Marc Joseph Nutrition **Client Information Questionnaire Child - Autism** Last Name_____

Child

First Name:_____ Last Name: _____ Date_____

Age:____ Birthdate: _____ Sex: _____ Height: _____ Weight: _____

Parents: Single / Married / Unmarried / Separated / Divorced

Mother

First Name:_____ Last Name: _____ Phone (H): _____

Address: Street _____ Phone (W): _____

City _____ State _____ Zip _____ Phone (C): _____

Occupation: _____ Email: _____ Fax: _____

Father

First Name:_____ Last Name: _____ Phone (H): _____

Address: Street _____ Phone (W): _____

City _____ State _____ Zip _____ Phone (C): _____

Occupation: _____ Email: _____ Fax: _____

Referred by (name, relationship to you): _____

Alternate Contact (name, phone, relationship to you): _____

Primary Doctor: Name: _____ Phone: _____

Address: _____

Permission to contact?: Yes / No

Child's Current Health Concerns & Symptoms

When did they begin?: _____

Did onset of the condition occur after a significant event? (e.g., vaccination, infection) _____

_____

Please describe them (attach extra pages if necessary): _____

_____

_____

_____

_____

Have you seen a doctor for these issues? Yes / No

If so, what was the diagnosis? _____ Age diagnosed? _____

Have you seen other health practitioners for these issues? Yes / No

If so, what type (e.g., behavioral therapist, BioSET, other nutritionist etc.)?: _____

_____

Your Goals - Please describe your health goals and what you'd like nutrition counseling to help your child to achieve:

_____

_____

_____

Child number in the family (e.g., 1 of 2) _____ Delivery: natural / C-section

Pregnancy complications? yes / no Please describe: _____

_____

Mother have amalgam ("silver") fillings? If so, how many? _____

Mother have dental work during or just preceding pregnancy? If so, please describe: _____

_____

Mother have vaccinations during or just preceding pregnancy? If so, please describe: _____

_____

Mother have Rhogam shot during pregnancy? yes / no Did it contain thimerosal? yes / no

Breast-fed or formula-fed? If breast-fed, for how long? _____

If formula-fed:

Which product? _____

For how long?_____

Your Child's Medical History

For your child's current condition/s:

What have you done that's helped? What have you done that's not helped?

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Current Rx Medications (please include condition - e.g., Nystatin for yeast, Valtrex for viral issues, etc.):

_____ _____

_____ _____

How often use antibiotics to treat infections?: Never / Rarely / Occasionally / Frequently

Past Rx Medications (please include condition & age - e.g., Augmentin (antibiotic) for ear infection at 14 months)

_____ _____

_____ _____

_____ _____

_____ _____

Any known medication allergies? (e.g., aspirin, Tylenol) _____

Vaccinations

Vaccine	Date Received	Contain Thimerosal?	Reactions
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Symptoms

	When Began	Frequency	Comments
( ) Diarrhea	_____	_____	_____
( ) Constipation	_____	_____	_____
( ) Gas	_____	_____	_____
( ) Bloating	_____	_____	_____
( ) Heartburn / reflux	_____	_____	_____
( ) Vomiting	_____	_____	_____
( ) Hyperactivity	_____	_____	_____
( ) Poor attention	_____	_____	_____
( ) Aggression	_____	_____	_____
( ) Eczema	_____	_____	_____
( ) Rash	_____	_____	_____
( ) Ear infections	_____	_____	_____
( ) Other infections	_____	_____	_____
( ) Dark circles under eyes	_____	_____	_____
( ) Red face	_____	_____	_____
( ) Red ears	_____	_____	_____

( ) Thrush	_____	_____	_____
( ) Persistent nasal congestion	_____	_____	_____
( ) Sneezing	_____	_____	_____
( ) Sleep problems	_____	_____	_____
( ) Early/late puberty changes	_____	_____	_____
( ) Growth delay	_____	_____	_____
( ) Weight gain / loss	_____	_____	_____

Do any of your other children have symptoms similar to those described above? If so, please describe:

_____

_____

_____

_____

_____

_____

_____

Family Health History

1. Please indicate family members who have been affected by these conditions.
2. Please use these initials with reference to your **child** (e.g., M = child's mother, B = child's brother):

M - mother B - brother MGM - maternal grandmother PGM - paternal grandmother
F - father S - sister MGF - maternal grandfather PGF - paternal grandfather

