



Aurora Therapeutics, Inc.

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Questionnaire for Children with Autism & Related Developmental and/or Attention Problems

Note: In this questionnaire "you" is used as if the child were answering questions, avoiding repetition of him/her.

Client Information

Last Name _____	Date of Birth _____
First Name _____	Social Security # _____
Street Address _____	Sex _____
City State Zip _____	Home Phone _____
Height _____	Weight _____
Eye Color _____	Hair Color _____
Allergies _____	Blood Type _____
Siblings _____	Age _____
Siblings _____	Age _____
Siblings _____	Age _____

Parent Information

Mother _____	Home Phone _____	Cell _____
Mother's Occupation _____		
Father _____	Home Phone _____	Cell _____
Father's Occupation _____		
Marital Status _____	Person Filling Out Form _____	
Primary Contact _____	E-Mail _____	

Reason for Visit

Please list diagnoses you have been given _____

Please list your goals and expectations for today's visit _____

Have you seen a naturopath before? _____ Who? _____
How did you hear about this office? _____

Laboratory Data

Evaluation/Test	Date	Done?	Abnormal?	Not sure?
24 hour urine amino acids				
Blood chemistry screen				
Blood test for fatty acids				
Blood test for food allergies				
CAT scan				
Colonoscopy				
DMSA loading study				
EEG				
Folic acid				
Fragile X chromosome study				
Hair elements				
Immune profile				
Intestinal permeability				
Liver Detoxification profile				
MRI				
Organic acids quantitative – fungal/bacterial metabolites				
Organic acids quantitative – metabolism				
Organic acids screen				
PET scan				
Pinworm prep				
Plasma amino acids				
Plasma or serum zinc				
RBC elements				
Serum Ferritin (iron stores)				
Serum methylmalonic acid				
Serum Vitamin A				
Small bowel biopsy				
Stool culture				
Stool parasites				
Thyroid Profile				
Uric acid test (blood or urine)				
Urinary Peptides				
Urine elements				

Personal Descriptive Information

With whom do you live? And what do they do? (Include children, parents, relatives, friends...please include ages)
{Example: Wendy, age 7, sister, George, Dad, age 40, Lawyer}

Who are the main people who care for you?

Please describe your strengths and/or unusual skills:

What pets live with you - indoor or outdoors only?

When and where have you lived or traveled outside of the United States?

Major life changes recent or soon for you or your family?

Have you experienced any major losses in life?

What is your religion and how important is religion/spirituality in you and your family's life?

Do you have a favorite toy or object?

Is there something else about you that I should know?

Past and Present Professionals

Primary Care:		Diagnosis: When Diagnosed: Dates Seen:
Primary Care		Diagnosis: When Diagnosed: Dates Seen:
Specialist:		Diagnosis: When Diagnosed: Dates Seen:
Specialist:		Diagnosis: When Diagnosed: Dates Seen:
Therapist:		Diagnosis: When Diagnosed: Dates Seen:
Other		Diagnosis: When Diagnosed: Dates Seen:
Homeopathic:		Diagnosis: When Diagnosed: Dates Seen:
Chiropractor:		Diagnosis: When Diagnosed: Dates Seen:
Who made the initial diagnosis of autism/other disorder? When?		Diagnosis: When Diagnosed: Dates Seen:

Past Evaluations

Please indicate if you have had any of the following evaluations, treatments, or consultations by placing a **check mark** in the appropriate columns. **Please attach any copies of reports or provide the addresses where the evaluations took place.** Add comments (to back or attach sheet if needed).

