CLIENT INFORMATION AND INTAKE

Section A: KEY INDENTIFYING INFORMATION AND FAMILY BACKGROUND

A1. Date form completed …….. …… ☐☐ ☐☐ ☐☐☐☐
MM DD YYYY

A2. Client's name: _____ Client's Date of Birth _____

A3. Person completing form: _____

Please indicate your relationship to the client:

- ☐ Self
- ☐ Parent
- ☐ Conservator
- ☐ Other

If "Other", specify_____

A4. Is the client married? ☐ No ☐ Yes

If married, Spouse's name and age_____

A5. Does the client have any children? ☐ No ☐ Yes If yes, how many and ages _____

_____

A6. Who is responsible for making medical decisions for the client?

- ☐ Self
- ☐ Parent
- ☐ Conservator
- ☐ Other

If "Other", specify_____

Please provide all court documents prior to your first appointment

A7. What is the primary living arrangement for client?

- ☐ Independently
- ☐ Parent(s)
- ☐ Spouse
- ☐ Community Agency; name of Agency _____
- ☐ Other

If "Other", specify_____

A7a. Please list all members of the household in which the client lives: _____

_____

A7b. Please list other individuals significant to the client, who do not reside in the household: _

_____

A8. Please provide names and relationships of primary caregivers caring for the client: _____

_____

A9. Primary Language: ☐ English ☐ Spanish ☐ Other, specify _____

A10. Who is client's current Primary Care Physician? _____

A11. Please list the names of Client's siblings, in order of age:

Sibling's Name	Age	Step-sibling?		Adopted sibling?	
		No	Yes	No	Yes

Section B: PREGNANCY HISTORY

B1. Is the pregnancy history of the biological mother available? ☐ No ☐ Yes

If "No" skip to H1

B1a. Please indicate the number of pregnancies of the biological mother: _____

B1b. And the number of live births: _____

Section C: PREGNANCY & PERINATAL HISTORY

C1. Did the mother receive assisted reproductive technology? ☐ No ☐ Yes ☐ Unsure

C2. Mother's age at birth of child: _____Years ☐ Don't Know

C3. Father's age at birth of child: _____Years ☐ Don't Know

Section D: ILLNESS/EVENTS DURING PREGNANCY

Please indicate whether the mother had any of the following illnesses/events during the pregnancy with the client:

D1. Fever over 101˚F (Exclude those occurring during labor & delivery) ☐ No ☐ Yes ☐ Unsure

D2. Any infection: ☐ No ☐ Yes ☐ Unsure

D3. Any other complications: ☐ No ☐ Yes ☐ Unsure

Section E: MEDICATIONS DURING PREGNANCY

E1. During this pregnancy, did the mother take any prescription medications? ☐ No ☐ Yes

If "Yes", complete the information below:

Prescription Medication	No	Yes	Unsure
E1a. Depakote: (Depakene, Valproic Acid)	☐	☐	☐
E1b. Lithium:	☐	☐	☐
E1c. Anti-epileptics or anti-seizures: (not including Depakote) e.g. Carbamazepine (Tegretol, Carbatrol),Gabapentin (Neurontin), Lamotrigine (Lamictal),Levetiracetam (Keppra), Oxcarbazepine (Trileptal),Phenobarbital, Phenytoin (Dilantin), Topiramate (Topamax)	☐	☐	☐

	No	Yes	Unsure
E1d. Antidepressants: e.g., Amitriptyline (Elavil), Bupropion (Wellbutrin), Citalopram (Celexa), Escitalopram (Lexapro), Fluoxetine (Prozac), Fluvoxamine (Luvox), Imipramine (Tofranil), Paroxetine (Paxil), Sertraline (Zoloft),Venlafaxine (Effexor)	☐	☐	☐
E1e. Mood stabilizers or antipsychotics:	☐	☐	☐

(not including Lithium)
e.g., Carbamazepine (Carbatrol, Tegretol), Chlorpromazine (Thorazine), Gabapentin(Neurontin), Haloperidol (Haldol), Lamotrigine(Lamictal), Olanzapine (Zyprexa), Oxcarbazepine (Trileptal), Quetiapine (Seroquel), Risperidone (Risperdal), Thioridazine (Mellaril), Topiramate (Topamax)

