



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 (exact years and months)	_____ years _____ months _____ Birthdate
Patient Marital Status	<input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Partner
Patient's Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex / Hermaphrodite <input type="checkbox"/> Transgender
Patient's Ethnicity	<input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Native American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Other (please specify)
Is patient a biological or adopted child?	<input type="checkbox"/> Biological <input type="checkbox"/> Adopted
How did you hear about our clinic?	

DIAGNOSIS HISTORY

Date diagnosed	
Primary Diagnosis (select only one)	<input type="checkbox"/> Autism Spectrum Delay (ASD) <input type="checkbox"/> Aspergers <input type="checkbox"/> ADD / ADHD <input type="checkbox"/> Pervasive Developmental Disorders (PDD) <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Other (please specify)
	Is Primary Diagnosis a concern? <input type="checkbox"/> Yes <input type="checkbox"/> No
Secondary Diagnosis (select only one)	<input type="checkbox"/> Autism Spectrum Delay (ASD) <input type="checkbox"/> Aspergers <input type="checkbox"/> ADD / ADHD <input type="checkbox"/> Pervasive Developmental Disorders (PDD) <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Other (please specify)
	Is Secondary Diagnosis a concern? <input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", what type of dental work?
Did mom have dental work before gestation?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", what type of dental work?
Did mom have vaccinations before gestation?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", which vaccines?
Did mom have vaccinations during gestation?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", which vaccines?
Did mom get RhoGAM while pregnant with patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does mom have high seafood diet?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has mom had industrial exposure to mercury?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-section
Complication at delivery (suction, forceps, etc)	
Complications after deliver (meconium)	
Apgar scores were	_____ and _____
Did patient require neonatal ICU?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Discharged from hospital after (# of days)	_____ days
Born before, at or after due date	<input type="checkbox"/> _____ days before due date <input type="checkbox"/> On due date <input type="checkbox"/> _____ days after due date
FAMILY HISTORY	
Neurological history - Mother	<input type="checkbox"/> Alzheimer's <input type="checkbox"/> Autism <input type="checkbox"/> Parkinson <input type="checkbox"/> Other (please specify)
Neurological history - Father	<input type="checkbox"/> Alzheimer's <input type="checkbox"/> Autism <input type="checkbox"/> Parkinson <input type="checkbox"/> Other (please specify)
Neurological history – Maternal Grandparents	<input type="checkbox"/> Alzheimer's <input type="checkbox"/> Autism <input type="checkbox"/> Parkinson <input type="checkbox"/> Other (please specify)
Neurological history – Paternal Grandparents	<input type="checkbox"/> Alzheimer's <input type="checkbox"/> Autism <input type="checkbox"/> Parkinson <input type="checkbox"/> Other (please specify)
CHILD'S HISTORY	
Number of vaccines from birth to symptoms	
Was initial development normal or abnormal	<input type="checkbox"/> Normal <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Agreed <input type="checkbox"/> Disagreed <input type="checkbox"/> Reassured
Referred/NOT referred for more evaluation?	<input type="checkbox"/> Referred <input type="checkbox"/> 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?	

Autism Intake Form

Select the appropriate option and/or provide an answer to each of the items below:

INITIAL SYMPTOMS BEFORE DIAGNOSIS	
Constitutional symptoms prior to diagnosis	<input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Appetite change <input type="checkbox"/> Sleep issues <input type="checkbox"/> Other (please specify)
Height when initial symptoms began	<input type="checkbox"/> Below <input type="checkbox"/> At <input type="checkbox"/> Above - Standard Growth Chart
Weight when initial symptoms began	<input type="checkbox"/> Below <input type="checkbox"/> At <input type="checkbox"/> Above - Standard Growth Chart
Appetite when initial symptoms began	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> No Appetite
When initial symptoms began, how many bowel movements did the child have daily?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4+
PERCIPITATING 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?	<input type="checkbox"/> only child <input type="checkbox"/> 2 nd child <input type="checkbox"/> 3 rd child <input type="checkbox"/> 4 th child <input type="checkbox"/> 5 th child <input type="checkbox"/> _____ child
Current vocabulary is how many words?	
How many words are used spontaneously?	
Expressive language (able to express thoughts with words or actions)	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Understandable <input type="checkbox"/> Limited <input type="checkbox"/> Minimal <input type="checkbox"/> None
Receptive language (ability to understand language heard or read)	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Understandable <input type="checkbox"/> Limited <input type="checkbox"/> Minimal <input type="checkbox"/> None
Child's attitude towards other children	<input type="checkbox"/> Affectionate <input type="checkbox"/> Tolerant <input type="checkbox"/> Indifferent <input type="checkbox"/> Cooperative <input type="checkbox"/> Aggressive <input type="checkbox"/> Violent
Parents consider Child to be	<input type="checkbox"/> Affectionate <input type="checkbox"/> Cooperative <input type="checkbox"/> Indifferent <input type="checkbox"/> Frustrated <input type="checkbox"/> Aggressive <input type="checkbox"/> Violent <input type="checkbox"/> Friendly <input type="checkbox"/> Emotional <input type="checkbox"/> Scared <input type="checkbox"/> Shy
How many bowel movements each day?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4+
Stool is normally	<input type="checkbox"/> Loose <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipated <input type="checkbox"/> Alternates <input type="checkbox"/> Normal
Is patient potty trained?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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	<input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Appetite change <input type="checkbox"/> Sleep issues <input type="checkbox"/> Other (please specify)
Current weight	<input type="checkbox"/> Below <input type="checkbox"/> At <input type="checkbox"/> Above - Standard Growth Chart

