For office use only

Regenecell Patient Folder No. ________________

Patient Evaluation Form – Autism Spectrum Disorders

Click or use the TAB key to move between fields

Full Name

Date of Birth

Occupation

Gender ☐ Male ☐ Female

Physical Address

Country

Postal Address

Zip/Postal Code

Tel No.

Cellphone

Email

Re-enter email

Skype user name

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Your Personal Doctor

Name

Telephone

Fax

Email

Contact in an emergency while at the clinic (caregiver, close friend or relative)

Name

Tel no.

Medical history:

Disease for which you are seeking treatment

Date of first diagnosis

Other Diagnoses

Date

What events lead up to you being diagnosed with this disease?

History of events after diagnosis

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How would you describe your current condition?

Your Height | Your Weight

Have you experienced sudden weight loss (above 5kg)? Yes ☐ No ☐

Do you have, or have you suffered from:

	Yes	No	If Yes, please elaborate
Allergies: food, vaccination, drugs, hayfever	☐	☐	
Heart problems	☐	☐	
High blood pressure	☐	☐	
Asthma	☐	☐	
Lung disease	☐	☐	
Epilepsy	☐	☐	
Psychiatric problems – nervousness, depression	☐	☐	
Gastrointestinal problems	☐	☐	
Liver problems	☐	☐	
Hepatitis type: A	☐	☐	
Hepatitis type: B	☐	☐	
Hepatitis type: C	☐	☐	
Renal problems	☐	☐	
Kidney infections	☐	☐	
Musculoskeletal problems	☐	☐	
Osteoporosis	☐	☐	
Osteoarthritis	☐	☐	
Rheumatoid arthritis	☐	☐	
Blood disorder	☐	☐	
Thrombosis	☐	☐	
Diabetes type 1	☐	☐	
Diabetes type 2	☐	☐	
Thyroid disorder	☐	☐	
Overactive	☐	☐	
Underactive	☐	☐	

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Menopause	☐	☐	______
HIV/AIDS	☐	☐	______
Cancer	☐	☐	______
Surgery	☐	☐	______
Are you on?			
Chemotherapy	☐	☐	______
Anticoagulants	☐	☐	______
Antibiotics	☐	☐	______
Steroids	☐	☐	______

Medication

Name	Dose	Strength	Date Started	Date Stopped

Smoking

Amount per day	
When started	
When stopped	

Alcohol

Type	Amount per day/week

Family history of disease:

Disease	Mother	Father	Grandmother	Grandfather	Brother	Sister
________	☐	☐	☐	☐	☐	☐
________	☐	☐	☐	☐	☐	☐
________	☐	☐	☐	☐	☐	☐
________	☐	☐	☐	☐	☐	☐

Supplementation

List all nutritional supplements – please include brand names.

Previous Stem Cell Therapy

Have you had stem cell treatment before? Yes ☐ No ☐

If *Yes*

What kind of cells did you receive?

How many cells did you receive?

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The following section follows the Autism Treatment Evaluation Checklist (ATEC)
Reference: Bernard Rimland, Ph.D. and Stephen M. Edelson, Ph.D. Autism Research Institute, San Diego.

Please click on the appropriate choice in the following 4 sections:

I. Speech/Language/ Communication	NOT TRUE	SOMEWHAT TRUE	VERY TRUE
1. Knows own name	☐	☐	☐
2. Responds to 'No' or 'Stop'	☐	☐	☐
3. Can follow some commands	☐	☐	☐
4. Can use one word at a time (No!, Eat, Water, etc.)	☐	☐	☐
5. Can use 2 words at a time (Don't want, Go home)	☐	☐	☐
6. Can use 3 words at a time (Want more milk)	☐	☐	☐
7. Knows 10 or more words	☐	☐	☐
8. Can use sentences with 4 or more words	☐	☐	☐
9. Explains what he/she wants	☐	☐	☐
10. Asks meaningful questions	☐	☐	☐
11. Speech tends to be meaningful/relevant	☐	☐	☐
12. Often uses several successive sentences	☐	☐	☐
13. Carries on fairly good conversation	☐	☐	☐
14. Has normal ability to communicate for his/her age	☐	☐	☐

II. Sociability	NOT DESCRIPTIVE	SOMEWHAT DESCRIPTIVE	VERY DESCRIPTIVE
1. Seems to be in a shell — you cannot reach him/her	☐	☐	☐
2. Ignores other people	☐	☐	☐
3. Pays little or no attention when addressed	☐	☐	☐
4. Uncooperative and resistant	☐	☐	☐
5. No eye contact	☐	☐	☐
6. Prefers to be left alone	☐	☐	☐
7. Shows no affection	☐	☐	☐
8. Fails to greet parents	☐	☐	☐
9. Avoids contact with others	☐	☐	☐
10. Does not imitate	☐	☐	☐
11. Dislikes being held/cuddled	☐	☐	☐
12. Does not share or show	☐	☐	☐
13. Does not wave ‘bye bye’	☐	☐	☐
14. Disagreeable/not compliant	☐	☐	☐
15. Temper tantrums	☐	☐	☐
16. Lacks friends/companions	☐	☐	☐
17. Rarely smiles	☐	☐	☐
18. Insensitive to other’s feelings	☐	☐	☐
19. Indifferent to being liked	☐	☐	☐
20. Indifferent if parent(s) leave	☐	☐	☐

