Autism Screening Child/Family Intake

Patient Name: _____ Date:_____

Gender: _____ DOB: _____ Age:_____

Primary Language:_____ Secondary Language:_____

Childs address:_____

Primary phone #:_____ Alternate phone #:_____

Email address:_____

Allergies:_____

Special Diet (Ex. Gluten/Casein Free): _____

_

Diagnosis: _____

Parent/Caregiver Concerns: _____

_____

Parent/Caregiver goals for therapy treatment:_____

_____

Family information:

Parent/agency with legal custody:_____

Other individuals living in the household with child:

Name & Age	Relationship	Developmental Concerns
_____	_____	_____
_____	_____	_____

_____ _____ _____

Parent Allergies/ Dietary Restrictions:
_____

School Caregiver Information

Name of School/Daycare:_____Phone:_____

Contact Person:_____Days/Times attending:_____

Medical Information:

Pediatrician:_____ Practice:_____

Address:_____

Phone:_____ Fax_____

Last well visit:_____ Immunizations up to date?_____

Hx of seizures?_____ Hx of Asthma?_____

Other Doctors or Specialists following your child:
Allergist:_____
Audiologist:_____
Neurologist:_____
Developmental Pediatrician:_____
ENT:_____
Eye:_____
Gastro Intestinal:_____
Psychologist:_____
Other:_____

Medications/Supplements: Dosage/Frequency: Prescribing Physician:
_____
_____
_____
_____
_____
_____

Current Health Status:

Most recent hearing test: _____ Type:_____
Most Recent vision exam:_____ **Glasses**: y / n **Hearing Aid**: y / n
Current sleep patterns:_____
Urinary/Bowel:_____
Nutrition intake:_____

Birth History:

Any prenatal complications; if so, please specify: Ex: nutrition, diabetes, preeclampsia, drug, tobacco, or alcohol use._____
_____

Hospital of birth:_____

Type of delivery: _____Natural _____Induced _____C-section

Birth weight:_____

_____Premature _____Full-term _____Weeks Gestation

NICU stay? y / n Length of stay?_____

Reason for Stay:_____

Child's primary means of satiation: Breast Bottle Combination

Were any of the following problems present at birth? (if so explain)

___Required resuscitation _____
___Required oxygen_____
___Jaundice/ yellow_____
___Infection/ Sepsis_____
___Difficulty sucking or swallowing_____
___Fed by means other than bottle/breast (ie NG or G tube)_____
_____
___ Other (describe) _____

Child's health history: (Check any that apply and explain):

____Birth anomaly_____
___Ear Infections_____
___Swallowing/digestive (reflux, dysphagia, constipation)_____
___Sleep concerns_____
___Feeding concerns_____
___Visual concerns_____
___Hearing concerns_____
___Heart Concerns_____
___Lead Poisoning_____
___Communicable diseases(chicken pox, measles, CMV)_____
___Sinusitis/Tonsillitis_____

___Respiratory problems (asthma, pneumonia, croup)_____
___Head injury/ unconsciousness_____
___Seizures_____ Frequency_____ Duration_____
___Fractures_____
___Equipment_____
___Chronic Diagnosis_____
___Other_____

Please list any surgeries, ER visits, or hospitalizations (Include nature of visit, hospital, and when):

Developmental History:

Self help/gross/fine motor:
Age your child first self fed:_____
Age your child crawled:_____
Age your child began to walk:_____

Speech:
Age of first babble:_____
Age of first word:_____

Potty trained (if so at what age?) y / n _____

Current Skills:

Language: Check all that apply to your child:
_____non-verbal communication (Gesturing/Pointing)
_____ single words
_____ 2 word phrases
_____ Use full sentences/conversations
_____PECS/Augmentative Communication Device (Please list)_____

Social Skills: Check all that apply to your child:
_____Eye contact fleeting consistent (circle one)
_____Initiate play with others
_____Enjoy pretend play
_____Social games
_____Take turns

Sensory: Check all that apply to your child:
_____Demonstrate repetitive behaviors
_____Seek engagement through touch or movement
_____Avoid touching certain textures
_____Picky eater
_____Sensitive to noise or crowds

Behavior: Check all that apply to your child:
_____Difficulty with transitions
_____Resistant to change in routine
_____Tantrum more than expected for age
_____Respond to their name

Family History
Brief family history of parents and siblings, please check all that apply and explain:

___Congenital disorders_____
___Speech disorders_____
___Eating disorders_____
___Sleep disorders_____
___Psychological Dx (anxiety, depression, etc)_____
__ Other_____
_____

Please list any other habilitations or evaluations your child has had in the past (include when, where, frequency, duration, and reason) and please share with clinic:

What are your goals for you child?

Please list any concerns you have regarding your child's health and development:

Please list and explain any potential barriers to therapy (i.e transportation, chronic illness, financial, scheduling, etc)

If therapy is warranted what is your availability for scheduling?

Parent/Caregiver signature:_____ Date:_____
Evaluation Date:_____ Received by:_____