

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: _____

Medical History

Has the patient ever had or been diagnosed with any of the following conditions?

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

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

Prior Medical Evaluations

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

<u>Evaluation</u>				If yes, results?:	
	No	Yes	Unsure	Normal	Abnormal
Audiologic Evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision Evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head Imaging (MRI, CT or Ultrasound)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EEG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genetic Testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Evaluations, Procedures, or Results	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

- | | No | Yes | <u>If “Yes”, provide date & explanation</u> |
|--|--|--------------------------|--|
| 2. Has the patient ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3. Has the patient had any surgeries? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 4. Are the patient’s immunizations up to date? | <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown | | |

Patient’s Name: _____

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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?

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)

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").

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

Developmental History

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

	No	Yes	If yes, approximate age (years)
Smile When Smiled At	<input type="checkbox"/>	<input type="checkbox"/>	
Pointing	<input type="checkbox"/>	<input type="checkbox"/>	
Walk (Independently)	<input type="checkbox"/>	<input type="checkbox"/>	
First Words other than Mama/Dada	<input type="checkbox"/>	<input type="checkbox"/>	
First 2-3 Word Phrases	<input type="checkbox"/>	<input type="checkbox"/>	
Toilet Training: Bladder	<input type="checkbox"/>	<input type="checkbox"/>	
Toilet Training: Bowel	<input type="checkbox"/>	<input type="checkbox"/>	
Toilet Training: Night	<input type="checkbox"/>	<input type="checkbox"/>	
Use of Spoon or Fork	<input type="checkbox"/>	<input type="checkbox"/>	

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: _____

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: _____

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Date: _____

7. Are there concerns regarding any of the following areas?

	<u>No</u>	<u>Yes</u>	If "Yes", please explain
Responding to sound	<input type="checkbox"/>	<input type="checkbox"/>	
Responding to touch	<input type="checkbox"/>	<input type="checkbox"/>	
Responding to light	<input type="checkbox"/>	<input type="checkbox"/>	
Emotional reactions/regulation	<input type="checkbox"/>	<input type="checkbox"/>	
Aggression Towards Others	<input type="checkbox"/>	<input type="checkbox"/>	
Self-Injurious Behavior	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty with Transitions	<input type="checkbox"/>	<input type="checkbox"/>	
Understanding social cues (e.g. gestures, facial cues)	<input type="checkbox"/>	<input type="checkbox"/>	
Eye contact	<input type="checkbox"/>	<input type="checkbox"/>	
Inappropriate conversations	<input type="checkbox"/>	<input type="checkbox"/>	
Inappropriate Behavior	<input type="checkbox"/>	<input type="checkbox"/>	
Ritualistic behavior	<input type="checkbox"/>	<input type="checkbox"/>	
Repetitive behavior (e.g. hand flapping, rocking)	<input type="checkbox"/>	<input type="checkbox"/>	
Fixation (e.g. computers, certain TV program, watching spinning toy)	<input type="checkbox"/>	<input type="checkbox"/>	
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	
Other Concerns	<input type="checkbox"/>	<input type="checkbox"/>	

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: _____

Patient's Name: _____

Patient's Date of Birth: _____

Date: _____

Additional Comments

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