X if Yes	X Abnormal	Date	Evaluation/Test
		_____	Psychological Evaluations
		_____	Wechsler Preschool & Primary Scale of Intelligence
		_____	Speech and Language Evaluations
		_____	Genetic Evaluation
		_____	Neurological Evaluations
		_____	Gastroenterology Evaluations
		_____	Celiac/Gluten testing
		_____	Allergy Evaluation
		_____	Nutritional Evaluation
		_____	Auditory Evaluation
		_____	Vision Evaluation
		_____	Osteopathic
		_____	Acupuncture
		_____	Physical Therapy
		_____	Occupational Therapy
		_____	Sensory Integration Therapy
		_____	Language Classes
		_____	Sign Language
		_____	Homeopathic
		_____	Naturopathic
		_____	Craniosacral
		_____	Chiropractic

Hospitalizations

Age	Reason for hospitalization	Discharge summary attached
		<input type="checkbox"/>
		<input type="checkbox"/>

Mother's Past Pregnancies: number of:

Pregnancies _____

Live births _____

Miscarriages _____

Mother's Pregnancy: Place a **check mark** if any of the following occurred during your mother's pregnancy:

Did your mother:	(Please describe if applicable)
Difficulty getting pregnant (more than 6 months)	
Infertility drugs used	Specify:
In vitro fertilization	
Drink alcohol	
Drink coffee	
Smoke tobacco	
Take Progesterone	
Take prenatal vitamins	
Take antibiotics	During Labor? []
Take other drugs	Specify:
Excessive vomiting, nausea (more than 3 weeks)	
Have a viral infection	
Have a yeast infection	
Have amalgam fillings put in teeth	
Have amalgam fillings removed from teeth	
Have how many fillings in her teeth during?	Number of fillings in your mom's teeth when pregnant?
Have bleeding (which months?)	
Have birth problems	
Group B strep infection	
Have c-section because of	
Use induction for labor (such as Pitocin)	
Have anesthesia -what was used?	
Use oxygen during labor	
Have an x-ray	
Have Rhogam, if so how many shots	How many when pregnant? _____
Gestational Diabetes	
High blood pressure (pre-eclampsia)	
High blood pressure/toxemia	
Have chemical exposure	
Father have chemical exposure	
Move to a newly built house	
House painted indoors	
House painted outdoors	
House exterminated for insects	

Pregnancy:

Total weight gain during pregnancy _____ lb	Total weight loss during pregnancy _____ lb
Please describe diet during pregnancy	Please describe labor
_____	_____
_____	_____
_____	_____

Perinatal:

Pregnancy duration: X following the week of gestation. 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40 (full term), 41, 42, 43, 44 Weeks		
	YES	NO
Very active before birth		
Hospital/Birthing Center		
Needed Newborn Special Care		
Appeared healthy		
Easily consoled during first month?		
Antibiotics first month		
Experienced no complications first month of life		

Birth Weight and Apgar

Weight at birth: _____ lbs	Apgar score at one minute _____	Apgar score at 5 mins _____
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Early Childhood Illnesses

Number of earaches in the first two years: _____
Number of other infections in the first two years: _____
Number of times you had antibiotics in the first two years of life: _____
Number of courses of prophylactic antibiotics in first 2 years of life: _____
First antibiotic at _____ months.
First illness at _____ months.

Description of Developmental Problems

At what age did developmental problems appear to begin? 0-1 months [] 2-6 months [] 6-15 months [] 16-24 months [] After 24 months
Is this impression shared among parents and others caring for the child?: _____ ...Or does this impression as to the timing of onset differ among parents and others caring for the child? _____
Is the impression as to the timing of onset weak? _____ ... or is the impression strong: _____

Developmental History

Please indicate the approximate age in months for the following milestones: (example: walking 14 months):

	_____ months	Never []
Sitting up	_____ months	[]
Crawl	_____ months	[]
Pulled to stand	_____ months	[]
Potty trained	_____ months	[]
Walked alone	_____ months	[]
Dry at night	_____ months	[]
First words ("mama, dada" etc.)	_____ months	[]
Spoke clearly	_____ months	[]
Lost language	_____ months	[]
Lost eye contact	_____ months	[]

Food

In the past:	Yes	No
Were you breast fed		
Problem "latching on"		
Vigorous sucker		
Good sucker		
Poor sucker		
Choke or gag on milk		
Were you bottle fed		
Did you refuse to chew solids		
Exclusively breast-fed until _____		months
Exclusively formula fed until _____		months
Exclusively soy formula fed until _____		months
Exclusively milk based* formula until _____		months
Introduction of cow's milk at _____		months
Introduction of rice cereal _____		months
Introduction of wheat and other grains _____		months

*Enfamil, Similac, SMA, etc.