Condition	Family member/s
Diabetes - Type 1	
Diabetes - Type 2	
Hypoglycemia	
Obesity	
Stroke	
High blood pressure	
Osteoporosis	
Osteoarthritis	
Rheumatoid arthritis	
Allergies	
Asthma	
Chronic congestion	
Insomnia	
Hypothyroid	
Hyperthyroid	
Chronic fatigue	
Fibromyalgia	
Lupus	
Multiple Sclerosis	
Athlete's foot	
Jock itch	
Yeast infection	
Eczema	
Psoriasis	
Rashes	

Condition	Family member/s
Cancer (list type)	
Celiac disease	
Crohn's disease	
Diverticulosis/itis	
Gallstones	
Irritable bowel	
Liver disease	
Ulcer	
Ulcerative colitis	
ADD/ADHD	
Asperger's syndrome	
Autism	
Down's syndrome	
Dyslexia	
Learning disability	
OCD	
Alzheimer's	
Parkinson's	
Alcoholism	
Drug addiction	
Anorexia	
Bulimia	
Anxiety	
Bipolar disorder	
Depression	

Any other conditions not listed above? Please describe:

Condition	Family member/s

Condition	Family member/s

Any conditions that run in the family? (e.g., autoimmune-related diseases): _____

_____

Any family members in your home smoke? _____

Vital Signs & Lab Test Results

1. Please indicate the most recent date that your child has had his/her vital signs measured and/or the lab tests below performed.
2. Please list any other relevant tests not included below.
3. Please include copies of your child's vital sign records and lab test results when you fax or mail your information in advance of the scheduled appointment.

Test	Description	Date
Vital Signs	pulse, blood pressure, body temperature	
Blood Lipids	total cholesterol, LDL, HDL, triglycerides, etc.	
Fasting Blood Glucose		
Hemoglobin A1C		
Complete Blood Count (CBC)	WBC - count & differential, RBC, Hgb, Hct, MCV, platelet count, etc.	
Chemistry (Metabolic) Panel	BUN, creatinine, liver enzymes, electrolytes, etc.	
Thyroid Panel	TSH, T3, T4, free T3, free T4	
Iron Panel	ferritin, TIBC, serum, etc.	
Homocysteine		
C-Reactive Protein		
Red blood cell (RBC) elements		
Hair analysis		
Fatty acid analysis		
Plasma cysteine/sulfate		
Digestive stool analysis		
Intestinal permeability		
Food allergy - IgE		
Food allergy - IgG		
Organic acid analysis		
Amino acid analysis		
Immunity - viral titers		
Immunity - T cells, TNF-alpha, etc.		
Other (please list)	(e.g., fibrinogen, urine porphyrins, genetic SNPs)	

Clinical Observations

Hair
- Recent change in condition? no / more dry / more oily
- Recent increase in loss? yes / no
- Recent change in color? yes / no
- Easily plucked? yes / no
- Dandruff? yes / no

Skin
- Recent change in condition? no / more dry / more oily

- Eczema? If so, where? _____ When appeared? _____

- Rash? If so, where? _____ When appeared? _____

Nails
- Condition - soft / brittle / normal
- Hangnails? yes / no
- Visible lines? horizontal / vertical When first appeared? _____
- Nail bed color? pink / white / red
- Fungal infections? no / feet / hands

Mouth
- Lips dry/cracked? yes / no
- Tongue - normal / smooth / cracked / red / sore / coated / other _____
- Breath - normal / slightly bad / bad
- Amalgam ("silver") fillings? yes / no If so, how many? _____
- Gum disease? yes / no
- Gums bleed? yes / no

Neurologic
- Recent change in:
  Concentration? yes / no Sociability? yes / no Coordination? yes / no

- Irritable, short-tempered? yes / no Fearful? yes / no Depressed? yes / no
- Anxious, nervous? yes / no Weepy? yes / no Sensitive to noise? yes / no
- Restless legs? yes / no

Energy Level
- How would you describe your child's overall energy level? 1 to 5, with 1 very low and 5 high _____
- Is your child easily fatigued? yes / no
- Does your child have difficulty waking up in the morning, not feeling refreshed? yes / no
- Is your child tired during the day? yes / no If so, at what times?_____
- Does your child feel his/her best at night? yes / no

Temperature
- Are your child's feet and/or hands often cold? feet / hands / neither
- Is your child sensitive to cold? yes / no Heat? yes / no
- Does your child perspire - A lot? An average amount? A little? Not at all?

