Insightful Wellness
Sherry@insightfulwellness.com
860-942-4434

ASD Nutrition Intake

Please fill out the following information and include copies of lab test results and a photo of your child.

Child's Name: _____ Height: _____ Current Weight: _____

Last Name: _____ Percentile Height: _____ Percentile Weight: _____

Date of Birth: _____ Age: _____ Ideal Weight: _____

Physician: _____

Referred By: _____

Mother's Name: _____ Phone (H): _____

Address: _____ Phone (W): _____

Mother's Email: _____ Phone (C): _____

Father's Name: _____ Phone (H): _____

Address: _____ Phone (W): _____

Father's Email: _____ Phone (C): _____

Parents: Single / Married / Unmarried / Separated / Divorced Child lives with: _____

Health objectives and conditions interested in addressing:

When did your child first experience these health concerns? Did anything trigger or precede health condition?

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Practitioner: **Phone:** **Email**:

Describe your diet when the condition started:

If your child is of school age, how many days of school have they missed? _____

What would you like to learn and gain from working with a nutrition consultant? *(i.e. how foods affect an ailment, understanding of how the body works, lifestyle improvement, meal ideas, etc.)*

HEALTH HISTORY OF CHILD

Describe the health history of the child from birth (i.e. ear infections, illnesses, viruses, emotional trauma or loss):

How many times has the child received antibiotics and at what age? Please describe.

Is your child currently taking any medication? _____

Please list ***supplements*** child is taking (or include separate sheet). Mark most effective with *

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Has your child tried cod liver oil and was there any improvement? _____

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PRENATAL/BIRTH/INFANCY

Number of children in family and order

Name	Age

Describe the pregnancy _____

Gestation (in weeks) _____

Birth Weight _____

Describe the birth (vaginal/c-section) and any interventions such as antibiotics during labor:

_____

Was child breast-fed? How long? _____

Was the mother taking any antibiotics or prescription medications while nursing? _____

Did the child receive formula? What type (cow, soy)? _____

What was the reaction to formula? _____

Did child have thrush/yeast as a baby? _____

Did child receive any vaccines at birth? _____

Has child received all vaccinations? _____ Did you notice any vaccine reaction? _____

Has the mother had any miscarriages? _____

Was the mother exposed to any toxins including mold, heavy metals, pesticides *during* pregnancy, or *before*? _____

Did the *mother* receive any medications, amalgam fillings or vaccinations (including Rh immune globulin or flu shot)? _____

Does mother have thyroid issues? Did mother have low thyroid during pregnancy? _____

Did mother have an autoimmune disorder during pregnancy? _____

Did mother take a multivitamin before or during? If so, which one, and what type of folate did it have?

_____

Does mother or father have MTHRF or other methylation impairments? _____

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Last Name: _____

ASD

Diagnosis (What diagnoses has your child received from your child's doctors): _____

_____

Age symptoms first appeared _____ Age when diagnosed _____

Did any events accompany onset of autism? _____

What conditions or symptoms are most significant? _____

_____

Does your child have sensory processing disorder (sensitivity to light, sound, touch, etc.)? _____

How does it affect them? _____

Is your child verbal? _____

Describe a bit about your child

What is your level of knowledge on nutrition intervention for ASDs?

- ❑ Very well read
- ❑ Have done some reading and have started dietary intervention
- ❑ Very new to all of this

Therapies/Protocols *(Indicate: what you are using, tried in past, or interested in. Mark which have been most effective with a *)*

Biomedical Intervention _____

Special diets _____

Supplements _____

B12 injections _____

Chelation/Detox _____

Antifungal/viral/biotic _____

NAET, Bioset, allergy elim. _____

Medications (LDN, IVIG) _____

Feeding therapy _____

Speech therapy _____

OT/PT/Bodywork_____

Cranial-sacral, chiropractic _____

EFT, Energy work, etc. _____

CBD or Cannabis _____

Other _____

_____

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Practitioner: **Phone:** **Email**:

DIET

Is your child on any of the following special diets?

