 0 1 2 3
53. Afraid of the dark, animals, or bugs 0 1 2 3
54. Sets very high goals for self 0 1 2 3
55. Fidgets with hands or feet or squirms in seat 0 1 2 3
56. Short attention span 0 1 2 3
57. Touchy or easily annoyed by others 0 1 2 3
58. Has sloppy handwriting 0 1 2 3
59. Has difficulty playing or engaging in leisure activities quietly 0 1 2 3
60. Shy, withdrawn 0 1 2 3
61. Blames others for his/her mistakes or misbehavior 0 1 2 3
62. Fidgeting 0 1 2 3
63. Messy or disorganized at home or school 0 1 2 3
64. Gets upset if someone rearranges his/her things 0 1 2 3
65. Clings to parents or other adults 0 1 2 3
66. Disturbs other children 0 1 2 3
67. Deliberately does things that annoy other people 0 1 2 3
68. Demands must be met immediately-easily frustrated 0 1 2 3
69. Only attends if it is something he/she is very interested 0 1 2 3
70. Spiteful or vindictive 0 1 2 3
71. Loses things necessary for tasks or activities (e.g., school assignments, pencils, books, tools or toys) 0 1 2 3
72. Feels inferior to others 0 1 2 3
73. Seems tired or slowed down all the time 0 1 2 3
74. Spelling is poor 0 1 2 3
75. Cries often and easily 0 1 2 3
76. Leaves seat in classroom or in other situations 0 1 2 3

SUPPLEMENTS

Please check the supplements list below and indicate taken now or past and the appropriate response
Now/ past
Very Good
Good
None
Bad
Very Bad
Bad then Good

Vitamin A
Vitamin C
Vitamin D
Vitamin E
Vitamin K
Vitamin B1,Vitamin B2, Vitamin B3 (Niacin), Vitamin B5, Vitamin B6, P5P,Vitamin B12
IV Methylcobalamin
5 HydroxyTryptophan
Alpha Keto Glutarate (AKG)
Biotin
Amino Acid Mix
Dimethylglycine (DMG)
GABA
Glutamine
SAMe (SAM, Samyr)
TMG
Tryptophan
Tyrosine
Iodine (seakelp)
Calcium
Magnesium
Manganese
Selenium
Zinc
Human Growth Factor
IV Immune globulin
Taurine
Oral Immune globulin
Secretin (IV)
Secretin (transdermal/sublingual/homoeopathic)
Digestive enzymes
DHA rich oils, EPA rich oils, Omega 6 rich oils, combined omega 3,6,9 oil.
Cod liver oil
Flax oil
Activated Charcoal
Alka Seltzer Gold
Spirulina
Chromium
Sulphate (MSM/Epsom salts)
Phosphatydlcholine
Iron
Molybdenum
Sodium
Potassium
Inositol
Probiotics such as lactobacillus and bifidus
Prebiotics such as Fructooligosaccharides
Therapies and Diets

THERAPIES AND DIETS

Please indicate therapies and diets you have used now or past and the appropriate response:

Now /Past
Very Good
Good
None
Bad
VeryBad
Bad then Good

Comments

Acupuncture
Auditory Integration Training
Cranio-sacral
Energy Therapy (Specify)
Homeopathy
Lovaas (ABA)
PECS
Sonrise
Naturopathy
Neural Therapy
Occupational Therapy
Osteopathy
Physical Therapy
Sensory Diet
Speech Therapy
Other:

Diets

Now /Past
Very Good
Good
None
Bad
Very Bad
Bad then Good

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

IF YOU HAVE ANY QUESTIONS RELATING TO ANY ASPECT OF AUTISTIC SPECTRUM DISORDERS PLEASE LIST THEM BELOW:

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Please bring/send several pictures of your child, specifically portraying the change he or she has experienced i.e. if your child has regressed, bring in pictures that clearly show them before regression, and after regression.

Photographs may focus specifically on areas such as rashes, sores, eczema, abdominal distention (bloating), dark eye circles and other problems.

You should personally keep a video as he/she undergoes treatment.

I would like to thank you for completing and returning this questionnaire. Your detailed feedback is greatly appreciated and will provide such necessary information to specifically formulate the correct approach and protocol to help in addressing your child's areas of concerns.

All information will remain strictly confidential.

What to do now.

1. Please return this questionnaire with copies of any former diagnostic test results or information you may feel will provide further information outside of this questionnaire to the address given on the cover page.

2. Please complete the disclaimer on the following page.

Many thanks

Kind regards

Jonathan

Jonathan Tommey

THE AUTISM FILE CLINIC POLICIES

Effective September 2008

CLINIC POLICY:

To be considered an active patient and receive ongoing care, we require that a child be seen in clinic at least once per calendar year. All other follow up appointments may be in person or by telephone (unless otherwise determined by clinician or requested by parent/guardian).

CANCELLATION POLICIES:

All services are provided by appointment only and this scheduled time is reserved for your exclusive use. The cancellation policy differs by the type of appointment, as documented below.

CANCELLATION OF APPOINTMENTS:

All new patient appointments must be cancelled 7 days prior to your scheduled appointment.

Appointments not cancelled within 7 days of the scheduled appointment will be charged at 50% of the standard initial consultation fee.

FOLLOW UP APPOINTMENT CANCELLATION:

We require 48 hours notice for follow up consultations, which includes office visits or telephone consults. Appointments not cancelled within 48 hours of the scheduled appointment will be billed at 50% of the standard fee for the followup service.

Fees for non cancellation of follow up appointments are nonrefundable and may not be used as credit to a future consultation or procedure.

If you cannot reach us in person by phone, you can leave a detailed voicemail message with your name, patient's name, date and time of your scheduled appointment.

EMAIL POLICIES

As part of our continued effort to provide you with the very best medical care, I use email as a form of communication within The Autism Clinic.

EMAIL GUIDELINES:

Email communication is viewed as chargeable time, as is an office visit or telephone consultation.

Any email that requires at least 15 minutes will be billed as per that hourly rate.

If you have any questions regarding any of these policies, please call our office at 0208 979 2525 or 07714 957309

Your cooperation and understanding in this matter are greatly appreciated.

Thank you.

I, *(please print name)* ....

have read and understand the above outlined polices.

Signature ....

Date ....