Weight: _______(kg) Height:_______(cm)

AUTISM RECOVERY CENTRE

Blk 1 Thomson Road #03-342E Singapore 300001
Tel: (65) 6253 6257 **Fax:** (65) 6251 0159

PATIENT'S PARTICULARS

Name: ____________________________________ Reg No.: __________________
(Underline Surname)

Passport / FIN / NRIC No.: ____________________ Birth Date: __________________

Sex: Male / Female Race: ________________ Nationality: __________________

Address:____________________________________ Postal Code: __________________

____

Tel: _________________(H)________________ (O) _______________________ (Hp)

Email: ____

PATIENT'S PARENTS OR NEXT OF KIN'S PARTICULARS

Mother's Name: ______________________________ Occupation:____________________________

Tel: ______________________ Hp: ____________________ Email:____________________________

Father's Name: ______________________________ Occupation:____________________________

Tel: ______________________ Hp: ____________________Email:____________________________

Next Of Kin's Name: __________________________________ Relationship:_______________________

Tel: ______________________ Hp: ____________________Email: ____________________________

How did you come to know about our clinic?

____

____
Patient / Parent's Signature & Date

Please fill the following pages as best as you can and leave blank any areas you are not sure about.

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PRENATAL HISTORY

Maternal age at delivery: years
Illnesses during pregnancy:
Dental work during pregnancy:
Any amalgams tooth fillings during pregnancy:
Medication during pregnancy:
Other complications during pregnancy:
Complications during labor and delivery:
Mode of delivery: C-section/vaginal? If C-section, explain why:
If vaginal delivery, did you have forceps/vacuum?
Medication(s) during labor and delivery?
Full term/premature? (Circle one) **How many weeks?**
Complications after delivery?
Medications given to child during hospital stay?

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CHILD'S MEDICAL HISTORY

Major surgeries – Please describe and give details

SURGERY	DATE	RESULTS

Major injuries – Please describe and give details

INJURY	DATE	RESULTS

Illnesses – Please list appropriate dates and any complications:

ILLNESS	DATE	COMPLICATIONS
Ear Infection		
Sinus Infections		
Bronchitis		
Pneumonia		
Thrush		
Chicken Pox		
Seizures		
Others: (Please list):		

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DIETARY / NUTRITIONAL HISTORY

Whole milk? Yes/No (Circle One) If yes, begun at what age?_________

Known allergies to food? (Please list):_____________________________________

Food cravings? (Please list):____

Food my child eats: (Place tick in appropriate column)

Food	Daily	3-5 times a week	1-3 times a week	Never / Seldom	Used to, now never
Cookies					
Candy					
Sweet foods					
Caffeine					
Chocolate					
Milk					
Cheese					
Ice Cream					
Salty Food					
Meat					
Pasta					
Bread					
Others					

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DIETARY / NUTRITIONAL HISTORY (Continued)

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

Please list the foods and beverages normally consumed for two typical days:

Day 1
Breakfast:
Morning snack's):
Lunch:
Afternoon snack's):
Dinner:
Other
Day 2
Breakfast:
Morning snack's):
Lunch:
Afternoon snack's):
Dinner:
Other

Please indicate therapies and diets you have used and/or are using.

Now	Past	Therapies	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments
		Acupuncture							
		Auditory Training							
		Craniosacral							
		Homeopathy							
		Lovaas (ABA)							
		Neuralfeedback							
		Occupation Thera							
		Speech Therapy							
		Diets							
		Gluten Free							
		Casein Free							
		Specific Carbohydrate Diet							

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SIGNS AND SYMPTOMS

Please tick any signs/symptoms your child may demonstrate and note duration and details if appropriate:

No.	Description	Mild	Moderate	Severe	Duration	Unique details
1	Stimming (repetitive actions or movements)					
2	Rocking					
3	Head banging					
4	Self-mutilation					
5	Nail biting					
6	Hand/arm biting					
7	Nail/skin picking					
8	Aggressiveness (hitting, kicking, biting others)					
9	Mood swings					
10	Irritability/tantrums					
11	Fears/anxieties					
12	Hyperactivity					
13	Impulsive					
14	Breath holding					
15	Seizures					
16	Poor coordination					
17	Problems with buttons, ties, snaps or zippers					
18	Processing problems - visual, motor, language, etc.					
19	Problems with social interactions					
20	Sensitive to crowds					
21	Trouble remembering					
22	Low self-esteem					
23	Fatigue					
24	Cold hands/feet					
25	Cold intolerance					
26	Heat intolerance					
27	Recurrent/chronic fever					
28	Difficulty falling to sleep					
29	Night waking					
30	Bed wetting/soiling					
31	Day time wetting/soiling					
32	Dark circles/puffiness under eyes					

33	Congestion					
34	Dripping nose					
35	Sensitivity to bright lights					
36	Earaches					
37	Sensitive to sounds/noise					
38	Bad breath					
39	Cough					
40	Wheezing					
41	Mouth Ulcers					
42	Swollen gums					
43	Diarrhea					
44	Constipation					
45	Bloating					
46	Passing gas					
47	Belching					
48	Stomach ache					
49	Refusal to eat					
50	Sensitive to texture of food					
51	Difficulty swallowing					
52	Food Craving					
53	Grinding teeth					
54	Mucous/blood in stools					
55	Anal itching					
56	Eczema					
57	Hives					
58	Sensitivity to insect bites					
59	Sensitive to texture of clothes					
60	Strong stool odor					
61	White spots/lines on nails					
62	Any OCD (obsessive compulsive) behaviors					
63	Strategies to put pressure on abdomen					
64	Reflux					
65	Persistent colic					
66	Toe walking					