- ❑ GFCF
- ❑ SCD/GAPS
- ❑ Paleo
- ❑ Autoimmune Paleo
- ❑ Feingold/Failsafe
- ❑ Body Ecology Diet
- ❑ Low oxalate
- ❑ Low FODMAPS
- ❑ Low Histamine
- ❑ Low Carbohydrate
- ❑ Ketogenic Diet
- ❑ Vegetarian
- ❑ Vegan
- ❑ No special diet

Which of the following foods does your child have **allergies** or **food sensitivities**, and does your child **currently avoid** them. Mark the following:

Serious Allergy	Sensitivity	Avoiding		Serious Allergy	Sensitivity	Avoiding	
☐	☐	☐	Gluten	☐	☐	☐	Others _____
☐	☐	☐	Dairy / Casein	☐	☐	☐	
☐	☐	☐	Soy	☐	☐	☐	
☐	☐	☐	Corn	☐	☐	☐	
☐	☐	☐	Eggs	☐	☐	☐	
☐	☐	☐	Sugar	☐	☐	☐	
☐	☐	☐	Chocolate	☐	☐	☐	
☐	☐	☐	Peanuts	☐	☐	☐	
☐	☐	☐	Citrus	☐	☐	☐	

How were the food sensitivities determined…. What type of allergy testing identified these allergens/sensitivities (skin/scratch, IgE/IgG, LEAP MRT, ALCAT, muscle testing, dietary elimination, known reaction, other)?_____

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Last Name: _____

If your child **isn't gluten free currently,** do you suspect they are:

Gluten sensitive _____ **Casein** sensitive _____ Explain _____

Has child tried a strict gluten/casein-free diet? _____ If yes, for how long? _____

Did you notice a reduction in symptoms? _____

Does your child have any other dietary restrictions (purines, lectins, thiols/sulfur, nightshades, etc.)?

_____

Describe your child's diet now

DIET HISTORY

Please describe your experience with special diets (i.e. how has your diet evolved, history of what diet changes made in the past, what gains you received, what symptoms did not improve)

Date	Diet	Results, Notes, and Comments

Does your child eat fish? How often and what type? _____

Does your child eat sauerkraut? How often and what type? _____

Does your child consume bone broth? How often and what type? _____

How much water does your child drink per day? _____ What type (tap, bottled, filtered) _____

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Practitioner: **Phone:** **Email**:

Last Name: _____

Does your child consume:

- ❑ Coffee
- ❑ Caffeine
- ❑ Soda
- ❑ Diet soda
- ❑ Sweetened drinks
- ❑ Artificial sweeteners
- ❑ Trans fats
- ❑ MSG
- ❑ Canned soups
- ❑ Canned/boxes broths
- ❑ Non-organic GF packaged foods
- ❑ Non-organic meat, eggs or dairy
- ❑ Non-organic fruits and vegetables
- ❑ Non-organic corn, soy, canola, "sugar" (beet), papaya, summer squash

Does your child have exposure to the following?

- ☐ Fluoridated water
- ☐ Chlorinated pools
- ☐ Chemical cleaning supplies
- ❑ Perfume/fragrance
- ❑ Fabric softener/drier sheets
- ❑ Tobacco

Are you familiar with phenols, salicylates, and faulty sulfation? _____

Do you suspect your child has a phenol sensitivity? _____

Is there a craving or reaction (hyperactivity, red cheeks, aggression, etc.) to phenols/salicylates?

_____

Does your child have reactions (consume large amounts/craves for) to any of the following?

- ❑ Berries
- ❑ Apples/juice
- ❑ Grapes/raisins
- ❑ Bananas
- ❑ Honey
- ❑ Curry powder
- ❑ Spices/culinary herbs
- ❑ Medicinal herbs
- ❑ Wine
- ❑ Bone broth
- ❑ Sauerkraut
- ❑ Fermentations
- ❑ Soy Sauce
- ❑ Parmesan cheese
- ❑ Vegemite/Marmite
- ❑ Tomato sauce
- ❑ Artificial colors
- ❑ Artificial flavors
- ❑ Preservatives
- ❑ Sulfites
- ❑ Fragrance/perfume
- ❑ Aspirin
- ❑ Tylenol (acetaminophen)

Does your child consume a lot of the following:

- ❑ Spinach
- ❑ Swiss chard
- ❑ Nuts
- ❑ Almond/almond flour
- ❑ Chia seeds
- ❑ Tahini
- ❑ Beans
- ❑ Soy
- ❑ Chocolate
- ❑ Black tea
- ❑ Amaranth
- ❑ Buckwheat
- ❑ Blackberries
- ❑ Figs
- ❑ Kiwi
- ❑ Beets

Do ***mother*** *or* ***father*** have food intolerances that might be relevant to child? _____

Practitioner: **Phone:** **Email**:

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Last Name: _____

FEEDING/EATING HABITS

Is your child a picky eater? Describe _____

Does your child eat less than 20 foods? _____

Does your child get vegetables in their diet? ☐Never ☐Rarely ☐Moderate ☐Quite a bit

Vegetables in what form? ☐Juiced ☐Pureed and hidden ☐Eat outright

Does your child only eat foods of certain **textures**? _____

Are there any **textures** your child will *not* eat? _____

Does he/she tend to focus on one **taste** (sweet, bitter, sour, salty, spicy)_____

Are there any **tastes** he/she will not eat? _____

Does your child have any significant food cravings or sneak food? _____

Does your child ever experience "food jags" where they burnout on a food they ate frequently?