In the present do you eat:	Yes	No
A lot of ice cream		
A lot of sweet food		
A lot of sugar/candy		
Large amounts of food		
Only cold food		
Only 3-5 foods daily		
A lot of cookies		
A lot of white bread		
A lot of soda/diet soda		
Only one or two foods daily		
Only hot food		
Milk at least once a day		
Salty foods		
Sensory issues with food		

Past and Present Symptoms

Please use a lower case x to indicate the best description of your symptoms. Indicate frequency and severity unless (mild, moderate or severe) and (occasional, frequent or always) do not apply. If the problem was present in the past, please check the "PAST ONLY" column. Many of the descriptions are similar – use the ones that best fit your impressions. (please make any text comments outside this table or on a printed copy – I will be moving the table to Excel to distill it for the record and it is best for me to just have to deal with x's. Thanks.)

		MILD	MOD	SEVERE	OCCAS	FREQ	ALWAYS	PAST ONLY
1	STRENGTHS							
2	Especially attractive							
3	Accepts new clothes							
4	Cuddly							
5	Physically coordinated							
6	Happy							
7	Pleasant/easy to care for							
8	Sensitive/affectionate							
9	Wants to be liked							
10	Responsible							
11	Draws accurate pictures							
12	Sensitive to peoples feelings							
13	OK if parents leave							
14	Answers parent							
15	Follows instructions							
16	Pronounces words well							

		MILD	MOD	SEVERE	OCCAS	FREQ	ALWAYS	PAST ONLY
17	Unusual memory							
18	Perfect musical pitch							
19	Good with math							
20	Good with computer							
21	Good with fine work							
22	Good throwing and catching							
23	Good climbing							
24	Strong desire to do things							
25	Swimming							
26	Bold, free of fear							
27	Likes to be held							
28	Likes to be swaddled							
29	SLEEP							
30	Sleeps in own bed							
31	Sleeps with parent(s)							
32	Awakens screaming/crying							
33	Awakes at night							
34	Difficulty falling asleep							
35	Early waking							
36	Insomnia							
37	Sleeps less than normal							
38	Daytime sleepiness							
39	Jerks during sleep							
40	Nightmares							
41	Sleeps more than normal							
42	PHYSICAL							
43	Looks sick							
44	Glazed look							
45	Overweight							
46	Underweight							
47	Pupils unusually large							
48	Unusual long eye lashes							
49	Pupils unusually small							
50	Dark circles under eyes							
51	Red lips							
52	Red fingers							
53	Red toes							
54	Webbed toes							
55	Red ears							
56	Double jointed							
57	High arched palate							
58	Lymph nodes enlarged neck							
59	Head warm							
60	Head sweats							
61	Night sweats							
62	Abnormal fatigue							
63	Failure to thrive							
64	Cold all over							
65	Cold hands and feet							
66	Cold intolerance							
67	Hands/feet - very sweaty							
68	Head very hot/sweaty							
69	Night sweats							
70	Perspiration - odd odor							
71	SKIN							

		MILD	MOD	SEVERE	OCCAS	FREQ	ALWAYS	PAST ONLY
72	Paleness, severe							
73	Fungus / fingernails							
74	Fungus / toenails							
75	Dandruff							
76	Chicken skin							
77	Oily skin							
78	Patchy dullness							
79	Seborrhea on face							
80	Thick calluses							
81	Athletes foot							
82	Feet - stinky							
83	Diaper rash							
84	Odd body odor							
85	Strong body odor							
86	Acne							
87	Dark circle under eyes							
88	Ears get red							
89	Eczema							
90	Flushing							
91	Red face							
92	Sensitive to insect bites							
93	Stretch marks							
94	Blotchy skin							
95	Bugs love to bite you							
96	Cradle cap							
97	Dry Hair							
98	Dry Scalp							
99	Hair Unmanageable							
100	Bites nails							
101	Nails brittle							
102	Nails frayed							
103	Nails pitted							
104	Nails soft							
105	Skin pale							
106	Dark birth mark(s)							
107	Easy bruising							
108	Inability to tan							
109	Light birth mark(s)							
110	Ragged cuticles							
111	Thickening finger nails							
112	Thickening toenails							
113	Vitiligo							
114	White spots or lines in nails							
115	Dry skin in general							
116	Feet cracking							
117	Feet peeling							
118	Hands cracking							
119	Hands peeling							
120	Lower legs dry							
121	Skin lackluster							
122	Itchy skin in general							
123	Itchy scalp							
124	Itchy ear canals							
125	Itchy eyes							
126	Itchy nose							

