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Autism Evaluation Clinic History Form

Please complete and bring with you to your first appointment.

Child's History/Information:

Child's Name: ______________________ M F Birthdate:___________ Age: _____
Referred by: ___________________ Specialty: _____________________ Date:______________
Why do you want your child evaluated? ____

CURRENT CONCERNS ABOUT YOUR CHILD

Please check all that apply:

- ☐ Aggression
- ☐ Overactivity
- ☐ Preoccupations
- ☐ Hitting
- ☐ Appetite/food selections
- ☐ Motor skills
- ☐ Peer relationships
- ☐ Language abilities
- ☐ Temper tantrums
- ☐ Self-injury
- ☐ Inattentive
- ☐ Depressed or anxious
- ☐ School environment
- ☐ Toilet training
- ☐ Biting
- ☐ Sleep problems
- ☐ Self-help skills
- ☐ Medication
- ☐ Self-stimulatory behaviors: rocking, spinning, flapping hands, visual scrutiny
- ☐ Muscle tone
- ☐ Other:____

CHILD'S CURRENT LIVING SITUATION

With whom does the child currently reside? (please mark all that apply)

- ☐ Biological Mother
- ☐ Biological Father
- ☐ Step-mother
- ☐ Step-father
- ☐ Adoptive Mother
- ☐ Adoptive Father
- ☐ Foster Mother
- ☐ Foster Father
- ☐ Other (please describe:____)

Complete the following for the child's BIOLOGICAL PARENTS to the best of your ability, *even if you are not the child's biological parent.*

Biological Mother's name:______________________________ Age:_____ Birth date:___________

Occupation:__________________________________Ethnic/Cultural Background:_____________________

Work Phone:__________________________________ Home Phone: __________________________________

Biological Father's name:_____________________________ Age:_____ Birth date:___________

Occupation:__________________________________Ethnic/Cultural Background:_____________________

Work Phone:__________________________________ Home Phone: __________________________________

If the child currently resides with parents OTHER than biological parents, please describe them here.

Parent One's name:__________________________________ Age:_____ Birth date:___________

Relationship to child: ☐ Adoptive Parent ☐ Step-parent ☐ Foster Parent ☐ Other:__________

Occupation:__________________________________Ethnic/Cultural Background:_____________________

Work Phone:__________________________________ Home Phone: __________________________________

Parent Two's name:______________________________ Age:_____ Birth date:____________

Relationship to child: ☐ Adoptive Parent ☐ Step-parent ☐ Foster Parent ☐ Other:__________

Occupation:______________________________Ethnic/Cultural Background:____________________

Work Phone:______________________________ Home Phone: ______________________________

Highest level of education by each parent:____

If child does not live with BOTH biological parents, who has legal custody of the child?_______________

How often does the other biological parent see this child?______________________________________

If child is with ADOPTIVE parent, age child was first in home:_____ Date of legal adoption:____________

What has the child been told about the adoption?____

If your child spends a significant amount of time with a caregiver other than someone described above (i.e., spends more than 4 hours/day) EXCLUDING school personnel, please complete the following information for that person here:

Name:___________________________________ Age:_____ Birth date:____________

Relationship to child:____________________ Ethnic/Cultural Background:____________________

Occupation:________________________ Highest level of education:________________________

Siblings: (please list whether the siblings live in the child's home or not)

Name	Age	Sex	Full/Step/Half?	Grade	In child's home?

Other occupants of child's residence NOT listed above:_______________________________________

What languages does this child use (List PRIMARY language first):______________________________

What other languages is this child exposed to?____

HISTORY

Prenatal/Pregnancy

Did the biological mother have any of the following immediately before/after or during pregnancy?

☐ Maternal injury. Describe:____

☐ Hospitalization during pregnancy. Reason:______________________________________

☐ X-rays during pregnancy. What month of pregnancy?______________

☐ Any other problems during pregnancy?____

Delivery

Was the infant born full-term? ☐ Yes ☐ No

If premature, how early?_______________ If overdue, how late?_______________
Birth weight:____________________ Apgars: at 1 minute ______ at 5 minutes ______
Type of anesthetic used: ☐ None ☐ Spinal ☐ Local ☐ General
Length of active labor:__________

Describe any complications during delivery:__________________
____

Check all of the following that applied to the delivery:
☐ Spontaneous ☐ Breech ☐ Forceps
☐ Head first ☐ Multiple births ☐ Cord around neck
☐ Induced; Reason:_________________________________
☐ Cesarean; Reason: _________________________________