E1f. Asthma medication: ☐ ☐ ☐

e.g., Fluticasone (Flovent), Budesonide (Pulmicort),Triamcinolone (Azmacort), Flunisolide (Aeobid),Beclomethasone (Qvar), Ipratropium (Atrovent),Salmterol (Serevent Diskus), Cromolyn (Latal), Formoterol (Foradil Aerolizer), Nedocrmi (Tilade),Montelukast (Singulair), Zafirlukast (Accolate)

E1g. Other:
If "Other", specify: _____

Section F: PRE-NATAL SUBSTANCE USE

Note: Please be aware that all information shared is kept strictly confidential

During the pregnancy with the client, please indentify whether the mother participated in any of the following activities:

F1. Alcohol Use: ☐ No ☐ Yes ☐ Unsure

F2. Use of cigarettes or other tobacco products ☐ No ☐ Yes ☐ Unsure

F3. Other substance use, specify: _____ ☐ No ☐ Yes ☐ Unsure

Section G: LABOR & DELIVERY

G1. Was the client a product of a multiple birth pregnancy? ☐ No ☐ Yes
If "No", skip to G2

If "Yes", were the multiple births: ☐ Twins ☐ Other Multiple
If "Twins", what type: ☐ Identical ☐ Fraternal ☐ Unsure

G2. Was Pitocin used to induce or augment this labor? ☐ No ☐ Yes ☐ Unsure

G3. Any labor or delivery complications? ☐ No ☐ Yes ☐ Unsure
If "Yes", describe: _____

G4. How much did client weigh at birth? ___ ___lbs ___ ___oz OR ___.____kg
Enter in pounds and ounces OR kilograms

G5. Was the client admitted to the NICU (neonatal intensive care unit)? ☐ No ☐ Yes ☐ Unsure

If "Yes"

G5a. For what reason? _____

G5b. How old was client when discharged from the NICU: _____ _____ _____ days

Section H: NEWBORN PROBLEMS AND DEVELOPMENT

Instructions: Answer sections H-M questions with respect to the child

H1. Was client initially breast or bottle fed? ☐ Bottle ☐ Breast ☐ Both

H2. If breastfed did client have any feeding difficulty during his/her first month of life? (e.g. difficulty latching on) ☐ No ☐ Yes ☐ Unsure

Section I: DEVELOPMENT HISTORY

Please specify when/if the client accomplished any of the following (If "Yes", please provide your best estimate of the age achieved. If unsure of age, white "unsure")

		a. Achieved? No	a. Achieved? Yes	b. If "Yes" age achieved	
I1.	Sit (without support when placed):	☐	☐	___ ___ ___	Months
I2.	Walk (without holding up):	☐	☐	___ ___ ___	Months
I3.	First words (other than mama/dada):	☐	☐	___ ___ ___	Months
I4.	First phrases (2-3 words):	☐	☐	___ ___ ___	Months
I5.	Toilet training: day, bladder	☐	☐	___ ___ ___	Months
I6.	Toilet training: day, bowel	☐	☐	___ ___ ___	Months
I7.	Toilet training: night, bladder	☐	☐	___ ___ ___	months

Section J: PAST MEDICAL HISTORY/HEALTH CONDITION

Directions: For each condition or symptom listed below, please **check** the extent to which it has been a health problem for client.

