ayurvedashram HOLISTIC WELLNESS CENTER

ASD Intake Form

Form A-11

Please fill the questionnaire as completely as you can. You can write additional information under the notes section:

1) Name of Child: _____
2) Sex of child: □ Male □ Female
3) Date of Birth: _____ (MM/DD/YYYY) Age:_____
4) Height of Child: _____
5) Weight of Child: _____ Any Drastic Changes in the last 12 months?_____
6) Ethnicity: _____
7) Name of person completing the form_____

a) Relationship to child □ Mother □ Father □ Other _____

5) Address: _____

_____

6) Phone: _____ 7) Email: _____

	Highest Education e.g. High School/undergrad degree/graduate	Occupation during pregnancy/birth	Occupation now
Father			
Mother			

8)

9)**When was the Child first diagnosed?** _____ (month/year)

a) Diagnosed by: _____Where? _____
b) Any other diagnoses? _____

10) **Total Number of Biological Kids**_____ Are any of the Siblings Autistic? □N/A □Yes □No

11) Please attach copy of diagnosis questionnaire/tests if any

12) Pregnancy/early childhood related information (Please complete as fully as possible)

Pre-Pregnancy
Age of mother while pregnant? _____
Any family history of anxiety/depression? □ Mother □ Father □ Mother's family □ father's family
Did the Parent/s undergo fertility treatment? □ IVF □ IUI □ ICSI □ Clomid □ Other □ None

Obstetrics history if applicable	□ Miscarriage □ Abortion □ Chemical pregnancy □ Ectopic pregnancy □ Other
Was pregnancy/delivery normal?	□ Both normal □ problems during pregnancy/delivery □ pregnancy troubled, normal delivery □ pregnancy normal, problems during delivery
During Pregnancy	
Did Mother take any medications, supplements or herbs during pregnancy? If yes, list them below along with their dosages:	
Mother's stress level during Pregnancy?	□ low/nonexistent □ stressed □ Highly stressed
Other diagnosis during pregnancy	□ Gestational diabetes □ High B.P □ Pre-eclampsia
Duration of Pregnancy?	□ Normal □Premature Birth □Prolonged
Approximate Duration of Labor?_____	
Any Complications during Delivery?_____	
Post-Pregnancy	
Child's Birth Weight:_____	

Feeding information of child	Breastfed	Formula
0-3 months		
3-6 months		
6 -12 months		

Additional information if any:

13) List all medications (with dosage) and vitamins/supplements/herbs that the child is currently on:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

14) What therapies (behavioral/diet) is the child currently?

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

15) Using the scale below please rate based on your(caregiver) opinion:

1 = Not satisfied at all

2 = Needs substantial improvement

3 = Needs improvement

4 = Ok, can be better

5 = No issues / fully satisfied

Date of	Initial visit	Follow up	Follow up	Follow up
Sleep quality and duration				
Regular bowel movements				
Diet range (number of menu items tolerated)				
Ability to tolerate food textures				
Follows directions				
Responds to questions, expresses his/her needs in clear language				
Ability to focus on task at hand, attention span				

Interaction with sibling/s and peers				

16)

Initial visit	**Follow up**	**Follow up**	**Follow up**
Additional information about your child	Changes observed since previous visit	Changes observed since previous visit	Changes observed since previous visit