		MILD	MOD	SEVERE	OCCAS	FREQ	ALWAYS	PAST ONLY
127	Itchy roof of mouth							
128	Itchy arms							
129	Itchy hands							
130	Itchy legs							
131	Itchy feet							
132	Itchy Anus							
133	Itchy penis							
134	Itchy vagina							
135	DIGESTIVE							
136	Breath bad							
137	Increased salivation							
138	Drooling							
139	Cracking lip corners							
140	Cold sores on lips, face							
141	Geographic tongue (map-like)							
142	Sore tongue							
143	Tongue coated							
144	Canker sores in mouth							
145	Gums bleed							
146	Teeth grinding							
147	Tooth cavities							
148	Tooth with amalgam fillings							
149	Mouth thrush (yeast infection)							
150	Sore throat							
151	Fecal belching							
152	Burping							
153	Nausea							
154	Reflux							
155	Spitting up							
156	Vomiting							
157	Abdominal bloating							
158	Lower abdominal bloating							
159	Colic							
160	Abdomen distended							
161	Abdominal pain							
162	Colic							
163	Intestinal parasites							
164	Pinworms							
165	Crampy pain with pooping							
166	Constipation							
167	Diarrhea							
168	Farting - regular							
169	Farting - stinky							
170	Anal fissures							
171	Red ring around anus							
172	Stools bulky							
173	Stools light color							
174	Stools very stinky							
175	Stools with blood							
176	Stools with mucous							
177	Stools with undigested food							
178	Flatulence							
179	Stool odor foul							
180	Stool odor yeasty							
181	Stools pale							

		MILD	MOD	SEVERE	OCCAS	FREQ	ALWAYS	PAST ONLY
182	Stools slimy							
183	Stools watery							
184	EATING							
185	Poor appetite							
186	Thirst							
187	Extreme water drinking							
188	Bingeing							
189	Bread craving							
190	Craving for carbohydrates							
191	Craving for juice							
192	Craving for salt							
193	Diet soda craving							
194	Pica (eating non-edibles)							
195	Abnormal food cravings							
196	Carbohydrate intolerance							
197	Starch/disaccharide intol.							
198	Sugar intolerance							
199	Salicylate intolerance							
200	Oxalate intolerance							
201	Phenolics intolerance							
202	MSG intolerance							
203	Food coloring intolerance							
204	Gluten Intolerance							
205	Casein intolerance							
206	Specific food(s) intolerance							
207	Lactose intolerance							
208	Behavior worse with food							
209	Behavior better when fasting							
210	BEHAVIOR							
211	Behavior purposeless							
212	Unusual play							
213	Uses adults hand for activity							
214	Aloof, indifferent, remote							
215	Doesn't do for self							
216	Extremely cautious							
217	Hides skill/knowledge							
218	Lacks initiative							
219	Lost in thought, unreachable							
220	No purpose to play							
221	Poor focus, attention							
222	Sits long time staring							
223	Uninterested in live pet							
224	Watches television long time							
225	Won't attempt/can't do							
226	Poor sharing							
227	Rejects help							
228	Curious/gets into things							
229	Erratic							
230	Unable to predict actions							
231	Destructive							
232	Hyperactive							
233	Constant movement							
234	Melt downs							
235	Tantrums							
236	Self mutilation							