		No Problem	Mild Problem (infrequent/ resolved)	Moderate Problem (recurrent/ affects life)	Severe Problem (frequent/ impacts quality of life)
J1.	Head of skull abnormalities				
	J1a. Large head	☐	☐	☐	☐
	J1b. Misshapen	☐	☐	☐	☐
	J1c. Open soft spot	☐	☐	☐	☐
	J1d. Other, specify: _____	☐	☐	☐	☐
J2.	Headaches	☐	☐	☐	☐
J3.	Eye Conditions				
	J3a. Near sighted	☐	☐	☐	☐
	J3b. Far sighted	☐	☐	☐	☐
	J3c. Lazy eye	☐	☐	☐	☐
	J3d. Other, specify: _____	☐	☐	☐	☐
J4.	Ear conditions				
	J4a. Infections	☐	☐	☐	☐
	J4b. Hearing	☐	☐	☐	☐
	J4c. Other, specify: _____	☐	☐	☐	☐
J5.	Nose problems				
	J5a. Sinus infections	☐	☐	☐	☐
	J5b. Blockage	☐	☐	☐	☐
	J5c. Other, specify: _____	☐	☐	☐	☐

		No Problem	Mild Problem (infrequent/ resolved)	Moderate Problem (recurrent/ affects life)	Severe Problem (frequent/ impacts quality of life)
J6.	Lip or Throat problems				
	J6a. Infections	☐	☐	☐	☐
	J6b. Large tonsils	☐	☐	☐	☐
	J6c. Cleft lip or palette	☐	☐	☐	☐
	J6d. Other, specify: _____	☐	☐	☐	☐
J7.	Dental problems				
	J7a. Cavities	☐	☐	☐	☐
	J7b. Enamel	☐	☐	☐	☐
	J7c. Routine checkups	☐	☐	☐	☐
	J7d. Other, specify: _____	☐	☐	☐	☐
J8.	Heart Conditions				
	J8a. Murmur	☐	☐	☐	☐
	J8b. Hole in heart or structural problem	☐	☐	☐	☐
	J8c. Rapid rate	☐	☐	☐	☐
	J8d. Other, specify: _____	☐	☐	☐	☐
J9.	Lung conditions				
	J9a. Asthma	☐	☐	☐	☐
	J9b. Pneumonia	☐	☐	☐	☐
	J9c. Bronchitis	☐	☐	☐	☐
	J9d. Other, specify: _____	☐	☐	☐	☐
J10.	Breast enlargement or milk discharge	☐	☐	☐	☐
J11.	Stomach problems				
	J11a. Vomiting	☐	☐	☐	☐
	J11b. Reflux	☐	☐	☐	☐
	J11c. Diarrhea	☐	☐	☐	☐
	J11d. Constipation	☐	☐	☐	☐
	J11e. Pain	☐	☐	☐	☐
	J11f. Other, specify: _____	☐	☐	☐	☐
J12.	Kidney, Bladder, or Urine problems				
	J12a. Infections	☐	☐	☐	☐
	J12b. Stones	☐	☐	☐	☐
	J12c. Urine reflux	☐	☐	☐	☐
	J12d. Day or nighttime wetting	☐	☐	☐	☐
	J12e. Other, specify: _____	☐	☐	☐	☐

		No Problem	Mild Problem (infrequent/ resolved)	Moderate Problem (recurrent/ affects life)	Severe Problem (frequent/ impacts quality of life)
J13.	Genital problems				
	J13a. Hernia	☐	☐	☐	☐
	J13b. Undescended testicle	☐	☐	☐	☐
	J13c. Other, specify: _____	☐	☐	☐	☐
J14.	Bone or Joint problems				
	J14a. Spine curvature	☐	☐	☐	☐
	J14b. Arthritis	☐	☐	☐	☐
	J14c. Osteoporosis	☐	☐	☐	☐
	J14d. Club foot	☐	☐	☐	☐
	J14e. Other, specify: _____	☐	☐	☐	☐
J15.	Skin Conditions				
	J15a. Eczema	☐	☐	☐	☐
	J15b. Psoriasis	☐	☐	☐	☐
	J15c. Moles	☐	☐	☐	☐
	J15d. Café au lait	☐	☐	☐	☐
	J15e. Rash	☐	☐	☐	☐
	J15f. Acne	☐	☐	☐	☐
	J15g. Other, specify: _____	☐	☐	☐	☐
J16.	Endocrine or hormone problems				
	J16a. Diabetes	☐	☐	☐	☐
	J16b. Thyroid	☐	☐	☐	☐
	J16c. Early or late puberty	☐	☐	☐	☐
	J16d. Menstrual problems	☐	☐	☐	☐
	J16e. Other, specify: _____	☐	☐	☐	☐
J17.	Growth problem				
	J17a. Short stature	☐	☐	☐	☐
	J17b. Growth hormone	☐	☐	☐	☐
	J17c. Over or under weight	☐	☐	☐	☐
	J17e. Other, specify: _____	☐	☐	☐	☐
J18.	Tics or movement disorders				
	J18a. Tourettes	☐	☐	☐	☐
	J18b. Eye blinking	☐	☐	☐	☐
	J18c. Shrugging	☐	☐	☐	☐