III. Sensory/Cognitive Awareness	NOT DESCRIPTIVE	SOMEWHAT DESCRIPTIVE	VERY DESCRIPTIVE
1. Responds to own name	☐	☐	☐
2. Responds to praise	☐	☐	☐
3. Looks at people and animals	☐	☐	☐
4. Looks at pictures (and T.V.)	☐	☐	☐
5. Does drawing, coloring, art	☐	☐	☐
6. Plays with toys appropriately	☐	☐	☐
7. Appropriate facial expression	☐	☐	☐
8. Understands stories on T.V.	☐	☐	☐
9. Understands explanations	☐	☐	☐
10. Aware of environment	☐	☐	☐
11. Aware of danger	☐	☐	☐
12. Shows imagination	☐	☐	☐
13. Initiates activities	☐	☐	☐
14. Dresses self	☐	☐	☐
15. Curious, interested	☐	☐	☐
16. Venturesome – explores	☐	☐	☐
17. “Tuned in” — Not spacey	☐	☐	☐
18. Looks where others are looking	☐	☐	☐

IV. Health/Physical Behavior:

	NOT A PROBLEM	MINOR PROBLEM	MODERATE PROBLEM	SERIOUS PROBLEM
1. Bed-wetting	☐	☐	☐	☐
2. Wets pants/diapers	☐	☐	☐	☐
3. Soils pants/diapers	☐	☐	☐	☐
4. Diarrhea	☐	☐	☐	☐
5. Constipation	☐	☐	☐	☐
6. Sleep problems	☐	☐	☐	☐
7. Eats too much/too little	☐	☐	☐	☐
8. Extremely limited diet	☐	☐	☐	☐
9. Hyperactive	☐	☐	☐	☐
10. Lethargic	☐	☐	☐	☐
11. Hits or injures sell	☐	☐	☐	☐
12. Hits or injures others	☐	☐	☐	☐
13. Destructive	☐	☐	☐	☐
14. Sound-sensitive	☐	☐	☐	☐
15. Anxious/fearful	☐	☐	☐	☐
16. Unhappy/ciying	☐	☐	☐	☐
17. Seizures	☐	☐	☐	☐
18. Obsessive speech	☐	☐	☐	☐
19. Rigid routines	☐	☐	☐	☐
20. Shouts or screams	☐	☐	☐	☐
21. Demands sameness	☐	☐	☐	☐
22. Often agitated	☐	☐	☐	☐
23. Not sensitive to pain	☐	☐	☐	☐
24. “Hooked” or fixated on certain objects/topics	☐	☐	☐	☐
25. Repetitive movements (stimming, rocking, etc.)	☐	☐	☐	☐

Expectations

What do you expect to achieve from the treatment?

You understand that this is a treatment and not a cure? Yes ☐ No ☐

Mobility Assessment

Please describe your ability to move by choosing a number in the list below which best describes you.

Enter the number here: ☐

0. Asymptomatic; fully active.
1. Walks normally, but reports fatigue that interferes with athletic or other demanding activities.
2. Abnormal gait or episodic imbalance; gait disorder is noticed by family and friends; able to walk 25 feet (8 meters) in 10 seconds or less.
3. Walks independently; able to walk 25 feet in 20 seconds or less.
4. Requires unilateral support (cane or single crutch) to walk; walks 25 feet in 20 seconds or less.
5. Requires bilateral support (canes, crutches, or walker) and walks 25 feet in 25 seconds or less; *or* requires unilateral support but needs more than 20 seconds to walk 25 feet.
6. Requires bilateral support and more than 20 seconds to walk 25 feet; may use wheelchair on occasion.
7. Walking limited to several steps with bilateral support; unable to walk 25 feet; may use wheelchair for most activities.
8. Restricted to wheelchair; able to transfer self independently.
9. Restricted to wheelchair; unable to transfer self independently.

Autism Spectrum Disorders
Please include a detailed medical report from your child's specialist.

How did you hear about Regenecell?

Internet Search ☐

Personal referral ☐ By whom: ____________________

Other ☐ Details: ____________________

I understand that Regenecell Stem Cell Therapy is not a US FDA-approved procedure and is in no way to be construed or presented as a cure for any condition, degenerative disease or injury, and clinical benefits from this therapy cannot be guaranteed.

I accept the above ☐

Return this form as an attachment to info@regenecell.com

Or

By Fax: + 27 86 503 2563

From the UK: 00 27 86 503 2563
From the USA: 011 27 86 503 2563

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