		MILD	MOD	SEVERE	OCCAS	FREQ	ALWAYS	PAST ONLY
237	Runs away							
238	Jumps when pleased							
239	Whirls self like a top							
240	Climbs to high places							
241	Insists on what wanted							
242	Tries to control others							
243	Head banging							
244	Falls gets hurt running climbing							
245	Does opposite/asked							
246	Teases others							
247	Silly							
248	Shrieks							
249	Holds hands in strange pose							
250	Spends time w/ pointless task							
251	Stares at own hands							
252	Toe walking							
253	Arched back with bright lights							
254	Imitates others							
255	Finger flicking							
256	Flaps hands							
257	Licking							
258	Likes spinning objects							
259	Likes to flick finger in eye							
260	Likes to spin things							
261	Rhythmic rocking							
262	Slapping books							
263	Tooth tapping							
264	Visual stims							
265	Wiggle finger front of face							
266	Wiggle finger side of face							
267	Bites or chews fingers							
268	Bites wrist or back of hands							
269	Chews on things							
270	MOOD							
271	Apathy							
272	Blank look							
273	Depression							
274	Detached							
275	Disinterested							
276	Eye contact poor							
277	Isolates							
278	Negative							
279	Fright without cause							
280	Always frightened							
281	Anguish							
282	Discontented							
283	Does not want to be touched							
284	Inconsolable crying							
285	Irritable							
286	Looks like in pain							
287	Moaning							
288	Moaning, groaning							
289	Phobias							
290	Restless							

		MILD	MOD	SEVERE	OCCAS	FREQ	ALWAYS	PAST ONLY
291	Severe mood swings							
292	Unhappy							
293	Agitated							
294	Anxious							
295	SENSORY							
296	Bothered by certain sounds							
297	Covers ears with sounds							
298	Ear pain							
299	Ear ringing							
300	Hearing acute							
301	Hearing loss							
302	Likes certain sounds							
303	Sensitive to loud noise							
304	Sounds seem painful							
305	Tinnitus							
306	Acute sense of smell							
307	Examines by smell							
308	Intensely aware of odors							
309	Blinking							
310	Bothered by bright lights							
311	Distorted vision							
312	Conjunctivitis							
313	Eye crusting							
314	Eye problem							
315	Lid margin redness							
316	Examines by sight							
317	Fails to blink at bright light							
318	Likes fans							
319	Likes flickering lights							
320	Looks out of corner of eye							
321	Poor vision							
322	Puts eye to bright light or sun							
323	Strabismus (crossed eye)							
324	Fearful of harmless object							
325	Fearful of unusual events							
326	Unaware of danger							
327	Unaware of peoples feelings							
328	Unaware of self as person							
329	Upset if things change							
330	Upset of things aren't right							
331	Adopts complicated rituals							
332	Car, truck, train obsession							
333	Collects particular things							
334	Draws only certain things							
335	Fixated on one topic							
336	Lines objects precisely							
337	Repeats old phrases							
338	Repetitive play/objects							
339	Finger tip squeezing							
340	Hates wearing shoes							
341	Insensitive to pain							
342	Likes head burrowed							
343	Likes head pressed hard							
344	Likes head rubbed							
345	Likes head under blanket							

		MILD	MOD	SEVERE	OCCAS	FREQ	ALWAYS	PAST ONLY
346	Likes to be held upside down							
347	Likes to be swung in the air							
348	Very insensitive to pain							
349	Very sensitive to pain							
350	NEUROMUSCULAR							
351	Clumsiness							
352	Coordination							
353	Fine motor poor							
354	Gross motor poor							
355	Holds bizarre posture							
356	Hyperactivity							
357	Physically awkward							
358	Rocking							
359	Stiffens body when held							
360	Calf cramps							
361	Foot cramps							
362	Muscle pain							
363	Muscle tone tense							
364	Muscle twitches							
365	Fist clenching							
366	Jaw clenching							
367	Poor muscle tone/limp							
368	Tics							
369	Muscle tone low trunk							
370	Muscle weakness, atrophy							
371	Muscle tone low all over							
372	Tremors							
373	Cognitive delays							
374	Memory poor							
375	Poor attention, focus							
376	Slow and sluggish							
377	Expressive language delay							
378	SPEECH							
379	Never spoke							
380	Occas. words when excited							
381	Expressive language poor							
382	No answers simple questions							
383	Points to objects/can't name							
384	Speech apraxia							
385	Does not asks questions							
386	Babbling							
387	Asks using "you" not "I"							
388	Answers by repeating question							
389	Receptive language poor							
390	Says "I"							
391	Says "no"							
392	Says "yes"							
393	Lost language @ 12-24 months							
394	Lost language after 24 months							
395	Scripting							
396	Stuttering							
397	Talks to self							
398	Poor auditory processing							