		No Problem	Mild Problem (infrequent/ resolved)	Moderate Problem (recurrent/ affects life)	Severe Problem (frequent/ impacts quality of life)
	J18d. Head movements	☐	☐	☐	☐
	J18e. Tongue movements	☐	☐	☐	☐
	J18f. Hand wringing	☐	☐	☐	☐
	J18g. Coordination or gait problems	☐	☐	☐	☐
	J18h. Other, specify: _____	☐	☐	☐	☐
J19.	Allergies				
	J19a. Foods, specify: _____	☐	☐	☐	☐
	J19b. Medications, specify: _____	☐	☐	☐	☐
	J19c. Environmental, specify: _____	☐	☐	☐	☐
J20.	Loss of previous acquired skill				
	J20a. Language, specify: _____	☐	☐	☐	☐
	J20b. Motor, specify: _____	☐	☐	☐	☐
	J20c. Academic, specify: _____	☐	☐	☐	☐
J21.	Seizures				
	J21a. Staring spells	☐	☐	☐	☐
	J21b. Rhythmic jerking	☐	☐	☐	☐
	J21c. Febrile seizures	☐	☐	☐	☐
	J21d. Other diagnosed seizures	☐	☐	☐	☐
	J21e. Other, specify: _____	☐	☐	☐	☐
J22.	Previously diagnosed psychiatric illness				
	J22a. Anxiety	☐	☐	☐	☐
	J22b. Depression	☐	☐	☐	☐
	J22c. Manic	☐	☐	☐	☐
	J22d. Obsessive/compulsive	☐	☐	☐	☐
	J22e. ADHD	☐	☐	☐	☐
	J22f. Schizophrenia	☐	☐	☐	☐
	J22g. Other, specify: _____	☐	☐	☐	☐
J23.	Eating or craving non food items Specify item(s): _____	☐	☐	☐	☐

			Mild	Moderate	Severe

		No Problem	Problem (infrequent/ resolved)	Problem (recurrent/ affects life)	Problem (frequent/ impacts quality of life)
J24.	Was client born with any birth defects not noted above?	No ☐	Yes ☐	Unsure ☐	
	J24a. If “Yes”, specify: _____				
J25.	Has client ever had a hearing test by an audiologist?	No ☐	Yes ☐	Unsure ☐	
J25a. If “Yes”, what were the results of the most recent test?			Normal ☐	Abnormal ☐	Unsure ☐
J26.	Has client ever had a brain stem test (ABR) done for hearing?	No ☐	Yes ☐	Unsure ☐	
	J26a. If “Yes”, what were the results of the most recent test?	Normal ☐	Abnormal ☐	Unsure ☐	

Please indicate whether client has ever been diagnosed with or suspected of having any of the following genetic conditions:

		Never Diagnosed	Suspected of Having	Diagnosed	Unsure
J27.	Tuberous sclerosis (TS)	☐	☐	☐	☐
J28.	Down Syndrome	☐	☐	☐	☐
J29.	Rett Syndrome	☐	☐	☐	☐
J30.	Fragile X	☐	☐	☐	☐
J31.	Neurofibromatosis	☐	☐	☐	☐
J32.	Other Genetic condition If “other”, specify_____	☐	☐	☐	☐

Please indicate whether client has ever been diagnosed with or suspected of having any of the following Psychiatric disorders

		Never Diagnosed	Suspected of Having	Diagnosed	Unsure
J33.	Bipolar Mood Disorder	☐	☐	☐	☐
J34.	Anxiety Disorder	☐	☐	☐	☐
J35.	Obsessive Compulsive Disorder (OCD)	☐	☐	☐	☐
J36.	Attention Deficit Hyperactivity Disorder (ADHD)	☐	☐	☐	☐
J37.	Other Psychiatric disorder If "Other", specify _____	☐	☐	☐	☐

J39. Has client ever been hospitalized? ☐ No ☐ Yes ☐ Unsure

J39a. Record from most recent hospitalizations backwards; if client has been hospitalized more than 3 times, please only include the most recent three incidents.

