Last Name: _____

Autistic Spectrum Disorder Questionnaire

*Please fill out the following questionnaire. Please include copies of any **lab tests** that have been run and a **photo** of your child.*

Name (child) _____ Height: _____ Weight: _____

_____ Date of birth: _____ Age: _____

_____ Diagnosis: _____

Physician: _____

Referred by: _____

_____

Mother's Name _____ Phone (H) _____

Address: _____ Phone (W) _____

_____ Phone (C) _____

Mother's Email _____

Parents: Single / Married / Unmarried / Separated / Divorced Child lives with: _____

_____

Father's Name _____ Phone (H) _____

Address: _____ Phone (W) _____

_____ Phone (C) _____

Father's Email _____

Age autism symptoms first appeared _____ Age when diagnosed _____

Did any events accompany onset of autism? _____

What conditions or symptoms are most significant? _____

_____

Is child verbal?_____

What is your level of knowledge on nutrition intervention for ASDs ?

- ❑ Very well read
- ❑ Have done some reading and have started dietary intervention
- ❑ Very new to all of this

How can a nutrition consultant best support you? _____

_____

Therapies/Protocols *(**Indicate:** what you are you interested in, are using, or tried in past)*

Defeat Autism Now! Protocol _____ Diet Intervention _____ Sensory integration _____

Chelation _____ Yeast protocol _____ Homeopathy_____

NAET, Bioset _____ Energy work _____ Other _____

PRENATAL/INFANT

Number of children in family and order (i.e. 2nd of 3 children) _____

Names/ages other children _____ _____ _____

Describe the pregnancy _____

Was child breast-fed? How long _____

Did the child receive formula? What type (cow, soy)? _____

What was the reaction to formula? _____

Did child have thrush as a baby? _____

Was the *mother* exposed to any chemicals or medications during pregnancy, or received any amalgam fillings or vaccinations (including Rh immune globulin or flu shot)?

_____

Did child receive all vaccinations? _____ Did you notice any vaccine reaction? _____

HEALTH HISTORY OF CHILD

Describe the health history of the child from birth (i.e. ear infections, illnesses, viruses):

_____

_____

_____

How many times has the child received antibiotics and at what age? Please describe

_____

_____

Does child have heavy metal or other toxicity? _____

Is child currently taking any medication? _____

Please list **supplements** child is taking (or include separate sheet):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Have you tried cod liver oil and was there any improvement? _____

DIET

Is child on any of the following diets?

GFCF _____ Specific Carbohydrate Diet _____ Yeast diet _____

Feingold _____ Body Ecology Diet _____ Low oxalate _____

Other/Combination of…_____

Vegetarian Yes / No _____

Eat fish? How often and what type? _____

Please describe any special diet or variation of the diets above that child is on:

_____

_____

Do you (circle one) suspect or know that your child is:

Gluten sensitive _____ **Casein** sensitive _____ Explain _____

Has child tried a strict gluten/casein-free diet? _____ If yes, for how long? _____

Did you notice a reduction in symptoms? _____

Does child have any **allergies or food sensitivities (put a * next to serious allergies)**?

Eggs	Corn	Sugar	Soy
Chocolate	Peanuts	Citrus	

Other_____

Does child have any significant food cravings, or demand or sneak food? _____

Phenols/Salicylates

Are you familiar with phenols, salicylates, and faulty sulfation? _____

Do you suspect your child has a **phenol sensitivity**? _____ Is there a **craving** or reaction - [hyperactivity, red cheeks, aggression, etc.] to the following phenols/salicylates? (circle):

Apples/juice	Grapes/raisins	Tomatoes	Berries/Bananas/other fruit
Curry powder/Spices	Nitrates/nitrites	Preservatives	Artificial colors/flavors
Sulfites	Fragrance/perfume	Aspirin	Tylenol (acetaminophen)

Does your child get any vegetables in their diet?: Never Rarely Moderate Quite a bit

Vegetables in what form?: Juiced • Pureed and hidden • Eat outright

Does your child only eat foods of certain **textures**? _____

Are there any **textures** your child will *not* eat? _____

Does he/she tend to focus on one **taste** (sweet, bitter, sour, salty, spicy)_____

Are there any **tastes** he/she will not eat? _____

Favorite foods: _____

What food does your child typically eat (please also complete the "food/mood" diet record):
Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Drinks _____

DIGESTION AND ELIMINATION

Does child have frequent gas or bloating? _____

Does gas have a strong odor? _____

Does child appear to have abdominal pain? _____

Does child have diarrhea or soft, unformed stool? _____

Does child have constipation? _____

Does child have heartburn or acid reflux? Does child take antacids or acid blockers?

