

# Patient Information Form

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*Please bring this form completed to your first visit.*

## PATIENT INFORMATION

<b>Patient Name:</b>			
<b>Preferred Name:</b>			
<b>Date of Birth (MM-DD-YY):</b>			
<b>Social Security Number (XXX-XX-XXXX):</b>			
<b>Weight (Lbs):</b>		<b>Height (Inches):</b>	

## PARENT OR GUARDIAN INFORMATION

<b>Mother's Name:</b>			
<b>Father's Name:</b>			
<b>Address:</b>			
<b>City:</b>			
<b>State:</b>		<b>Zip</b>	
<b>Home Tel:</b>		<b>Home Fax:</b>	
<b>Mother's Cell:</b>		<b>Father's Cell:</b>	
<b>Mother's Email:</b>			
<b>Father's Email:</b>			

**EMPLOYMENT INFORMATION (FATHER)**

Employer Name:			
Address:			
City:			
State:		Zip	
Employer Tel:		Employer Fax:	

**EMPLOYMENT INFORMATION (MOTHER)**

Employer Name:			
Address:			
City:			
State:		Zip	
Employer Tel:		Employer Fax:	

**PRENATAL HISTORY**

1a. Were there any maternal infections?  YES  NO

If YES, Explain:

1b. Maternal vaccinations during pregnancy?  YES  NO

If YES, Select:

Rhogam  Flu Vaccine

Hep B  Other?

1c. Any maternal medications during pregnancy or while breast feeding?  YES  NO

If YES, Explain:

1d. Does mother have dental amalgams or receive dental work during pregnancy?  YES  NO

1e. Did mother receive prenatal care?

- YES
- NO

1f. When did prenatal care start?

- At 20 Weeks or sooner
- Between 20 to 30 Weeks
- At 30 Weeks or later

1g. Was mother Group B Strep Carrier?

- YES
- NO
- UNCERTAIN

1h. Does mother have Hepatitis B?

- YES
- NO
- UNCERTAIN

### PERINATAL HISTORY

2a. Were there any complications around time of delivery?

- YES
- NO

If YES, Select:

- Pre-term Labor
- Premature Rupture of Membranes
- Maternal Antibiotics
- PIH
- Other?

### BIRTH HISTORY

3a. Apgar Scores at 1 Minutes after Birth?

	(1 – 10)
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3b. Apgar Scores at 5 Minutes after Birth?

	(1 – 10)
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3c. Gestational Age at Birth?

	Weeks
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3d. Method of Delivery? (Select all that apply)

- Normal Spontaneous Vaginal
- Vacuum
- Emergent C-Section
- Epidural
- Other?
- Induced
- Forceps
- Scheduled C-Section

**3e. Complications during Delivery? (Select all that apply)**

- Meconium Aspiration
- Nuchal Cord
- Other?
- Need for Resuscitation

**EARLY CHILDHOOD DEVELOPMENT**

**4a. Childhood Development Milestones (Fill in approximate AGE for each milestone below):**

	Social Smile		Verbalized Sounds Only
	Rolled Over		Verbal Imitation
	Sat Alone		Spontaneous Speech
	Walked		Single Words
	Responds to Emotion		Combination of Words
			Complete Sentences

**4b. At what AGE did you first notice something abnormal? (Age)**

**4c. Describe the early abnormalities noticed: (Fill in response below)**

**4d. Was there a regression from normal development?**  YES  NO

If YES, at what AGE?

**CURRENT LEVEL OF FUNCTIONING**

**5. Please complete the Autism Treatment Evaluation Checklist (ATEC) and bring it with you to your first visit to CBC of Utah**

\_\_\_\_\_

**IMMUNIZATION HISTORY**

**6a. Provide dates for immunizations received and note if any adverse reaction was noted shortly thereafter (fever, change in behavior, etc.)?**

**PLEASE ATTACH A COPY OF THE IMMUNIZATION RECORD**

Hep B		<input type="checkbox"/>	Adverse reaction?
OPV		<input type="checkbox"/>	Adverse reaction?
HiB		<input type="checkbox"/>	Adverse reaction?
DpaT		<input type="checkbox"/>	Adverse reaction?
MMR		<input type="checkbox"/>	Adverse reaction?
Varicella		<input type="checkbox"/>	Adverse reaction?