Sleep
- Average # hours per night _____ Go to sleep at _____ Wake at _____
- Go to sleep and wake at the same time each day? yes / no
- # of times your child gets up during the night? none / 1x / 2x / 3x / other_____
  Reason/s: Can't sleep / bathroom / other _____

Environmental Exposures

- Do you use pesticides either in or outside your home? yes /no

If so, please list: _____

- Is your child sensitive to:

- Fragrances? yes / no - Car fumes? yes / no - Cigarette smoke? yes / no

- Chemicals/ cleaners? yes /no Please list_____

- Have the child's parents been exposed to any chemicals:

At past jobs? yes / no Please describe _____

At current jobs? yes / no Please describe _____

- Have you had any work done on your home or apartment recently? (e.g., new flooring, painting, remodeling)

If so, please describe: _____

_____

- Do you or have you ever had a problem with mold in your home? If so, please describe: _____

_____

_____

- Do you live near a known source of environmental pollution (e.g., freeway, coal-fired power plant)? If so,

please describe: _____

_____

Dietary History

meals child eats per day? _____

Water intake

Meal pattern Y / N / Sometimes

- Eat breakfast? _____
- Eat lunch? _____
- Eat dinner? _____
- Snack (morning) _____
- Snack (afternoon) _____
- Snack (evening) _____

- at home - tap / filtered / bottled / distilled / other _____
- away from home - tap / filtered / bottled / distilled / other _____
- amount per day (oz.) _____

Vegetarian (eat eggs & dairy)? yes / no Vegan (no eggs & dairy)? yes / no

Other vegetarian type (please describe): _____

Eat fish? yes / no What types? _____ How often?_____

Favorite foods_____

_____

Least favorite foods _____

_____

What foods does your child typically eat for:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Drinks _____

Does your child eat foods or drinks with artificial sweeteners? yes / no Which sweeteners?_____

_____

Any recent change in your child's overall desire for food? no / increased / decreased

Does your child crave specific types of foods? salty / sweet / fatty / other _____

_____

Recent nausea or vomiting? yes / no

Any pain or discomfort when eating? If so, where? _____ When?_____

Any problems chewing or swallowing? yes / no Please describe _____

Any dental or oral problems making it difficult to eat? yes / no Please describe _____

_____

Food Allergies & Cravings

Has your child been tested for IgE or IgG antibodies to different foods? IgE / IgG / neither
(If yes to either, please include copies of test results when you fax or mail your information in advance of the scheduled appointment.)

Allergies (A) or cravings (C) for:

	Child	Sibling	Mother	Father
Gluten (wheat, barley, rye, etc.)				
Casein (milk, dairy, etc.)				
Eggs				
Corn				
Soy				
Chocolate				
Peanuts				
Citrus				
Sugar				
Nightshade vegetables (tomatoes, peppers, eggplant, etc.)				
Other (please list)				

Bowel Habits

# of bowel movements per day? 1x / 2x / 3x / every other day / other _____

Does your child frequently experience: Diarrhea? yes / no Constipation? yes / no
Bloating or gas? yes / no

Stool Characteristics

Form:	well-formed	mushy	watery	frothy	hard-pellets
Float or sink:	float	sink			
Color:	brown	light brown	green	yellow	black

Is there fat in the stool (i.e., sheen floating on top of the water)? yes / no

Is there blood in the stool? yes / no If so, what color? bright red / dark red / black

Growth & Development

Please describe your child's relationships with family members and peers _____

_____

_____

_____

_____

_____

Exercise / Play

Yes / No

Type (please describe): _____

Duration (e.g., 20 mins.): _____ Frequency (# times / week): _____

School

Grade level: _____

Classes: Normal / Special Education / Other _____

Performance: Poor / Ok / Average / Above Average

Any recent changes? If so, please describe: _____

_____

Progress Snapshot

Please circle the numbers that currently best describe your child.

Stool Quality	1 watery, diarrhea	2 muddy	3 partially-formed, light-colored	4 formed, light-colored	5 brown
Mood	1 tantrum	2 irritable	3 sad	4 happy	5 giddy
Social Communication (Self-initiated)	1 poor	2 minimal	3 good	4 very good	5 excellent
Social Communication (Response to others)	1 poor	2 minimal	3 good	4 very good	5 excellent
Self-regulation (impulse control)	1 zoning out	2 low	3 hyper	4 a little hyper	5 good
Attention	1 very poor	2 poor	3 some	4 good	5 excellent
Fine Motor Control	1 very poor	2 poor	3 some	4 good	5 excellent
Eye Contact	1 very poor	2 poor	3 some	4 good	5 excellent
Sensory Disturbances	1 very high	2 high	3 moderate	4 minimal	5 none

(Source: Adapted from Brenda Kerr document - Autism Research Institute site)