_____

Does child get nauseous or vomit? _____

Does child have yeast or bacterial overgrowth? _____

Describe any other digestive issues? _____

Is child potty trained or wear a diaper? _____

How frequently does child have a bowel movement? _____

What is consistency of stool?

Formed like a brown banana _____

Unformed, soft, or ribbon-like _____

Small balls formed into banana, or "rabbit-pellets" _____

Very large diameter _____

FAMILY HISTORY

Do *mother or father* have any food sensitivities? _____

Does *mother* have any heavy metal toxicity or exposure? _____

Common Familial Disorders

Please indicate any family history of the following and list family member affected, mark paternal or maternal with a "p" or "m". For example: p-grandmother, m-aunt

ADD/Hyperactivity _____
Asperger's or other ASDs _____
Alcohol/chemical dependency_____
Epilepsy_____
Rheumatoid arthritis_____
Food/environmental allergies_____
Impaired fat digestion/loose stools_____
Asthma_____
IBD/Crohn's disease_____
Cancers of GI Tract_____
Schizophrenia_____
Alzheimer_____
Other psychiatric condition_____

Depression, postpartum, SAD, bipolar _____
High estrogen/low progesterone _____
Threatened or actual miscarriage_____
Diabetes/hypoglycemia_____
Impaired immune function_____
Recurring yeast (vaginal, foot, etc.) _____
Recurring sinus infections_____
Dermatitis/rashes_____
Multiple chemical sensitivity_____
Fibromyalgia or chronic fatigue _____
Active Epstein-Bar virus_____
Hypothyroid_____
Autoimmune/inflammation _____

CONTACTING US:

Julie: 415-437-6807
Julie@NourishingHope.com

At scheduled appointment times, contact Julie at 415-437-6807
To arrange an appointment or for other questions, contact Martin at 415-235-2960

Last Name: _____

ASD Symptom Checklist

*Please rate the following behaviors or symptoms on a scale of 1 to 7 (1 mild; and 7 very true or severe) as they appear **today**. This will help determine how the child progresses.*

Communication	(0) Not apply						(1)Mild	(7)Very true
Cannot communicate verbally	0	1	2	3	4	5	6	7
Receptive language is difficult	0	1	2	3	4	5	6	7
Reverses pronouns such as you" and "I"	0	1	2	3	4	5	6	7
Has echolalia – repeats others' words	0	1	2	3	4	5	6	7
Can not rationalize with child	0	1	2	3	4	5	6	7
Behavioral/emotional symptoms								
Does not respond to requests by familiar people	0	1	2	3	4	5	6	7
Has picky eating habits	0	1	2	3	4	5	6	7
Throws frequent tantrums	0	1	2	3	4	5	6	7
Behaves aggressively, physically attacking others	0	1	2	3	4	5	6	7
Injures self with behavior (head-banging)	0	1	2	3	4	5	6	7
Frequent crying	0	1	2	3	4	5	6	7
Depression	0	1	2	3	4	5	6	7
Irritability	0	1	2	3	4	5	6	7
Panics easily or resists change	0	1	2	3	4	5	6	7
Behavior challenges 2-3 hours after meals	0	1	2	3	4	5	6	7
Hyperactivity	0	1	2	3	4	5	6	7
Spacey/Inattentive	0	1	2	3	4	5	6	7
Low impulse control	0	1	2	3	4	5	6	7
Physical Symptoms								
Is physically inactive, or passive	0	1	2	3	4	5	6	7
Fatigue/low muscle tone	0	1	2	3	4	5	6	7
Hypersensitive (sound, touch, etc)	0	1	2	3	4	5	6	7
Insensitive to pain	0	1	2	3	4	5	6	7
Headache	0	1	2	3	4	5	6	7
Tics/Tourette's	0	1	2	3	4	5	6	7
Asthma	0	1	2	3	4	5	6	7
Bedwetting/daytime wetting	0	1	2	3	4	5	6	7
Red checks or streaks on face	0	1	2	3	4	5	6	7
Dark circles under eyes	0	1	2	3	4	5	6	7
Hives/rashes	0	1	2	3	4	5	6	7
Congestion/runny nose/allergy symptoms	0	1	2	3	4	5	6	7
Resistance to go to bed	0	1	2	3	4	5	6	7
Difficulty falling asleep	0	1	2	3	4	5	6	7
Night waking/nightmares/erratic sleep	0	1	2	3	4	5	6	7
Seizure activity	0	1	2	3	4	5	6	7