**6b. Describe any adverse reactions to vaccinations selected above including date in relation to immunization received:**

[Empty box for describing adverse reactions]

**6c. Was your child sick at the time of any immunization (fever, cold symptoms, vomiting, ear infections, etc.)? If YES, state which vaccination(s) and describe:**

[Empty box for describing sickness at time of immunization]

**PAST MEDICAL HISTORY**

**7a. Current diagnosis on autism spectrum?**

- Autism
- Asperger's
- Pervasive Developmental Disorder
- Other

**7b. Any other congenital or developmental diagnoses?**

**7c. Previous illness (select all that apply)?**

- |   |                                       |  |
|---|---------------------------------------|--|
| <input type="checkbox"/> Colic                      | <input type="checkbox"/> Reflux       | <input type="checkbox"/> RSV                       |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Chicken Pox  | <input type="checkbox"/> Rotavirus                 |
| <input type="checkbox"/> Roseola                    | <input type="checkbox"/> Strep Throat | <input type="checkbox"/> Encephalitis              |
| <input type="checkbox"/> Pneumonia                  | <input type="checkbox"/> Eczema       | <input type="checkbox"/> Meningitis                |
| <input type="checkbox"/> Croup                      | <input type="checkbox"/> Seizures     |  |
| <input type="checkbox"/> Ear Infections/tubes       |                                       | <input type="checkbox"/> Frequent viral infections |
| <input type="checkbox"/> Allergic rhinitis/hayfever |                                       | <input type="checkbox"/> Herpes/Cold sores         |

**7d. List any previous hospitalizations:**

**7e. Estimate number of courses of antibiotics:**

- |                       |                                    |                               |                                       |
|-----------------------|------------------------------------|-------------------------------|---------------------------------------|
| 1 <sup>st</sup> Year? | <input type="checkbox"/> 3 or less | <input type="checkbox"/> 4-10 | <input type="checkbox"/> More than 10 |
| 2 <sup>nd</sup> Year? | <input type="checkbox"/> 3 or less | <input type="checkbox"/> 4-10 | <input type="checkbox"/> More than 10 |
| Current Year?         | <input type="checkbox"/> 3 or less | <input type="checkbox"/> 4-10 | <input type="checkbox"/> More than 10 |

**MEDICATIONS**

**8a. Current or previous medications and supplements (refer to intervention sheet):**

**OTHER INTERVENTIONS**

**9a. List any other interventions past or present (select all – list when):**

- |  |       |  |
|--|-------|--|
| <input type="checkbox"/> Behavior/Educational (ABA, other) | When: | <div style="border: 1px solid black; width: 150px; height: 25px;"></div> |
| <input type="checkbox"/> Speech therapy                    | When: | <div style="border: 1px solid black; width: 150px; height: 25px;"></div> |
| <input type="checkbox"/> Occupational therapy              | When: | <div style="border: 1px solid black; width: 150px; height: 25px;"></div> |
| <input type="checkbox"/> Auditory sensory integration      | When: | <div style="border: 1px solid black; width: 150px; height: 25px;"></div> |
| <input type="checkbox"/> Other                             | When: | <div style="border: 1px solid black; width: 150px; height: 25px;"></div> |

**MEDICAL EVALUATIONS TO-DATE**

**10a. List all medical evaluations to-date (include copy of results):**

<u>TEST</u>	<u>NO</u>	<u>YES</u>	<u>Normal</u>	<u>Abnormal</u>
Audiological evaluation/BAER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chromosomes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fragile X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<u>TEST</u>	<u>NO</u>	<u>YES</u>	<u>Normal</u>	<u>Abnormal</u>
Urine organic acids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Serum/Plasma amino acids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head CT scan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brain MRI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
One hour EEG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overnight 24 hour EEG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunoglobulins/Immune Sys. Tests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaccine titers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stool culture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CDSA (Complete Diagnostic Stool Analysis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy metals (Hair, urine or blood)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IgE Allergy testing (prick test / RAST)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IgG food allergy testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gluten or casein tests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brain autoantibodies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid tests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vitamin A level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Other tests – Describe below:**

	<u>YES</u>	<u>Normal</u>	<u>Abnormal</u>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**FAMILY HISTORY**

11a. Is there any family history for any of the following (select all that apply)?

