UW AUTISM CENTER INTAKE PACKET

Please complete this form to the best of your ability. We recognize that you may not have the answers to all questions. If you feel that there is not enough room or that you would like to elaborate further about a particular topic, please feel free to include it at the space provided at the end of the form. All information requested in this form is important and will allow us to provide you with the most accurate diagnosis and optimal treatment and care plans. Thank you for taking the time to complete it.

Reasons for Evaluation/ Treatment:

What are your primary patient concerns? Please be specific.

_________________________________________________________________________
_________________________________________________________________________
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What do you hope to gain from the evaluation/treatment services provided by the UW Autism Center?

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
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_________________________________________________________________________
Identifying Information and Healthcare Provider (for Child Patient)

1. Patient’s Name: __________________________  2. Patient’s Date of Birth: __________________________

3. Name of Person completing form: __________________________

   Please indicate your relationship to the patient:
   □ Parent ( □ Biological □ Adoptive □ Foster) □ Guardian □ Other, specify: __________________________

4. Please answer the following questions about the patient’s living situation:

   If the patient is a minor:
   Are the child’s parents Divorced/Separated?  □ No □ Yes
   If Divorced/Separated, who is responsible for medical decisions for the child?
   □ Joint □ Sole
   If Sole, which parent? __________________________

   With whom does the child reside?

   Household 1: ______% time
   Name of Parent or Guardian #1: __________________________
   Name of Parent or Guardian #2: __________________________
   Names, ages, and relation to child of all other individuals in the home:
   __________________________________________________________________________________________

   Household 2 (if applicable): ______% time
   Name of Parent or Guardian #1: __________________________
   Name of Parent or Guardian #2: __________________________
   Names, ages, and relation to child of all other individuals in the home:
   __________________________________________________________________________________________

   Are both parents aware of services being sought at the UW Autism Center? □ No □ Yes
   Does your child have a Guardian Ad Litem? □ No □ Yes
   If Yes, please provide their name: __________________________

   Names and ages of any other siblings (i.e. those not living with the child):
   __________________________________________________________________________________________

5. Primary Language: □ English □ Other, specify __________

   Percent time child is exposed to non-English language(s): _____%

6. Primary Care Physician: __________________________

   Clinic Name: __________________________ Phone Number: __________________________
   Address: __________________________

Patient’s Name: __________________________  Patient’s Date of Birth: __________________________  Date: __________________________
### Medical History

<table>
<thead>
<tr>
<th>Condition</th>
<th>No</th>
<th>Yes</th>
<th>Seizures</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing Loss</td>
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<tr>
<td>Vision or Eye Problems</td>
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<td></td>
<td>Sleep Problems</td>
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<tr>
<td>Birth Defects</td>
<td></td>
<td></td>
<td>Tics/ Movement Disorders</td>
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<tr>
<td>Chronic Stomach/Bowel Problems (i.e. constipation, diarrhea, vomiting, reflux)</td>
<td></td>
<td></td>
<td>Genetic Disorders (e.g. Fragile X, Tubercous Sclerosis, Down syndrome, Rett Syndrome, Neurofibromatosis)</td>
<td></td>
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<tr>
<td>Allergies (environmental, seasonal)</td>
<td></td>
<td></td>
<td>Other Medical Conditions</td>
<td></td>
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<tr>
<td>Multiple Ear Infections</td>
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<td></td>
<td>Autism/ASD</td>
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<tr>
<td>Frequent or Chronic Headaches</td>
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<td></td>
<td>ADHD/ADD</td>
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<tr>
<td>Head Abnormalities</td>
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<td></td>
<td>Depression</td>
<td></td>
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<tr>
<td>Chronic Heart Conditions/Disease</td>
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<td></td>
<td>Mania / Bipolar Disorder</td>
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<tr>
<td>Lung Disease (Asthma, other)</td>
<td></td>
<td></td>
<td>Obsessive-Compulsive Disorder</td>
<td></td>
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<tr>
<td>Kidney/Bladder/Genital Problems</td>
<td></td>
<td></td>
<td>Anxiety</td>
<td></td>
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<tr>
<td>Chronic Skin Problems</td>
<td></td>
<td></td>
<td>Schizophrenia</td>
<td></td>
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<tr>
<td>Hormone/ Growth Problems</td>
<td></td>
<td></td>
<td>Other Psychiatric Illnesses</td>
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</tr>
</tbody>
</table>

If you answered “Yes” to any of the above, please explain:

__________________________________________________________________________________

### Prior Medical Evaluations

1. Has the patient had any of the following evaluations?

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>No</th>
<th>Yes</th>
<th>Unsure</th>
<th>Normal</th>
<th>Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiologic Evaluation</td>
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<tr>
<td>Vision Evaluation</td>
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<tr>
<td>Head Imaging (MRI, CT or Ultrasound)</td>
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<td>EEG</td>
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<tr>
<td>Genetic Testing</td>
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<tr>
<td>Other Evaluations, Procedures, or Results</td>
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</tbody>
</table>

If any of the above were “Abnormal”, please explain:

__________________________________________________________________________________

2. Has the patient ever been hospitalized?   

No [ ]  Yes [ ]  If “Yes”, provide date & explanation ________________________________

3. Has the patient had any surgeries?  

No [ ]  Yes [ ]  ________________________________

4. Are the patient’s immunizations up to date?  

No [ ]  Yes [ ]  Unknown [ ]

Patient’s Name: ____________________  Patient’s Date of Birth: ___________  Date: ___________
Medications & Biomedical Interventions

1. Is the patient currently taking any medications (prescribed or over the counter), vitamins, or supplements?

<table>
<thead>
<tr>
<th>Medication, Vitamin, or Supplement Name</th>
<th>Purpose</th>
<th>Date Started</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

2. Does the patient follow any special diets or have special dietary needs?  
   If Yes, please explain: ________________________________  
   ____________________________________________________  

3. Please list any other biomedical interventions: __________________________________________________________  
   __________________________________________________________

4. Is the patient allergic to any medications?  
   ☐ No ☐ Yes  
   If “Yes”, please explain.  
   _______________________________________________________

5. Is the patient allergic to any foods?  
   ☐ No ☐ Yes  
   If “Yes”, please explain.  
   _______________________________________________________

Pregnancy & Birth History

1. How old were biological parents at time of the patient’s birth?  
   Biological mother: __________  
   Biological father: __________

2. How many times has biological mother been pregnant? ______

3. How many pregnancies have resulted in live births? _____

Pregnancy

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Were there fertility treatments to become pregnant with the patient?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. Was the patient part of a multiple birth pregnancy? (e.g., twins)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
| 3. Did the birth mother take any medications, vitamins or supplements during pregnancy?  
   If Yes, please specify below. | ☐ | ☐ | ☐ |
| 4. Did the birth mother use any alcohol, tobacco or recreational drugs during pregnancy?  
   If Yes, please specify below. | ☐ | ☐ | ☐ |
| 5. Were there any difficulties during pregnancy?  
   (e.g: bleeding, fever, infections, abdominal trauma, decrease in fetal movement)  
   If Yes, please specify below. | ☐ | ☐ | ☐ |

If “Yes” to any of the above, please explain:

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Patient’s Name: ___________________________  Patient’s Date of Birth: ___________  Date: ___________
Labor & Delivery and Neonatal Course

1. Was Pitocin used to induce or augment this labor?  ☐ No  ☐ Yes  ☐ Unknown
2. The delivery was:  ☐ Vaginal  ☐ By C-section  ☐ Unknown
   If C-Section, reason performed: ____________________________________________

3. Please provide the following information about the patient’s birth measurements:
   Birth weight: ______ lbs. & oz. / grams (circle one)
   APGAR scores (if known): _____ at 1 minute _____ at 5 minutes

4. Was the patient born premature?  ☐ No  ☐ Yes  ☐ Unknown
   If Yes, how many weeks premature? ______
5. Were there complications during labor or delivery?  ☐ No  ☐ Yes  ☐ Unknown
6. Was any special resuscitation required or was the patient admitted to the NICU? If Yes, how old was the client when discharged? _____ days

7. Did the patient experience any problems while still in the hospital? (e.g. feeding problems, breathing difficulties, infections, jaundice, seizures)
   ☐ No  ☐ Yes  ☐ Unknown

   If “Yes” to any of the above, please explain: ____________________________________________

Family History

1. Please indicate if anyone in the patient's biological family ever had any of these conditions (if so, please specify which family member, such as “mother,” “maternal grandmother,” “paternal uncle”).

<table>
<thead>
<tr>
<th>Condition:</th>
<th>Family Member(s)</th>
<th>Condition:</th>
<th>Family Member(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Problems</td>
<td></td>
<td>Hearing Problems</td>
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<tr>
<td>Epilepsy/Seizures</td>
<td></td>
<td>Tourette’s Syndrome</td>
<td></td>
</tr>
<tr>
<td>Genetic Disorders</td>
<td></td>
<td>Birth Defects</td>
<td></td>
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<tr>
<td>Multiple Miscarriages or Stillbirths</td>
<td></td>
<td>Childhood Deaths</td>
<td></td>
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<tr>
<td>Other Neurologic Disease</td>
<td></td>
<td>Other Chronic Illnesses</td>
<td></td>
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<tr>
<td>Intellectual Disability</td>
<td></td>
<td>Learning Difficulties</td>
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<tr>
<td>ASD (including autism, Asperger syndrome, &amp; PDD-NOS)</td>
<td></td>
<td>Speech &amp; Language Delays</td>
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<tr>
<td>Anxiety</td>
<td></td>
<td>Obsessive-Compulsive Disorder</td>
<td></td>
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<tr>
<td>ADD/ADHD</td>
<td></td>
<td>Depression</td>
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<tr>
<td>Bipolar Disorder</td>
<td></td>
<td>Schizophrenia</td>
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<tr>
<td>Psychotic Episodes</td>
<td></td>
<td>Suicide</td>
<td></td>
</tr>
<tr>
<td>Child Abuse</td>
<td></td>
<td>Delinquency</td>
<td></td>
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<tr>
<td>Other Conditions:</td>
<td></td>
<td>Other Conditions:</td>
<td></td>
</tr>
</tbody>
</table>
Developmental History

