AUTISM BIOMED CENTER
Armen Nikogosian, MD

***** Please bring **:***

1. *RECENT picture of your child that we may keep*
2. *BABY picture of your child that we may look at and return*

Patient Contact Information

Current Date _____ Patient Name _____

DOB _____ Gender of patient: M F

Home Address: _____
STREET

_____
CITY ST ZIP

Home Phone ( ) _____ Fax ( ) _____

Cell phone(s): Mom ( ) _____ Dad ( ) _____

Email _____

Who lives in the house? _____

Who referred you? _____

Parent or Legal Guardian Information

Marital Status: MARRIED / DIVORCED / OTHER

Mother's Legal Name _____ Father's Legal Name _____

Mother's DOB _____ Father's DOB _____

Mother's Occupation _____ Father's Occupation _____

Mother's Employer _____ Father's Employer _____

Phone # _____ Phone # _____

Emergency contact (*other than parent*): _____

Pharmacy Information

Name of preferred regular pharmacy _____

Phone # _____ Fax # _____

Name of compounding pharmacy _____

Phone # _____ Fax # _____

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Initial Interview Form

Appointment Date _____ **Patient's Age** _____**Height** _____**Weight** _____

Medication Allergies: _____

Genetic background (may check more than one):
☐ **Caucasian** (☐ Northern European ☐ Mediterranean ☐ Ashkenazi Jewish**)**
☐ **African** (☐ African American ☐ West African ☐ East African)
☐ **Asian** (☐ East Asian ☐ South Asian/Indian ☐ Pacific Islander)
☐ **Hispanic** ☐ **Native American** ☐ **Other** _____

Please list out your child's 3 greatest strengths:

1. **:**

2. **:**

3. **:**

Please list out your child's 3 greatest challenges (for example, speech, attention, etc):

1. **:**

2. **:**

3. **:**

What do you want to address during today's consult?

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Does your child swallow pills or capsules? Y N

What medications (*not supplements*) are being taken:	
Drug:	Dose:

What supplements are being taken?	
Supplement:	Dose:

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Dietary/Nutritional History:

Breast fed? Y N If yes, for how long: _____ Formula? For how long? _____

Brand of formula? _____ Begun at what age? _____

Foods? Begun at what age? _____

First foods? (Please list)

Cow's milk? Y N

If yes, begun at what age? _____

Wheat products (bread, pasta etc.)? Y N

If yes, begun at what age? _____

Known allergies to food? (Please list including reaction)

Suspected sensitivities to foods? (Please list including reaction):

Food cravings? (Please list):

Mark the most appropriate description below of your child's diet:

____Mostly baby foods
____Mostly carbohydrates (bread, pasta, etc.)
____Mostly dairy (milk, cheese, etc.)
____Mostly vegetarian (vegetables, fruits, grains, etc.)
____Mostly meat (beef, chicken, fish etc.)
____Other, describe:

Indicate the percentage of how your child's food is prepared (total should equal 100%):

____ From scratch with whole natural foods
____ From scratch with prepared ingredients (canned/frozen/lunch meats/pasta with bottled sauce)
____ Heating up prepared meals (frozen pizza, frozen dinners, mac and cheese, canned soup etc.)
____ Meals prepared by strangers (fast food, restaurants, cafeteria etc.)

Do you use a microwave oven to prepare food? Y N

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Food my child eats: (mark the appropriate column)

Food	Daily	3-5 times per week	1-3 times per week	Never or almost never	Used to eat in the past
Cookies					
Candy					
Sweet foods (desserts)					
Sweet drinks (soda, juices)					
Caffeine					
Artificial Sweeteners					
Chocolate					
Milk Whole					
2%					
1%					
Skim					
Cheese					
Ice Cream					
Fast Food					
Meat					
Pasta					
Bread White					
Wheat					
Fresh Veggies					
Fresh Fruit					
Fermented Foods (yogurt, kefir, pickles, kimchi etc.)					