Which of the following applied to the infant? (check all that apply)
☐ Breathing problems ☐ Required oxygen ☐ Required incubator
☐ Jaundice (Were Bilirubin lights used? ☐ No ☐ Yes - How long?___________)
☐ Feeding problems ☐ Sleeping problems ☐ Infection
☐ Rash ☐ Excessive crying ☐ Sleeping problems
☐ Seizures/convulsions ☐ Unusual appearance, describe:________________________________
☐ Bleeding into the brain

Did the infant require: ☐ X-Rays ☐ CT scans ☐ Blood transfusions
☐ Placement in the NICU (If so, for how long?_________________)

Length of stay in hospital: Mother_______________ Infant________________

Developmental History
During this child's first three years, were there any special problems noted in the following areas?
☐ Irritability ☐ Breathing problems ☐ Colic
☐ Difficulty sleeping ☐ Eating problems ☐ Temper tantrums
☐ Failure to thrive ☐ Excessive crying ☐ Withdrawn behavior
☐ Poor eye contact ☐ Early learning problems ☐ Destructive behavior
☐ Convulsions/Seizures ☐ Twitching ☐ Unable to separate from parent
☐ Other:____

Milestones. Indicate age when child:

_______ sat unaided _______ crawled _______ walked

_______ started solid foods _______ fed self with spoon _______ gave up bottle

_______ bladder trained- day _______ bladder trained- night _______ bowel trained

_______ rides tricycle _______ rides bike

Can child be described as clumsy/uncoordinated? ☐ Yes ☐ No Having fine motor delay? ☐ Yes ☐ No

Which hand does your child use for: Writing/drawing?__________ Eating? _________ Cutting? _______

Current eating behavior: ☐ Normal ☐ Picky ☐ Eats too much ☐ Weight loss/gain

Oral Motor concerns ☐ None ☐ Difficulty swallowing ☐ Drooling ☐ Gagging

Language Development

Indicate age when child began babbling, such as repeating syllables, in attempts to communicate?:________

Have there been any hearing concerns? ☐ No ☐ Yes Hearing testing- date?____________

Adaptive Skills

Feeds self	☐ No	☐ Yes, beginning at age______
Dresses self	☐ No	☐ Yes, beginning at age______
Bathes self	☐ No	☐ Yes, beginning at age______
Helps with household chores	☐ No	☐ Yes, beginning at age______
Knows phone number and address	☐ No	☐ Yes, beginning at age______
Says "please" and "thank you"	☐ No	☐ Yes, beginning at age______
Tells time accurately	☐ No	☐ Yes, beginning at age______

Has the child ever lost skills, which at one time he/she was able to perform? ☐ No ☐ Yes
If yes, please explain____

When your child is disruptive or misbehaves, what steps are you likely to take to deal with the problem?

☐ Time out ☐ Loss of allowance/privileges ☐ Physical punishment ☐ Yelling
☐ Ignoring ☐ Grounding ☐ Other, please describe____________________

Who is mainly in charge of discipline?____

What do you find most difficult about raising your child?____
____

Checklist: Please mark any of the following in each area that describe your child currently or in the past:

Speech

Past	Current	Past	Current
☐	☐ slow speech development	☐	☐ doesn't understand without gestures
☐	☐ unusual tone or pitch	☐	☐ repeats words/phrases over and over again
☐	☐ difficult to understand speech	☐	☐ repeats questions, instead of answering them
☐	☐ seldom speaks unless prompted	☐	☐ repeats dialogue from movies/songs verbatim
☐	☐ has language of his/her own (may sound like foreign language/jargon)		

Relating with other people

Past	Current	Past	Current
☐	☐ prefers to be by self	☐	☐ "in a world of his/her own"
☐	☐ aloof, distant	☐	☐ clings to people
☐	☐ fearful of strangers	☐	☐ not cuddly as a baby
☐	☐ doesn't like to be held	☐	☐ doesn't recognize parent
☐	☐ doesn't play with other children	☐	☐ prefers playing with younger or older children

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Imitation

Past Current

☐ doesn't imitate waving "bye-bye" or "patty cake" etc. (physical imitation)
☐ ☐ doesn't repeat words/things said to him/her
☐ ☐ doesn't repeat words generally, but usually does what he/she was asked to do

Response to Sounds, Speech

Past	Current	Past	Current
☐	☐ often ignores sounds	☐	☐ often ignores what is said to him/her (speech)
☐	☐ afraid of certain sounds	☐	☐ really likes certain sounds (music, motors, etc.)
☐	☐ seems to hear distant or soft sounds that most other people don't hear or notice		
☐	☐ unpredictable response to sounds (sometimes reacts, sometimes doesn't)		
☐	☐ responds to speech and sounds like other children of the same age		