_____

Are food jags lost completely or reacquired after a couple week's break? _____

Has your child ever permanently rejected a beloved food after it was "tampered" with (usually when healthy things are snuck inside, like veggies in a meatball)? _____

Has your child ever gone on a "food strike" when food they wanted was not served (not related to an illness)? What was the outcome? Did they end up in the hospital? _____

Describe their appetite. Does your child seem always hungry or never hungry? Is their appetite better as the day goes on? _____

Favorite foods: _____

What food does your child typically eat (please also complete the "food/symptom" diet record):

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Drinks _____

Does child still take a bottle? _____

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Last Name: _____

DIGESTION AND ELIMINATION

Does child have frequent gas? _____

Does child have bloating? _____

Does gas have a strong odor? _____

Does child appear to have abdominal pain? _____

Does child have diarrhea or soft, unformed stool? _____

Does child have constipation? _____

Does child have heartburn or acid reflux? Does child take antacids or acid blockers?

_____

Does child get nauseous or vomit? _____

Does child have yeast or bacterial overgrowth? _____

Describe any other digestive issues? _____

Is child potty trained or wear a diaper? _____

Does child have wetting accidents? Soiling accidents? _____

How frequently does child have a bowel movement? _____

What is consistency of stool?

Formed like a brown banana _____

Small balls formed into banana, or “rabbit-pellets” _____

Unformed, soft, or ribbon-like _____

Very large diameter _____

Energy/Mood/Sleep

Has your child been diagnosed or do you believe your child may have hypoglycemia or any blood sugar imbalance? _____

Does your child need to eat frequently? _____

Does your child get irritable, dizzy, headaches when they go too long without eating? _____

Describe mood and energy level _____

Stress level (1-10; 1 low and 10 high) and source _____

Does child have sensory sensitivity (texture, light, sound) or sensory integration challenges?

_____

How much sleep does your child get? _____

What time does your child go to bed, to sleep, and wake up? _____

Does your child have trouble falling asleep?_____

Does your child wake in the night? What time? _____ Reason? _____

How long does it take to fall back asleep? _____

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Practitioner: **Phone:** **Email**:

Does your child feel tired after a full night sleep? _____

Does child snore? Does child have sleep apnea? _____

Toxic Exposure

Has your child had exposure to any toxins (pesticides, chemicals, heavy metals, plastics, inhaled chemicals, industrial chemicals) that you are aware of at home or school?

_____

Are there any chemicals or smells that your child is sensitive to (headaches, nausea)?

_____

Have you recently remodeled or plan to remodel your home? What did you have done?

_____

Have mother or father been exposed to significant toxins? (Before or after birth of child)

_____

Infections and Toxins

Does your child have any of the following?

- ❑ Lyme disease and co-infections
- ❑ Candida overgrowth (yeast infections, nail fungus, athlete's foot)
- ❑ Viral infections: EBV, HVS, and others
- ❑ Clostridia or another gut pathogen
- ❑ SIBO
- ❑ Mold exposure and mycotoxins
- ❑ Exposure to water damaged building
- ❑ Glyphosate exposure
- ❑ Heavy metal toxicity

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Last Name: _____

FAMILY HISTORY

Common Familial Disorders

Please indicate any family history of the following and list family member affected, mark paternal or maternal with a "p" or "m" or CHILD. For example: p-grandmother, m-aunt