Hospitalization 1:

a. Date of Hospitalization: _____/____/_____
b. Reason: _____
c. Number of days hospitalized: _____

Hospitalization 2:

a. Date of Hospitalization: _____/____/_____
b. Reason: _____
c. Number of days hospitalized: _____

Hospitalization 3:

a. Date of Hospitalization: _____/____/_____
b. Reason: _____
c. Number of days hospitalized: _____

J40. Please indicate whether client is currently taking any medications

Medication	Dosage	Reason for taking	Length of time on Medication	Side effects

Section K: IMMUNIZATION RECORD

K1. Is client up to date on immunizations? ☐ No ☐ Yes ☐ Unsure

Section L: FAMILY HISTORY

Instructions: The questions below ask about the family history of the client. Please indicate if there is a family history of the disorder. If "Yes", indicate which family member(s). Include only biological (blood) relatives.

	Disorder	No	Yes	Unsure	If "Yes", specify all as related to the child	
L1.	Autistic Disorder (not including Asperger's disorder or Pervasive Developmental disorder, not otherwise specified)	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Child
	Disorder	No	Yes	Unsure	If "Yes", specify all as related to the child	
L2.	Asperger's Disorder	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Child
L3.	Pervasive Developmental Disorder, not otherwise specified (PDD-NOS)	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Child
L4.	Rett Syndrome	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Child
L5.	Intellectual Disability	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Child
L6.	Speech language disorder, received speech therapy	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Child
L7.	ADHD	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother

					☐ Cousin	☐ Child
L8.	Anxiety Disorder or Obsessive Compulsive Disorder	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Child
L9.	Depression	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Child
L10.	Manic depression or Bipolar disorder	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Child
L11.	Schizophrenia	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Child
L12.	Seizures	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Child
L13.	Neurofibromatosis	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Child
L14.	Fragile X	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Child
L15.	Tuberous Sclerosis	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Child
L16.	Auto-Immune disorders (e.g. Lupus, Rheumatoid Arthritis,	☐	☐	☐	☐ Grandmother ☐ Mother	☐ Grandfather ☐ Father

	Multiple Sclerosis)				☐ Aunt ☐ Sister ☐ Cousin	☐ Uncle ☐ Brother ☐ Child
L17.	Inflammatory Bowel Disease (e.g. Crohn's or Ulcertative Colitis)	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Child
L18.	Other condition that is in two or more generations: If "Yes", specify _____	☐	☐	☐	☐ Grandmother ☐ Mother ☐ Aunt ☐ Sister ☐ Cousin	☐ Grandfather ☐ Father ☐ Uncle ☐ Brother ☐ Child

Section M: LABS, IMAGING, EEG

Please indicate whether client has ever had any of the following procedures:

M1.	Karyotype	☐ No	☐ Yes	☐ Unsure
M2.	Fragile X DNA	☐ No	☐ Yes	☐ Unsure
M3.	CGH Microarray	☐ No	☐ Yes	☐ Unsure
M4.	Testing for Rett Syndrome (MECP2)	☐ No	☐ Yes	☐ Unsure
M5.	Plasma Amino Acids	☐ No	☐ Yes	☐ Unsure
M6.	Urine for Organic Acids	☐ No	☐ Yes	☐ Unsure
M7.	Uric Acid	☐ No	☐ Yes	☐ Unsure
M8.	MRI of the brain	☐ No	☐ Yes	☐ Unsure
M9.	EEG	☐ No	☐ Yes	☐ Unsure
M10.	Sleep Study	☐ No	☐ Yes	☐ Unsure
M11.	Lead Screening	☐ No	☐ Yes	☐ Unsure