THERAPIES

Familiarity with biomedical interventions? Little / Some / Very

	Interested In	Using Now	Tried in Past	Helpful (Y/N/Some)	Reason for Stopping
Diet					
- Gluten-free (GF)	( )	( )	( )	_____	_____
- Casein-free (CF)	( )	( )	( )	_____	_____
- Soy-free	( )	( )	( )	_____	_____
- Corn-free	( )	( )	( )	_____	_____
- SCD	( )	( )	( )	_____	_____
- Body Ecology	( )	( )	( )	_____	_____
- Feingold	( )	( )	( )	_____	_____
- Low-oxalate	( )	( )	( )	_____	_____
Other (please list)					
_____	( )	( )	( )	_____	_____
_____	( )	( )	( )	_____	_____
_____	( )	( )	( )	_____	_____

Please describe any other aspects about your child's diet that you think are important:

_____

_____

_____

_____

_____

_____

_____

Supplements	Interested In	Using Now	Tried in Past	Helpful (Y/N/Some)	Reason for Stopping	Product Name/Brand	Dose	Frequency
Multi-vitamin	( )	( )	( )					
Multi-mineral	( )	( )	( )					
Vitamin A	( )	( )	( )					
Vitamin C	( )	( )	( )					
Vitamin D	( )	( )	( )					
Vitamin E	( )	( )	( )					
B-complex	( )	( )	( )					
B6	( )	( )	( )					
Biotin	( )	( )	( )					
Methyl-B12	( )	( )	( )					
Folic acid (folate)	( )	( )	( )					
Folinic acid	( )	( )	( )					
DMG	( )	( )	( )					
TMG	( )	( )	( )					
Calcium	( )	( )	( )					
Magnesium	( )	( )	( )					
Zinc	( )	( )	( )					
Copper	( )	( )	( )					
Molybdenum	( )	( )	( )					
Selenium	( )	( )	( )					
Fish oil	( )	( )	( )					
Cod liver oil	( )	( )	( )					
Borage oil	( )	( )	( )					
Milk thistle	( )	( )	( )					
Probiotics	( )	( )	( )					
Enzymes	( )	( )	( )					
Colostrum	( )	( )	( )					
Transfer factor	( )	( )	( )					
Taurine	( )	( )	( )					
Carnosine	( )	( )	( )					
Creatine	( )	( )	( )					
Phosphatidylcholine	( )	( )	( )					
Coenzyme Q10	( )	( )	( )					

Other Supplements	Interested In	Using Now	Tried in Past	Helpful (Y/N/Some)	Reason for Stopping	Product Name/Brand	Dose	Frequency
_____	( )	( )	( )	_____				
_____	( )	( )	( )	_____				
_____	( )	( )	( )	_____				
_____	( )	( )	( )	_____				
_____	( )	( )	( )	_____				
_____	( )	( )	( )	_____				
_____	( )	( )	( )	_____				
_____	( )	( )	( )	_____				
_____	( )	( )	( )	_____				
_____	( )	( )	( )	_____				

Chelation	Interested In	Using Now	Tried in Past	Helpful (Y/N/Some)	Reason for Stopping	Product Name/Brand	Dose	Frequency
Oral								
- DMSA	( )	( )	( )	_____				
- DMPS	( )	( )	( )	_____				
- ALA (lipoic acid)	( )	( )	( )	_____				
				_____				
Transdermal								
- DMSA	( )	( )	( )	_____				
- DMPS	( )	( )	( )	_____				
- ALA (lipoic acid)	( )	( )	( )	_____				
				_____				
Other (please list)								
_____	( )	( )	( )	_____				
_____	( )	( )	( )	_____				
_____	( )	( )	( )	_____				

	Interested In	Using Now	Tried in Past	Helpful (Y/N/Some)	Reason for Stopping	Product Name/Brand	Dose	Frequency
Anti-Yeast								
OTC								
- Grapefruit seed extract	( )	( )	( )					
- Candidase	( )	( )	( )					
- Candex	( )	( )	( )					
- Biotin	( )	( )	( )					
- Caprylic acid	( )	( )	( )					
- S. Boulardii	( )	( )	( )					
Rx								
- Nystatin	( )	( )	( )					
- Diflucan	( )	( )	( )					
Other (please list)								
_____	( )	( )	( )					
_____	( )	( )	( )					
_____	( )	( )	( )					

	Interested In	Using Now	Tried in Past	Helpful (Y/N/Some)	Reason for Stopping	Product Name/Brand	Dose	Frequency
Anti-Viral								
OTC								
- Olive leaf extract	( )	( )	( )					
- Virastop	( )	( )	( )					
Rx								
- Acyclovir	( )	( )	( )					
- Valtrex	( )	( )	( )					
Other (please list)								
_____	( )	( )	( )					
_____	( )	( )	( )					