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Child History Record - ASD

(Autistic Spectrum Disorders)

KARUNA HEALTH CARE
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Allow 30 to 60 minutes to complete this form (4 pages)

Date:__________________

Child's name...Age..........Sex..........DOB..................

Parents' names: Mother..Father..

Address..Post Code......................................

Phone: **H:**..**W:** ....**Mob**...

Email...Health Fund...

GP's name, address and contact number: ....

Specialist's name, address and contact number:..

* For distance consultations, please indicate how we are able to contact you:
□ Email □ Telephone □ Fax (……)………………………… □ Skype user name…………………………....

Please complete the following pages ***in as much detail as you can****. Providing detailed information makes it easier to accurately assess your child's health status - no detail is too small!*

What would you like to have your child treated for*?* List complaints in order of importance

1...

2...

3...

4...

5 ....

Please list symptoms, in order of severity. (First symptom the most severe)

....

....

....

....

How and when did the symptoms start?

....

....

Are there any other health problems? If yes, please list:

....

....

What medical treatment(s) has your child had so far?

....

....

....

What natural therapies have you used so far?

....

....

....

Which of these treatments have you found to be the most effective?

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....

Please list **current** prescribed medications

....

....

Please list current supplements – vitamins, minerals, herbs etc

....

....

....

Any previous homeopathic medicines? Please list...

....

General information.

Please rate your child's energy levels (circle) [**No** energy] **0 1 2 3 4 5 6 7 8 9 10** [**high** energy]

Symptoms during sleep? *Please circle:*

Snoring, mouth breathing restlessness, sleepwalking, night sweats, perspiration, nightmares

Any other symptoms during sleep? ....

Regular wakefulness?...Time of waking? .... Reason for waking? ....

What **position** does your child usually sleep in? ....

How is your child in the morning on waking?. ....

Are there any drug, environmental, food, or other allergies? ....

How does your child tolerate hot weather? ....Cold weather? ....

Digestion: *please circle*

Is there: tummy pain, bloating, burping, diarrhoea, constipation, mushy stools, wind?

Before, during or after eating? ....

Please describe the frequency, texture and odour of bowel motions...

What are your child's favourite foods? ....

Foods he/she must have every day?

Which foods does your child really dislike? ....

Which, if any, foods cause symptoms? ....

List any foods your child really dislikes or is upset by................................. ....

Does your child generally prefer sweets (if so, which sweets) ....

Or savoury? If so, which savoury foods? ....

General health & lifestyle information:

Rate energy levels (circle) [No energy] **0 1 2 3 4 5 6 7 8 9 10** [high energy]

Are there any known drug, environmental, food, allergies?................................ ....

How does your child tolerate hot weather? ....Cold weather? ....

Does any type of weather affect symptoms? Please describe............................... ....

Does either parent have amalgams? (silver fillings) ....

Mental/Emotional
How would you describe your child's temperament?

....

....

....

Which situations will trigger upset? Please describe.

....

....

....

....

What soothes and calms your child (apart from TV & computer games)

....

....

Are there any fears or phobias? (eg heights, spiders, tunnels, crowds, snakes, the dark, thunderstorms)

....

Anxieties or worries?

....

....

Family History
Please describe **all known diseases** of the following family members eg heart disease; high blood pressure; diabetes; cancer; skin problems (eg psoriasis); TB; allergies; mental illness; alcoholism

Mother ....

Father ....

Immediate family (brothers, sisters, grandparents, aunts and uncles;

....

....

Please list medical tests you have had

TYPE OF TEST	DATE	REASON	RESULT
□ Blood test(s)			
□ X Ray(s)			
□ CT scan			
□ Ultrasound			
□ Hearing test			

□ Other			

HEALTH TIME LINE OF YOUR CHILD, PLUS MOTHER & FATHER

An accurate time line of illnesses & medical treatments of your child, plus <u>both parents</u> for two years prior to conception is crucial for accurate treatment.

Include ALL MEDICATIONS & RECREATIONAL DRUGS used by either parent up to 2YEARS PRIOR TO CONCEPTION. Also include any factors which may have had a significant impact: stressful events like moving house, a death in the family, family disruption, injuries, surgeries, hospitalisa-tions, vaccinations and medications taken. Note down the impact of any of these, including viruses, infections and allergic reactions.
Use an extra sheet if you need more space.

Month & Year (start 2 years before birth)	Which person?	Event/ illnesses	Medical treatment or drug taken	Mental, physical or emotional impact (if known)

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Where did you hear about this clinic?

☐ Word of Mouth ☐ Advertisement ☐ Brochure ☐ Yellow pages book ☐ Yellow Pages online
☐ Natural Therapy Pages ☐ Personal Internet search ☐ Other ……………………

BEFORE COMING TO YOUR APPOINTMENT:

- To help our chemically sensitive patients, please **do not wear perfume or aftershave** when attending the clinic.
- If you would like to know the amount of your Health Fund rebate, please check with your fund prior to your consultation.

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