Visual Response

Past	Current	Past	Current
☐	☐ stares vacantly around room	☐	☐ plays with turning lights on and off
☐	☐ often doesn't look at things	☐	☐ distracted by lights—stares at certain lights
☐	☐ likes to look at self in mirror	☐	☐ very interested in small parts of an object
☐	☐ likes to look at shiny objects	☐	☐ looks at things out of corners of eyes
☐	☐ stares at parts of his/her body (i.e. hands)		
☐	☐ often avoids looking at people when they are talking to him/her		

Other Senses

Past	Current	Past	Current
☐	☐ puts many objects in mouth	☐	☐ likes vibrations
☐	☐ licks objects	☐	☐ doesn't notice pain as much as most people
☐	☐ overreacts to pain	☐	☐ smells objects, esp. unusual or unfamiliar objects
☐	☐ chews or eats objects that are not supposed to be eaten		

Emotional Responses

Past	Current	Past	Current
☐	☐ temper tantrums	☐	☐ laughs/smiles for no obvious reason
☐	☐ overly responds to situations	☐	☐ moods change quickly/for no apparent reason
☐	☐ often has blank expression on face	☐	☐ cries/seems sad for no obvious reason
☐	☐ little response to what is happening around him/her		

MEDICAL HISTORY

Has your child ever had:

☐ Head injury Age______ Describe____

☐ Loss of consciousness Age______ How long?________ Describe____

☐ Allergies to food/medication List:____

☐ Surgery Age______ Reason______________ _ Describe____

☐ Ear Infections: Age______ Describe____

Is the child up to date on immunizations? ☐ Yes ☐ No, Why not?____________________________

____

<u>Doctors seen</u> (check all that apply)

☐ Pediatrician - Date of last visit:_____________ Diagnosis:_______________________________

☐ Developmental Pediatrician - Date:__________ Diagnosis:_______________________________

☐ Neurologist - Date:___________ Diagnosis:____

☐ Suspected seizures, describe:____

☐ Seizures diagnosed, type:____

☐ Geneticist - Date:___________ Diagnosis:____

☐ Psychiatrist - Date:_____________ Diagnosis:____

☐ Gastroenterologist - Date:___________ Diagnosis:____

☐ Stomach/intestinal problems, type:____

☐ Endocrinologist - Date:___________ Diagnosis:____

<u>Diagnosis Testing</u> (check all that apply)

☐ EEG (brain wave test) - Date:___________ Results:____

☐ MRI - Date:_____________ Results:____

☐ CT Scan - Date:____________ Results:____

☐ Ophthalmology Evaluation - Date:____________ Results:____________________________________

☐ Chromosomal/DNA testing (Genetic) - Date:__________ Results:_____________________________

☐ Other - Describe:____

<u>Medication History</u>

CURRENT medications **(PLEASE NOTE: <u>DO ADMINISTER</u> child's regularly scheduled medications, if any, on the day of your appointment.)**

Name of medication	Dose & Frequency	Date Started	Reason	Effectiveness

____

____

Who prescribes these medications?______________________ Date of last visit:__________

Please also list any medications your child has been on in the PAST:

Name of medication Dose & Frequency Date Started & Ended Reason Effectiveness

____

____

____

____

Who prescribed these medications?____

SCHOOL HISTORY

(If more space is necessary, please attach additional sheets or write on the back of this page.)

Current school:______________________________ School district:________________

Grade level:________ Type of class: ☐ Regular ed. ☐ Special ed. ☐ SDC ☐ ED ☐ RSP

Current # of: Students:______ Teachers:_____ Aides:______ Does your child has a 1:1 Aide?______

Has your child had special education testing in school? ☐ Yes ☐ No

☐ Psychological/Cognitive testing – Date:________ ☐ Academic testing – Date:_________

☐ Speech/Language testing – Date:________ ☐ Other testing – Date:_________

Is your child receiving any special education services at school? ☐ Yes ☐ No

Is your child on an IEP (Individual Education Plan)?_____ For what reason?________________

Please list all of the schools, including preschools, your child has attended:

Name of school Age/grade attended Hours per day Days per week

____

____

____

____

SERVICES – Please list services your child has received.

School District (Please bring copies of your most recent Individual Education Plan (IEP)

Child's age when school services began:________

Individual Education Plan (IEP) eligibility:_______________________________________

Which services is your child CURRENTLY receiving through the SCHOOL DISTRICT?

- ☐ Speech therapy
- ☐ Occupational therapy
- ☐ Physical therapy
- ☐ Adaptive physical education
- ☐ Discrete Trial Training (DDT/ABA)
- ☐ Social skills
- ☐ Other – Describe:____

____

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