1. Has the patient accomplished each of the following developmental milestones?

<table>
<thead>
<tr>
<th>Milestone</th>
<th>No</th>
<th>Yes</th>
<th>If yes, approximate age (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smile When Smiled At</td>
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<tr>
<td>Pointing</td>
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<tr>
<td>Walk (Independently)</td>
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<tr>
<td>First Words other than Mama/Dada</td>
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<tr>
<td>First 2-3 Word Phrases</td>
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<tr>
<td>Toilet Training: Bladder</td>
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<td></td>
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<tr>
<td>Toilet Training: Bowel</td>
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<tr>
<td>Toilet Training: Night</td>
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<tr>
<td>Use of Spoon or Fork</td>
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</table>

2. Has the patient ever had loss or regression of a previously learned skill? (e.g., language, motor, or social skill) ☐ No ☐ Yes
   If Yes, please explain: ____________________________________________________________

Educational History

1. Is the patient currently enrolled in school? ☐ No ☐ Yes
   School Name: ___________________________ School District: ________________ Program or Grade level: ____________

2. Is the patient receiving or has the patient received special services or accommodations at school? ☐ No ☐ Yes
   If Yes, please explain what type: (e.g. IEP, IFSP, 504 Plan) __________________________________________

3. Please list any school testing and/or other evaluations of the patient’s learning skills:
   A. Name of Provider / Agency: ___________________________
      Type of Evaluation: ___________________________ Date(s): ________________
      Result: ________________________________________________________________
   
   B. Name of Provider / Agency: ___________________________
      Type of Evaluation: ___________________________ Date(s): ________________
      Result: ________________________________________________________________

4. Has the patient experienced any challenges related to reading, math or writing ☐ No ☐ Yes
   If Yes, please explain: ______________________________________________________

5. Are there concerns around the patient’s organization, flexibility or attention? ☐ No ☐ Yes
   If Yes, please explain: ______________________________________________________

Patient’s Name: ___________________________ Patient’s Date of Birth: ____________ Date: ____________
Behavioral & Social History

1. Please describe any behavioral concerns you have at this time:

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

2. Does the patient make friends easily? □ No □ Yes
   If “No”, please explain: ________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

3. Are there any concerns regarding the patient’s social skills or interests? □ No □ Yes
   If “Yes”, please explain: ________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

4. Are there any concerns regarding anxiety and/or depression? □ No □ Yes
   If “Yes”, please explain: ________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

5. Has the patient been exposed to any form of abuse, neglect or domestic violence? □ No □ Yes
   If “Yes”, please explain: ________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

6. Has the patient experienced any recent significant stressors (e.g. moves, losses)? □ No □ Yes
   If “Yes”, please explain: ________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
7. Are there concerns regarding any of the following areas?

<table>
<thead>
<tr>
<th>Area</th>
<th>No</th>
<th>Yes</th>
<th>If “Yes”, please explain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responding to sound</td>
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<tr>
<td>Responding to touch</td>
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<tr>
<td>Responding to light</td>
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<tr>
<td>Emotional reactions/regulation</td>
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<tr>
<td>Aggression Towards Others</td>
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<tr>
<td>Self-Injurious Behavior</td>
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<tr>
<td>Difficulty with Transitions</td>
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<tr>
<td>Understanding social cues (e.g. gestures, facial cues)</td>
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<tr>
<td>Eye contact</td>
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<tr>
<td>Inappropriate conversations</td>
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<tr>
<td>Inappropriate Behavior</td>
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<td></td>
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<tr>
<td>Ritualistic behavior</td>
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<tr>
<td>Repetitive behavior (e.g. hand flapping, rocking)</td>
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<tr>
<td>Fixation (e.g. computers, certain TV program, watching spinning toy)</td>
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<tr>
<td>Toileting</td>
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<tr>
<td>Other Concerns</td>
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</table>

8. What are the patient’s interests and hobbies?

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

9. What are some of the patient’s strengths?

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

**Additional Evaluations and Interventions**

1. Has the patient ever been seen by an Occupational Therapist, Speech and Language Therapist, Psychiatrist, Psychologist, or other mental health counselor?  ☐ No  ☐ Yes  ☐ Unknown

If yes, please provide the following information:

A. Name: __________________ Type of Specialist________________ Date of evaluation: ____________
   Purpose of Evaluation / Services: ________________________________________________________
   Results of Evaluation: ________________________________________________________________

B. Name: __________________ Type of Specialist________________ Date of evaluation: ____________
   Purpose of Evaluation / Services: ______________________________________________________
   Results of Evaluation: ________________________________________________________________

C. Name: __________________ Type of Specialist________________ Date of evaluation: ____________
   Purpose of Evaluation: ______________________________________________________________
   Results of Evaluation: ________________________________________________________________
Additional Comments

Please feel free to discuss any questions or concerns not covered above or to elaborate on anything in the space below:

_____________________________________________________________________________________
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