ARI/Form
Mercury-4/01

Mercury Detoxification Evaluation Form
Autism Research Institute

4182 Adams Avenue, San Diego, CA 92116
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We are very interested in receiving comments and observations from parents of autistic children on the effects of the mercury detoxification process. Please make copies of this form and send a completed copy to the Autism Research Institute just before the child is started on the detoxification program. Send us follow-up reports monthly during the treatment. Findings will be reported on our web site and in the *Autism Research Review*. You may also obtain copies of this form on our web site, or you can complete this form electronically on our web site. You may track your child's improvement by entering the report every month on our web site, which will immediately give you your child's scores.

Name of Child _____ _____ ☐ Male Age _____ Date of Birth _____
Last First ☐ Female Today's Date _____

Functional Level:
Lo__ Med.__ Hi__ No. of Detox
_____ Date Detox Started _____ Treatments _____
Form completed by Relationship

Address: _____
Street City State Zipcode Phone Fax E-mail

Age of onset: _____ Do you believe child's autism was caused by a vaccine? Yes / No If so, which? _____

Name of physician treating child: _____ City/State: _____

If your child has not yet begun a mercury detoxification procedure, please complete only section A.
For 30-day follow-up reports, complete both sections A and B.

Section A -- Current Status

Circle the appropriate value

No Problem	Is a Problem Mild	Mod.	Severe	Symptoms
0	1	2	3	Aggression. . . . .
0	1	2	3	Agitation/Irritability. . . . .
0	1	2	3	Awkward body movements . . .
0	1	2	3	Constipation . . . . .
0	1	2	3	Diarrhea. . . . .
0	1	2	3	Eating/feeding problems. . . . .
0	1	2	3	Inappropriate use of toys . . . . .
0	1	2	3	Irrational fears . . . . .
0	1	2	3	Lack of awareness . . . . .
0	1	2	3	Lacks eye contact. . . . .
0	1	2	3	Lacks speech . . . . .
0	1	2	3	Obsessive/OCD behaviors . . . .
0	1	2	3	Poor attention . . . . .
0	1	2	3	Poor finger/hand skills . . . . .
0	1	2	3	Repetitive, self-stim behaviors .
0	1	2	3	Seizures . . . . .
0	1	2	3	Self-injury. . . . .
0	1	2	3	Sleep disturbances . . . . .
0	1	2	3	Social deficits/withdrawal. . . . .
0	1	2	3	Sound sensitivity. . . . .
0	1	2	3	Speech/language deficits. . . . .
0	1	2	3	Temper tantrums . . . . .

Section B -- Detox Effects

Place an x *on the scales below to indicate detox effects. Please base your ratings on changes observed since the detox procedure was initiated.*

Made Worse	No Effect	Possibly Helped	Helped a Little	Helped a Lot	Greatly Improved
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Please use the back of this form to tell us more about the benefits, if any, seen in the past month and about any adverse effects, if any, seen in the past month. Other comments and observations are also welcome.