		MILD	MOD	SEVERE	OCCAS	FREQ	ALWAYS	PAST ONLY
399	Unusual sound of cry							
400	Uses one word for another							
401	Rigid behaviors							
402	Poor confidence							
403	Timid							
404	Corrects imperfections							
405	Tidy							
406	RESPIRATORY							
407	Pneumonia							
408	Bad odor in nose							
409	Breath holding							
410	Bronchitis							
411	Congestion chg. season							
412	Congestion in the fall							
413	Congestion in the spring							
414	Congestion in the summer							
415	Congestion in the winter							
416	Cough							
417	Post nasal drip							
418	Runny nose							
419	Sighing							
420	Sinus fullness							
421	Wheezing							
422	Yawning							
423	REPRODUCTIVE:							
424	Girls: Early first period							
425	Boys: Large testicles							
426	Early breast development							
427	Early pubic hair							
428	Girls: vaginal odor							
429								
430								
431	URINARY:							
432	Frequent urination							
433	Bed wetting after age 4							
434	Odd urinary odor							
435	Urinary hesitancy							
436	Urinary tract infections							
437	Urinary urgency							
438	Dry at night							
439	Seizures - focal							
440	Seizures - generalized							
441	Seizures - petit mal							
442	Seizures - petit mal							
443	Unusual fast heart beat							
444	Heart murmur							
445	Headaches							
446	Joint pains							
447	Leg pains							
448	Muscle pains							

Environmental History (please indicate past and present exposures)		
Exposure:	Past	Present
Mold in bathroom		
Damp cellar		
Pest extermination - Inside		
Pest extermination - Outside		
Forced hot air heat		
Had water in basement		
Mold visible on exterior of house		
Heavily wooded or damp surroundings		
Mold in cellar, crawl space, or basement		
Moldy, musty school/daycare		
Tobacco smoke		
Well water		
Carpet in bedroom		
Carpet in most parts of house		
Feather or down bedding		

Some things about your parents:	
When were your parents married:	
If separated, when:	
If divorced, when	
If remarried, when	
Custody arrangements	
Mother - Personal	
Age at your birth	
Education	
Ethnicity	
Blood type	
Father - Personal	
Age at your birth	
Education	
Ethnicity	
Blood type	

Family Medical History	Mother's Side				Father's Side				
	Father	Mother	Sibling(s)	Grand-mother	Grand-father	Grand-mother	Grand-father	First Cousin	Other
Alcoholism									
Allergies									
Anorexia									
Anxiety									
Arthritis									
Asthma									
Autism									
Autoimmune problems									
Bulimia									
Celiac disease									
Colitis									
Crohn's disease									
Depression									
Diabetes									
Eczema									
Endometriosis									
Food allergies									
Gout/high uric acid level									
Hay Fever									
Heart disease									
High blood pressure									
Hives									
Hypoglycemia									
Identical twins									
Irritable									
Left handedness									
Malabsorption									
Mental Illness									
Mild respiratory allergy									
Milk (casein) sensitivity									
Mitral valve prolapse									
Obesity									
Retardation									
Schizophrenia Psychosis									
Stroke									
Strong moodiness									
Tendency to be "loner"									
Thyroid problem									
Wheat (gluten) sensitivity									
Yeast problems									

Thank you for taking the time and effort to complete this questionnaire.

You may wish to copy it for your records.

***Please bring one baby picture and one recent picture of your child to your first appointment.**