Diabetes/Hypoglycemia _____ Colitis/IBS/IBD _____

Heart Disease _____ Arthritis _____

Cancer _____ Autoimmune disorder _____

Obesity _____ Migraines/Headaches _____

Depression, anxiety _____ Postpartum depression _____

ADHD, Autism, LD _____ Bipolar, schizophrenia _____

Asperger's _____ Recurring yeast (vaginal, foot, etc.) _____

Hyperactivity, tics _____ Vulvadynia _____

Kidney stones _____ Sleep apnea _____

Alzheimer_____ Multiple chemical sensitivity_____

Alcohol/chemical dependency_____ Fibromyalgia _____

Epilepsy/seizures_____ Chronic fatigue Syndrome_____

Rheumatoid arthritis_____ Asthma _____

Hashimoto's thyroiditis _____ Hypothyroid_____

Do you suspect your child has (or has been diagnosed with) …

Mitochondrial dysfunction _____

Impaired methylation_____

Mast cell activation syndrome_____

Share any gene SNPS results (or attach results). Include MTHFR, CBS, COMT, etc. and any health implications you've identified and any interventions you are using.

Remember to complete Symptom/Diet Checklist (separate from ASD Symptom Checklist).

Include any labs results you have

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Last Name: _____

ASD Symptom Checklist

Please rate the following behaviors or symptoms on a scale of 1 to 7 (1 mild; and 7 very true or severe) **as they appear *today***. This will help determine how the child progresses.

Communication	*0 – Not Applicable, 1 – Mild, 7 – Very*							
Cannot communicate verbally	0	1	2	3	4	5	6	7
Receptive language is difficult	0	1	2	3	4	5	6	7
Reverses pronouns such as you" and "I	0	1	2	3	4	5	6	7
Has echolalia – repeats others' words	0	1	2	3	4	5	6	7
Cannot rationalize with child	0	1	2	3	4	5	6	7
Behavioral/emotional symptoms								
Does not respond to requests by familiar people	0	1	2	3	4	5	6	7
Has picky eating habits	0	1	2	3	4	5	6	7
Throws frequent tantrums	0	1	2	3	4	5	6	7
Behaves aggressively, physically attacking others	0	1	2	3	4	5	6	7
Injures self with behavior (head-banging)	0	1	2	3	4	5	6	7
Frequent crying/emotionally sensitive	0	1	2	3	4	5	6	7
Depression	0	1	2	3	4	5	6	7
Irritability	0	1	2	3	4	5	6	7
Panics easily or resists change	0	1	2	3	4	5	6	7
Behavior challenges 2-3 hours after meals	0	1	2	3	4	5	6	7
Hyperactivity	0	1	2	3	4	5	6	7
Spacey/Inattentive	0	1	2	3	4	5	6	7
Low impulse control	0	1	2	3	4	5	6	7
Physical Symptoms								
Is physically inactive, or passive	0	1	2	3	4	5	6	7
Fatigue/low muscle tone	0	1	2	3	4	5	6	7
Hypersensitive (sound, touch, etc)	0	1	2	3	4	5	6	7
Insensitive to pain	0	1	2	3	4	5	6	7
Headache	0	1	2	3	4	5	6	7
Tics/Tourette's	0	1	2	3	4	5	6	7
Asthma	0	1	2	3	4	5	6	7
Bedwetting/daytime wetting	0	1	2	3	4	5	6	7
Red checks or streaks on face	0	1	2	3	4	5	6	7
Dark circles under eyes	0	1	2	3	4	5	6	7
Hives/rashes	0	1	2	3	4	5	6	7
Congestion/runny nose/allergy symptoms	0	1	2	3	4	5	6	7
Resistance to go to bed	0	1	2	3	4	5	6	7
Difficulty falling asleep	0	1	2	3	4	5	6	7
Night waking/nightmares/erratic sleep	0	1	2	3	4	5	6	7
Seizure activity	0	1	2	3	4	5	6	7

Complete the ATEC (Autism Treatment Evaluation Checklist). Forward the results to us. Record score here _____. http://www.surveygizmo.com/s3/1329619/Autism-Treatment-Evaluation-Checklist-revised

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Practitioner: **Phone:** **Email**:

Last Name: _____

Food/Symptom Record

1. Please write out your daily diet. Fill out a diet record for at least two days. Include **portion size**, **beverages**, and any **supplements** or **medications**. Include **time** of day.
2. Additionally, record any symptoms you feel during or after eating, such as drowsy, irritable, etc.

MEAL	TIME	Food/Supplements	Mood/Energy/Symptoms
Example Only *Breakfast*	*9:00 am*	*1 cup of cereal with 3/4 c cow milk* *1 multi-vit/min, 500 mg vit C*	*9:00 Feel fine* *10:30 Low energy, stressed*
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Night-time/ Before bed			
Record sleep, elimination, and any other notes below...			

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