- |  |  |
|--|--|
| <input type="checkbox"/> Autism/PDD                  | <input type="checkbox"/> Alzheimer's disease           |
| <input type="checkbox"/> Asperger's syndrome         | <input type="checkbox"/> ADD/ADHD                      |
| <input type="checkbox"/> Seizures                    | <input type="checkbox"/> Mental retardation            |
| <input type="checkbox"/> Fragile X syndrome          | <input type="checkbox"/> Chromosomal Abnormalities     |
| <input type="checkbox"/> Other genetic abnormalities | <input type="checkbox"/> Tuberos scleriosis            |
| <input type="checkbox"/> Thyroid disease             | <input type="checkbox"/> Insulin dependent diabetes    |
| <input type="checkbox"/> Lupus                       | <input type="checkbox"/> Scleroderma                   |
| <input type="checkbox"/> Rheumatoid arthritis        | <input type="checkbox"/> Multiple Sclerosis (MS)       |
| <input type="checkbox"/> Fibromyalgia                | <input type="checkbox"/> Chronis fatigue syndrome      |
| <input type="checkbox"/> Other autoimmune disease    | <input type="checkbox"/> Depression                    |
| <input type="checkbox"/> Bipolar disorder            | <input type="checkbox"/> Obsessive-compulsive disorder |
| <input type="checkbox"/> Anxiety disorder            | <input type="checkbox"/> Schizophrenia                 |
| <input type="checkbox"/> Night blindness             | <input type="checkbox"/> Heart disease before age 60   |
| <input type="checkbox"/> Colon cancer                | <input type="checkbox"/> Pituitary adenoma             |
| <input type="checkbox"/> Inflammatory bowel disease  |  |

**REVIEW OF SYSTEMS – GASTROINTESTINAL**

12a. Gastrointestinal Review (select all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> Reflux          | <input type="checkbox"/> Diarrhea                 |
| <input type="checkbox"/> Constipation    | <input type="checkbox"/> Extremely foul stools    |
| <input type="checkbox"/> Floating stools | <input type="checkbox"/> Bloody stools            |
| <input type="checkbox"/> Mucous in stool | <input type="checkbox"/> Undigested food in stool |
| <input type="checkbox"/> Abdominal pain  | <input type="checkbox"/> Vomiting                 |

12b. Do antibiotics affect stool patterns?  YES  NO

**REVIEW OF SYSTEMS – NUTRITIONAL**

**13a. What are his/her favorite foods?**

**13b. Is child a picky eater?**

NO

To some extent

Extremely

**13c. How is behavior when hungry?**

**13d. How is behavior after just eaten?**

**13e. What liquids does the child drink?**

**13f. Any allergic reactions or change in behavior noticed after certain foods (red ears or cheeks, increased stims, etc.)?**

**13g. Was child breast fed?**

YES                       NO

**13h. If YES, How long was the child breast fed?**

**13i. Was child bottle fed?**

YES                       NO

**13j. If YES, which formula based was used?**

MILK                       SOY

**13k. Does child have brittle fingernails or hair?**

YES                       NO

**13l. Does child have white spots in fingernails?**

YES                       NO

**REVIEW OF SYSTEMS – NEUROLOGICAL/DEVELOPMENTAL**

14a. How are the child's fine motor skills (At age level)?

 Below
                                 
  Average
   
  Above

14b. How are the child's gross motor skills (At age level)?

 Below
                                 
  Average
   
  Above

14c. Hand flapping?

 YES
                                 
  NO

14d. Spinning?

 YES
                                 
  NO

14e. Mouthing objects/pica?

 YES
                                 
  NO

14f. Toe walking?

 YES
                                 
  NO
**REVIEW OF SYSTEMS – IMMUNOLOGIC/ALLERGY**

15a. Fevers with infections?

 YES
                                 
  NO

15b. Good response to antibiotics?

 YES
                                 
  NO

15c. Frequency of illnesses (compared to average children)?

 Below
                                 
  Average
   
  Above

15d. Any other seasonal/environmental allergies?

 YES
                                 
  NO

15e. Any allergies to medicines?

 YES
                                 
  NO

15f. Skin rashes?

 YES
                                 
  NO

**CHILD STRENGTHS AND PROBLEMS**

**16a. What are your child's specific strengths?**

**16b. What are your child's main problems?**