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Please list the foods and beverages normally consumed by your child for three typical days

DAY 1
Breakfast:
Morning snack:
Lunch:
Afternoon snack:
Dinner:
Other:
DAY 2
Breakfast:
Morning snack:
Lunch:
Afternoon snack:
Dinner:
Other:
DAY 3
Breakfast:
Morning snack:
Lunch:
Afternoon snack:
Dinner:
Other:

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ls your child Gluten and/or Casein Free? Y N

Do you feel your is child eating adequate quantities and varieties of food? Y N

Please describe your child's STOOL pattern (Examples: daily, foul, large, mushy, etc.):

Please indicate below how your child is doing in the following categories:

Expressive speech:

Receptive understanding:

Sleep patterns:

Eye contact:

Stereotypies (stimming/self-stimulatory behaviors):

Obsessive or compulsive behavior:

Attention:

Hyperactivity:

Play and interaction with peers (social interaction):

Bowel movements:

Fine motor:

Gross motor:

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Developmental Disorders			
	Age	Who Diagnosed	Treatments
Speech delay			
Fine Motor Delay			
Gross motor delay			
Global Delay			
Mental retardation			
Low I.Q.			
Other:			

Learning and Attention Disorders:

a. AD/HD
b. ADD (no hyperactivity)
c. Learning disability
d. Dyslexia
e. Dysgraphia
f. Dyscalculia
g. Other, please specify:

Social developmental disorders		
Autism	Pervasive Developmental Disorder (PDD)	Asperger syndrome
Others (please specify):		
Age at diagnosis:		
Who made diagnosis: a. Developmental pediatrician b. Pediatric neurologist c. Neurologist d. Psychiatrist e. Psychologist f. Other (please specify)		

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Behavioral and Educational Treatments	
Treatment	Start and Length of Treatment, and Intensity of Treatment
Resource room (assistance)	
Reading/writing	
Study skills	
Mathematics	
Social skills	
Accommodations	
Special education (self-contained)	
Speech therapy	
Physical therapy	
Occupational therapy	
Applied Behavioral Analysis (ABA)	
Other:	

GESTATIONAL HISTORY:

Gestation History			
Mother's Age at Birth		Father's Age at Birth	
Total Number of Pregnancies		Number of Miscarriages	
Pregnancy Number for This Child		Number of Preterm Pregnancies	
Infertility treatment if any			
IVF Treatment if any			

Was the mother on birth control pills when pregnant and if so what type?

If yes to above, then what type and at what week gestation was it discontinued?

How many alcoholic beverages per week were consumed during pregnancy?

How many packs of cigarettes were smoked per day while pregnant with the child?

Any dental work during pregnancy?

How many amalgams/fillings did mom have during pregnancy?

Any occupational exposure to mercury or other toxins?

Did mom receive a Rhogam injection during pregnancy?

Was there normal prenatal care when pregnant?

How many ultrasounds during pregnancy?

Did mom have an amniocentesis?

Vaccinations in mom just before or during pregnancy			
Vaccination	Brand or serial number, if known	Age of Gestation in Weeks	Side Effects
Tetanus toxoid			
MMR			
Hepatitis A			
Hepatitis B			
Influenza (flu)			
Other:			
Other:			

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Indicate all places of residency during pregnancy			
Type of Residence	Year Built	Address	Age in months
Apartment:			
Private Home:			

Mark the most appropriate description below of the mom's diet during pregnancy:
____ Vegan (NO meat, dairy or eggs) ____Vegetarian (vegetables, fruits, grains, dairy, eggs etc.)
____ Mostly carbohydrates (bread, pasta, etc.) ____Mostly meat _____ Mostly Seafood
____ Other:

Indicate how mom's food was prepared during pregnancy (total should equal 100%):
____ From scratch with whole natural foods
____ From scratch with prepared ingredients (canned/frozen/lunch meats/pasta with bottled sauce)
____ Heating up prepared meals (frozen pizza, frozen dinners, mac and cheese, canned soup etc.)
____ Meals prepared by strangers (fast food, restaurants, cafeteria etc.)

Fish consumed during pregnancy. Please indicate the approximate total number of times you ate the following groups of fish. Circle the specific fish you ate		
Fish Group	Fish	Number of Total Times for all Fish in Group
A	King Mackerel, Marlin, Orange Roughy, Shark, Swordfish, Tilefish, Bigeye or Ahi Tuna	
B	Bluefish, Grouper, Spanish or Gulf Mackerel, Chilean Sea Bass, Canned Albacore or Yellow fin Tuna	
C	Striped Bass, Carp, Alaskan Cod, Halibut, Lobster, Mahi Mahi, Monkfish, Sablefish, Snapper, Canned, chunk light or Skipjack Tuna or Sea Trout	

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Source of fluids during pregnancy		
Fluids	Brand	How often
Tap water a. From cup b. From Glass c. From plastic bottle	Do not fill for cup or glass	
Filtered Water		
Bottled water		
Soda		
Fruit juice		
Other		