Autism Intake Form

Select the appropriate option and/or provide an answer to each of the items below:

Current appetite	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> No Appetite
Experiencing any pain?	<input type="checkbox"/> Yes <input type="checkbox"/> 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)	<input type="checkbox"/> Speech therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Sensory integration therapy <input type="checkbox"/> ABA therapy <input type="checkbox"/> Nutritional interventions <input type="checkbox"/> Secretin <input type="checkbox"/> DMSA <input type="checkbox"/> Alpha Lipoic Acid <input type="checkbox"/> Glutathione IV <input type="checkbox"/> Glutathione TD <input type="checkbox"/> Hyperbaric Oxygen <input type="checkbox"/> Caesin free, gluten free diet <input type="checkbox"/> Specific carbohydrate diet <input type="checkbox"/> Rotating food allergy diet <input type="checkbox"/> IV immunoglobulins <input type="checkbox"/> Stem cell treatments <input type="checkbox"/> DMPS IV <input type="checkbox"/> DMPS oral <input type="checkbox"/> EDTA IV <input type="checkbox"/> Other attempts to reduce metal toxicity <input type="checkbox"/> Anti fungal prescriptions <input type="checkbox"/> TTFD <input type="checkbox"/> Di Methyl Glycine <input type="checkbox"/> Methyl B12 injections <input type="checkbox"/> Cranio-sacral treatments
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PARENTS AWARENESS STATUS

Are parents aware of DMPS?	<input type="checkbox"/> Not aware <input type="checkbox"/> Somewhat aware <input type="checkbox"/> Fully aware
Are parents aware of the extensive testing done at our clinic?	<input type="checkbox"/> Not aware <input type="checkbox"/> Somewhat aware <input type="checkbox"/> Fully aware
Are parents aware of "non-excretor status"?	<input type="checkbox"/> Not aware <input type="checkbox"/> Somewhat aware <input type="checkbox"/> Fully aware
Are parents aware patient may worsen before improving?	<input type="checkbox"/> Not aware <input type="checkbox"/> Somewhat aware <input type="checkbox"/> Fully aware
Parents wish to	<input type="checkbox"/> Start protocol immediately <input type="checkbox"/> Schedule to begin protocol at later date <input type="checkbox"/> Only have this consultation

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


Autism Intake Form

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: _____



Immune Intake Form

Initial Intake Synopsis Example

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: _____

September 17, 2009 I had surgery to remove a fibroid. The fibroid was a tumor. My obgyn removed the tumor. left ovary and left fallopian tube. 97% chance tumor would be benign. It was cancer. Very rare tumor. Granulosa cell tumor. I went to MD Anderson for a second opinion. In Kansas City I had 6 rounds (1 every 3 weeks from November 2009 to March 2010) of chemo (carboplatin and Taxol). God blessed us with a miracle! January 2012. we had a healthy baby girl! Because of my history my obgyn asked me to decide if we were having other children and if not do at hysterectomy. November 14, 2012. at 40 I had a my port removed. total hysterectomy. and omentum removed. While removing the omentum they found 3 more nodules. I woke up to my husband telling me they found more nodules and they wanted to do chemo. I knew at that moment chemo did not work and I was not doing it again.

December of 2012, I read the Knock out book by Suzann Somers. We went to Clinic M and to Dr A for a second opinion. Clinic M had never worked with my tumor. Dr A recommended more chemo even when the chemo sensitivity test from Caris results showed no compatible chemo with my tumor. I chose to go a natural approach. March of 2013 I started with Dr. G. I am still on the program. I do coffee enemas twice daily. drink 4 carrot juices daily and take almost 200 pills daily. I soak in the bathtub and do monthly cleanses.

June of 2014 my OBGYN felt something during my annual exam. He requested a CT scan and found 3 masses. My local oncologist used a robot surgery in July of 2014 to remove the masses. We discovered my tumor marker is inhibin B. Every couple months we checked inhibin B after surgery and it continued to go up. Oncologist requested a scan in November of 2014. Found another mass. (I believe the mass was there during surgery but it was too small for Dr. to see).

December of 2014. we were going to try hormonal therapy. I went on Megas for 2 weeks and Tamoxifen for 2 weeks. However, on 2 day of Tamoxifen. I had such terrible pain I went to the emergency room. The ER doctor did a chest X-ray, blood and urine test. All was normal. I stopped taking the pills.

June 28, 2015 I was having terrible pain on my right side and thought I was having an appendicitis. Blood work and urine work showed an infection. CT scan showed 2 masses in my pelvic and “multiple locations suggesting widespread abdominal and peritoneal tumor involvement.” I believe I had gastroenteritis (also mentioned in the CT scan) and that is why my intestines were looped. My husband had a similar infection the week before. I went to my primary doctor 2 days later and they did an X-ray to confirm there was no bowel obstruction and loops were back to normal. I should have gone to a different hospital because this hospital misdiagnosed me in 2009 but I was in pain and went to the closest hospital.

July 14, 2015. my local oncologist did an exam and could feel the tumors. She said it felt like a grapefruit and a pear connected. not sure she could use the robot to remove. Oncologist requested I contact Dr. A for a second opinion and commit to a therapy before she can do surgery.

August 2015 I went to Dr. F in Reno. I was interested to see what their sensitivity test and hair analysis would show.

October 2015. I asked my primary doctor to have my blood tested for inhibin B. my tumor marker. It was 85 in August and is 154. I need a new doctor and a plan to shrink the tumors. I am very interested to hear about your program and if you think it can help me. I appreciated your comments on the Quest for the Cure. I believe God has blessed me every step of the way and I am praying for direction for the next step.

EXAMPLE