Please remember to include copies of any lab tests that have been run

- ❑ **No tests have been run yet**

Last Name: _____

Food/Mood Record

1. Please write out child's daily diet. (If diet varies, fill out a diet record for at least two days). Include portion size and any supplements or medications. Include time of day.
2. Additionally, record any symptoms experienced during or after eating, such as drowsy, irritable, energized. Include bowel movements.

	Time	Food/Supplements	Mood/Energy/Symptoms
Example	***9:00***	***1 cup of Cheerios with 3/4 c of cow milk 1 Flintstone's multi-vit/min, 500 mg vit C***	***10:00 Hyperactive Constipation***
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Night-time Eating			

Last Name: _____

Nutrition Consultant Service Agreement

On behalf of my child _____ I, _____, am consulting with Julie Matthews, Certified Nutrition Consultant to gain information on health and wellness. I understand that Julie Matthews is not a physician and that she does not dispense medical advice nor prescribe treatment. Rather, she provides information to enhance my knowledge of how nutritious foods, herbs, supplements, and lifestyle affect health.

Julie Matthews' training includes a two-year certification program in nutrition education and consultation from Bauman College. The methods of evaluation employed on my behalf, which may include diet, supplementation, and assessment analysis, are not intended to diagnose disease. I specifically authorize the use of these assessments, so that we can develop an appropriate dietary and health-supporting program for me and/or my child, and to monitor my progress towards achieving my health goals.

These services are not a substitute for medical care, and do not claim to diagnose, treat, or alleviate disease. Nutrition consultation services are not licensed by the state of California, they are alternative or complementary to the healing arts services licensed by the state. For medical diagnosis and treatment of disease, I would need to consult with a medical physician, or other licensed healing arts practitioner.

I am acting solely on behalf of myself and my child. I do not represent any other person, entity, and/or governmental agency.

My child currently is ❑ is not ❑ under the care of a physician for a health problem or medical condition. By providing the following information, I give Julie Matthews permission to contact his/her physician, _____, at the following phone number _____ on my behalf. The purpose of this contact would be to attain additional information from my doctor on his/her diagnosis or recommended treatment, in order that Ms. Matthews may best provide me with appropriate and complementary information. I know that Julie is not, and cannot be, a primary healthcare provider.

I agree to hold Julie Matthews and Healthful Living harmless for any claims or damages in association with our work together. This is a contract between Julie Matthews/Healthful Living and myself and a general release of liability for Julie Matthews and Healthful Living.

I understand Healthful Living has a 48-hour cancellation policy, and am aware that I will be charged a $50 cancellation fee for a missed appointment if proper notice is not given (by phone NOT e-mail).

For prepaid and discounted Appointment Packages, unused portions are not refundable. It is highly recommended that Appointment Packages be fully utilized within 6 months of their original purchase date, as this best serves client and practitioner objectives for motivation and timely results. Portions of prepaid packages will be forfeited if unused after 9 months.

Mother's Signature: _____
Name: _____
For (child's name) _____
Date: _____

Father's Signature: _____
Name: _____
For (child's name) _____
Date: _____

{Please have mother and/or father sign form. Keep a copy for your records}