Were any of the following problems experienced during pregnancy?		
Illness	Medication (if any) with dose and treatment length	Gestation in Weeks
Viral illness		
Bacterial Illness / UTI (urinary tract infection)		
Vomiting requiring hospitalization		
Bleeding or spotting		
Preterm labor		
Pre-eclampsia		
Eclampsia/HELLP syndrome		
Hypertension		
Emotional distress		
Gestational diabetes		
Other:		
Other:		

List any medications or drugs the mother took during pregnancy:			
Medication	Dose	Gestation in Weeks when treatment started	Reason for Medication

Travel History During Pregnancy			
Place travelled	Medications/ vaccinations needed	Gestation in weeks at that time	Illness or Side effects of medication

Birth History	
Number of weeks gestation	
Was labor induced?	
Birth Weight	
Birth Length	
Birth Head Circumference	
Vaginal or C-section?	
Epidural in mom?	
Apgar Scores?	

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Please circle all of the following complications that apply to the delivery of the child:

a. Drop in fetal heart rate
b. Fetal Distress
c. Meconium
d. Planned Caesarian Section
e. Emergency Caesarian Section
f. Required Forceps
g. Required Vacuum Extraction
h. Cord around the child's neck
i. Infection in child
j. Admitted to NICU
k. Others (please specify):

Were any of the below treatments necessary?		
Treatments	**Yes or No**	**How many days**
Required intubation (breathing tube)		
Required oxygen without a breathing tube		
Feeding tube needed		

Please circle all of the following neonatal conditions the child had:
(Duration, Age (Day of life), Treatment)

a. Jaundice
b. Pneumonia
c. Transient breathing difficulties
d. Chronic lung disease /bronchopulmonary
e. Feeding difficulties
f. Necrotizing enterocolitis
g. Intraventricular hemorrhage
h. Periventricular leukomalacia
i. Seizure(s)
j. Brain damage
k. Patent ductus-arteriosis
l. Congenital heart disease
m. Other, please specify:

Early Life History of Child (up to 1 year old)

Feeding of the baby:			
	Percentage of Feeds Per Day	Ages in months when fed in this manner	Brand of Bottle and/or Formula and solid food
Breast fed			
Breast Milk in Bottle			
Formula			
Formula			
Formula			
Solids			
Solids			
Solids			

Food or Formula Allergies: _____

Cow or milk intolerance in the first year of life: No Yes

Any special diet in the first year of life?

Any pica (eating or chewing non-food items)?

Please indicate all places of residence & approximately when residence was build			
Type of Residence	Year Built	Zip code or city	Ages in months
Apartment:			
Private Home:			

Mattress brand/type used for child:

Estimate the number of antibiotic courses given to child in the first 2 years of life:

Developmental History

Is child right or left handed?

Age when you first suspected a delay or problem in development:

Which of the following best describes your child:

a. a period of normal development followed by a loss in skills
b. a period of normal development followed by a plateau, stagnation or non-progression in skills
c. developmental delay from birth or early in life
d. other (please describe):

Which activities of daily living does your child need help with?

a. Personal hygiene and grooming
b. Dressing and undressing
c. Feeding
d. Transfers (e.g., assistance getting into bathtub)
e. Bowel or bladder management
f. Walking

Speech Milestone:	
Communication Milestones	**Age at which first occurred (months)**
First speech like sounds	
First time the child said “mama” or “dada”	
First word besides from “mama” or “dada”	
First time child used words to refer to something specifically	
First time the child put words together in a phrase	
Pointing	

Motor Milestone:	
Motor Milestones	**Age at which first occurred (months)**
Rolling over	
Sitting without support	
Crawling	
Creeping / Cruising	
Standing Independently	
Walking Independently	
Potty trained: urine / stool	

If your child lost skills (regressed) please fill out the table below:				
Skill	**Age when regression occurred**	**Duration of Regression**	**Was regression abrupt or slow**	**Age at which skill was regained**
Speech				
Fine Motor Skills				
Coordination				
Social Interaction				
Pointing				
Eye Contact				
Other:				

Was regression associated with any of the following factors?			
	Duration	Treatment	Other Details
Viral Illness			
Seizure			
Fever			
Rash			
Vaccine			
Mitochondrial dysfunction			

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Immunizations				
Immunizations	***# of times immunized***	***Thimerosal Containing Yes/No/Unknown***	***Complications***	***Premedication for Vaccine***
Hepatitis B				
Inactivated polio vaccine				
MMR				
Influenza				
Meningococcal				
Rotavirus				
Diphtheria, Tetanus, Pertussis				
Pneumococcal				
Varicella				
Hepatitis A				
Other:				

Did you notice a decline after vaccination? Please describe.

