Jon Gamble BA ND Adv Dip Hom:
jon@karunahealthcare.com.au

Nyema Hermiston RN ND Adv Dip Hom BSc Hons:
nyema@karunahealthcare.com.au

CHILD ASD HISTORY RECORD

(Autistic Spectrum Disorder)

Allow 20 minutes to complete this form (4 pages).

Date:

Child's Name: Age: Sex: DOB:

Parents'Names: Mother Father

Address: Postcode:

Phone: Email:

Health Fund:

GP's Name & Address:

Specialist's Name & Address:

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

What would you like your child treated for? List your complaints in orders of importance:

1.
2.
3.
4.
5.

Please list symptoms in orders of severity:

1.
2.
3.
4.
5.

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?

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What natural therapies have you used so far?

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

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?

☐ 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 like to sleep in?

How is your child in the morning on waking?

Does your child have any drug, environmental, food, or other allergies? Please state:

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)

Digestion: Is there:

☐ Tummy Pain ☐ Wind ☐ Bloating ☐ Mushy Stools ☐ Constipation

☐ Diarrhoea ☐ Burping

When does your child get these symptoms in relation to eating? Before, during or afterwards?

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Please describe the frequency, texture and odour of bowel motions

What are your child's favourite foods?

Foods he / she must eat every day?

Which foods does your child really dislike?

Which, if any, foods cause symptoms?

Does your child generally prefer sweets (if so which sweets)?

Or savory? If so, which savory foods?

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 of phobias? (e.g. heights, spiders, tunnels, crowds, snakes, the dark, thunderstorms)

Anxieties or worries?

Family History

Please describe all known diseases of family members e.g. heart disease, high blood pressure, diabetes, cancer, skin problems (e.g. psoriasis), TB, allergies, mental illness, alcoholism.

Mother

Father

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

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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 illness & medical treatments of your child, plus both parents for two years prior to conseption is cruicial for accurate treatment. Include ALL MEDICATIONS & RECREATIONAL DRUGS used by either paranet up to 2 YEARS PRIOR TO CONCEPTION. Also include any factors which may have a significant impact: stressful events like moving house, a death in the family, family disruption, injuries, surgeries, hospitalisations, vaccinations and medications taken. NoteNote down the impacts of any of these, including viruses, infections and allergic reactions.

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

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Anything else you would like to mention?

BEFORE COMING TO CLINIC:

- If you would like to know your health fund rebate amount, please check with your fund prior to the consultation.

Where did you hear about the clinic?

PARENTS

☐ I agree to the Terms and Conditions, found in the **Policies** section on the Booking page at https://karunahealthcare.com.au/book-appointment/