Section N: BEHAVIORAL/SOCIAL HISTORY

N1. List any behavioral concerns you have at this time: _____

_____

N2. Has client been aggressive to an adult or child in the last 3 months? ☐ No ☐ Yes, If "Yes", how?_____

_____

N3. Has client engaged in any self injurious behavior? ☐ No ☐ Yes, If "Yes", please explain:

_____

N4. Does client make friends easily? ☐ No ☐ Yes If "No", please explain: _____

_____

_____

N5. Do you have any concerns regarding client's social skills or interests? ☐ No ☐ Yes,
If "Yes", please explain: _____

_____

_____

N6. Do you have any concerns regarding anxiety and/or depression? ☐ No ☐ Yes, If "Yes", please explain: _____

_____

N7. Has client been exposed to any form of abuse, neglect, or domestic violence? ☐ No ☐ Yes,
If "Yes", please explain: _____

_____

N8. What is your client's favorite toy or free-time activity? _____

_____

N9. Has client experienced any recent significant stressors (e.g. moves, losses)? ☐ No ☐ Yes,
If "Yes" please explain: _____

_____

Section O: COGNITIVE/LEARNING/SCHOOL PLACEMENT

O1. Has client been evaluated by a specialist such as a neurologist, psychiatrist, psychologist, geneticist, or developmental pediatrician? ☐ No ☐ Yes

Name & Type of Specialist	Date/Purpose of Evaluation	Results of Evaluation

O2. Is client in school? ☐ No ☐ Yes (If no, proceed to next section)

O1a. School Name: _____

O1b. School District: _____

O1c. What type of program: _____

O3. Is client currently or has he/she in the past received special services or accommodations at school?

☐ No ☐ Yes If "Yes" what type (e.g. IEP, IFSP, 504 plan)? _____

O4. Please list school testing and/or other evaluations of client's learning skills:

Type of Evaluation	Name of Provider/Agency	Phone Number

O5. Please list services client *currently* receives outside of school/privately (e.g. OT, SLP):

Type of Service	Name of Provider/Agency	Phone Number

O6. Has client experienced any challenges related to reading, math, or writing? ☐ No ☐ Yes,
If "Yes", please explain: _____

O7. Do you have any concerns with client's organization, flexibility, or attention? ☐ No ☐ Yes,
If "Yes", please explain: _____

Section P: OTHER INFORMATION

P1. Do you have any concerns about client in the following areas? For all "Yes" answers, please explain.

	No	Yes	If "Yes", please explain
Responding to sound	☐	☐	
Responding to touch	☐	☐	
Responding to light	☐	☐	
Emotional reactions	☐	☐	
Transitions	☐	☐	
Eye contact	☐	☐	
Toileting	☐	☐	
Ritualistic behavior	☐	☐	
Inappropriate conversations	☐	☐	
Understanding social cues (e.g. gestures, facial cues)	☐	☐	
Repetitive behavior (e.g. hand flapping, rocking)	☐	☐	
Fixation (e.g. computers, certain TV program, watching spinning toy)	☐	☐	
Anger	☐	☐	
Aggression	☐	☐	

Section Q: EMPLOYMENT HISTORY

Q1. Has the client had paid employment? ☐ No ☐ Yes

Q2. Is the client currently employed? ☐ No ☐ Yes

If, Yes:

Q2a. Current place of employment _____

Q2b. Length of employment _____

Q2c. Current job responsibilities _____

_____

_____

Q2d. Previous place of employment _____

Q2e. Length of employment _____

Q2f. Previous job responsibilities _____

_____

_____

Q3. Has client ever had any vocational/career training? ☐ No ☐ Yes If, yes please specify _____

_____

_____

_____

Q4. What type of occupational difficulties is the client experiencing (if any) _____

_____

_____

_____

_____

Q5. What type of support does the client need to stay employed or to become employed? _____

_____

_____

_____

_____

_____

_____