Child's Medical Disorders

Allergic disorders and treatment			
Allergic disorders	When diagnosed	Severity	Duration
Asthma			
Allergies			
Allergic rhinitis			
Seasonal allergies			
Eczema			
Food allergies			
Others (please specify)			

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Please list all treatments for the above disorders			
Medication	Dose	Duration of Treatment	Side effects

Infectious diseases:			
Infectious disease	Data of First Infection	Date of Last Infection	Duration of medication
Sore throat			
Strep throat			
Ear infections			
RSV			
Others:			
Others:			

Please list all treatments for the above disorders, including treatments for each and every infection.			
Medication	Dose	Duration of Treatment	Side effects

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Neurological disorders and treatment			
Neurologic disorder	When diagnosed	Severity	Duration of medication
Microcephaly			
Macrocephaly			
Hypotonia (low muscle tone)			
Tremor			
Ataxia / Unsteadiness			
Poor Coordination			
Easy Fatigability			
Exercise Intolerance			
Muscle Disorder / Myopathy			
Chronic headaches			
Epilepsy			
Febrile seizures			
Nystagmus			
Migraine headaches			
Head injury			
Cerebral palsy			
Tic disorder			
PANDAS/PANS			
Tourette syndrome			
Others (please specify)			

Please list all treatments for the above disorders			
Medication	Dose	Duration of Treatment	Side effects

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Psychiatric disorders:			
Psychiatric disorders	When diagnosed	Severity	Duration of medication
Mood disorder (e.g. bipolar)			
Depression			
Aggressive and/or self-injurious behavior			
Obsessive compulsive disorder			
Anxiety disorder			
Eating/body image disorder			
Addiction			
Sensory Integration Disorder			
Other (please specify):			

Sleep disorders:			
Sleep disorder	When diagnosed	Severity	Duration of medication
Sleep apnea			
Restless leg syndrome			
Periodic limb movements			
Narcolepsy			
Sleep disordered breathing			
Other (please specify):			

Please list all treatments for the above disorders			
Medication	Dose	Duration of Treatment	Side effects

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Gastrointestinal disorders:			
Gastrointestinal disorders	When diagnosed	Severity	Duration of medication
Colic			
Chronic constipation			
Chronic diarrhea			
Gastroesophageal reflux disease			
Food intolerance			
Eosinophilic esophagitis			
Dysbiosis / Bacterial Overgrowth			
Lymphoid Nodular Hyperplasia			
Celiac Disease			
Enterocolitis / Inflammation			
Ulcer			
Ulcerative colitis			
Crohn's disease			
Other (please specify):			

Please list all treatments for the above disorders			
Medication	Dose	Duration of Treatment	Side effects

Other disorders:			
Disorders	When diagnosed	Severity	Duration of medication
Growth Failure			
Hearing loss			
Visual loss			
Cardiovascular disease			
Renal (Kidney) Disorder			
Hematological disease			
Mitochondrial Disorder			
Metabolic Disorder			
Immunological Disorder			
Cerebral Folate Deficiency			
Chronic abdominal pain			
Cancer			
Diabetes			
Genetic disorder			
Sickle-cell anemia			
Hypothyroidism			
Hyperthyroidism			
Obesity			
Incontinence			
Other (please specify):			

Please list all treatments for the above disorders			
Medication	Dose	Duration of Treatment	Side effects

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Surgical procedures:			
Tonsillectomy	Adenoidectomy		Ear tube placement
Appendix	Circumcision		Hernia
Other:			
Name of anesthesia during surgery	Type and dose	Surgical Procedure	Side effects

Has your child been tested for any of the following:

Immune Disorders:			
Test	Tested	Abnormal	Value of Test
Immunoglobulin IgG	Yes / No	Yes / No	
Immunoglobulin IgM			
Immunoglobulin IgA			
Immunoglobulin IgE			
ANA (Antinuclear Antibody)			
Thyroid Autoantibodies			
Brain Endothelial Autoantibodies			
PANDAS / Strep Autoantibodies			
Folate Transporter Autoantibodies			
CAM Kinase			
Other (please specify):			

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Biomedical or Complementary Therapies and Treatment				
Alternative Therapies and Treatments				
Treatment	Dose	Duration	Positive Effects	Adverse Effects

Travel History of Child			
Place travelled	Medications/ vaccinations needed	Age at that time	Illness or Side effects of medication

Family History

Mark all the sleep disorders in the child's biological family:									
	Mom	Dad	Sibling	Mom's parents	Dad's parents	Mom's siblings	Dad's siblings	Maternal cousin	Paternal cousin
Insomnia									
Snoring									
Sleep apnea									
Restless leg syndrome									
Periodic limb movement									
Sleep walking / terrors									
Sleep talking									
Narcolepsy									
Other:									

Mark all the developmental disorders in the child's biological family:									
	Mom	Dad	Sibling	Mom's parents	Dad's parents	Mom's siblings	Dad's siblings	Maternal cousin	Paternal cousin
Speech delay									
Gross motor delay									
Fine motor delay									
Global developmental delay									
Mental retardation									
Low IQ									
Other									

Mark all the social developmental disorders in the child's biological family:									
	Mom	Dad	Sibling	Mom's parents	Dad's parents	Mom's siblings	Dad's siblings	Maternal cousin	Paternal cousin
Autism									
Asperger syndrome									
Pervasive Developmental Disorder (PDD)									
Other									

Mark all the infectious disorders in the child's biological family:									
	Mom	Dad	Sibling	Mom's parents	Dad's parents	Mom's siblings	Dad's siblings	Maternal cousin	Paternal cousin
Recurrent sore throats									
Recurrent strep throats									
Recurrent ear infections									
Other									

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Mark all the neurological disorders in the child's biological family:									
	Mom	Dad	Sibling	Mom's parents	Dad's parents	Mom's siblings	Dad's siblings	Maternal cousin	Paternal cousin
Epilepsy / seizures									
Febrile seizures									
Migraine headaches									
Chronic headaches									
Tic disorder									
PANDAS/PANS									
PITANDS									
Tourette syndrome									
Cerebral palsy									
SIDS									
Other									

Mark all the inflammatory disorders in the child's biological family:									
	Mom	Dad	Sibling	Mom's parents	Dad's parents	Mom's siblings	Dad's siblings	Maternal cousin	Paternal cousin
Allergies									
Asthma									
Psoriasis									
Hashimoto's thyroiditis									
Lupus									
Rheumatoid arthritis									
Autoimmune disorder, other									

Mark all the learning and attention disorders in the child's biological family:									
	Mom	Dad	Sibling	Mom's parents	Dad's parents	Mom's siblings	Dad's siblings	Maternal cousin	Paternal cousin
Learning disability									
Dyslexia									
Dysgraphia									
Dyscalculia									
ADHD									
ADD (without hyperactivity)									
Other									

Mark all the psychiatric disorders in the child's biological family:									
	Mom	Dad	Sibling	Mom's parents	Dad's parents	Mom's siblings	Dad's siblings	Maternal cousin	Paternal cousin
Mood disorder									
Depression									
Aggressive / self-injurious behavior									
Obsessive compulsive disorder (OCD)									
Anxiety disorder									
Alcoholism									
Bipolar disorder									
Schizophrenia									
Other									

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Mark all the gastrointestinal disorders in the child's biological family:									
	Mom	Dad	Sibling	Mom's parents	Dad's parents	Mom's siblings	Dad's siblings	Maternal cousin	Paternal cousin
Chronic diarrhea									
Chronic constipation									
Gastro-esophageal reflux									
Food intolerance									
Irritable bowel syndrome									
Ulcers									
Celiac disease									
Ulcerative colitis									
Crohn's disease									
Other									

Mark all the other disorders in the child's biological family:									
	Mom	Dad	Sibling	Mom's parents	Dad's parents	Mom's siblings	Dad's siblings	Maternal cousin	Paternal cousin
Hypothyroidism									
Chronic abdominal pain									
Chronic fatigue syndrome									
Fibromyalgia									
Bulimia									
Anorexia									
Breast cancer									
Cancer, other									
Diabetes									

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Genetic disorder									
Hypertension									
Blood clots									
Anemia									
Sickle-cell anemia									
Alzheimer's disease									
Parkinson disorder									
Prematurity									
Neural tube defects									
Multiple miscarriages									
Other									

Please list anything else you may think is helpful for Dr. Nikogosian to know: