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 this 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 this form.

Child Information

Child's Name: _____

Date of Birth: _____

Today's Date: _____

Family Information

Primary Caregiver's name(s): _____

Person completing this form: _____
(If different than primary caregiver, please include relationship to patient)

Other household members:

Name	Age/Relationship to child

Are the child's parents Divorced/Separated/Never Married? ☐ **No** ☐ **Yes**

If Divorced/Separated, who is responsible for medical decisions for the child? ☐ **Joint** ☐ **Sole**

If Sole, which parent?

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:

Primary Language: ☐ English ☐ Other, specify _____

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

How would you like UWAC to refer to your child's race/ethnicity? _____

Intake Information

What are your primary concerns about your child's development? Please be specific.

What are your child's strengths/interests?

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

Medical Information

Primary Care Physician: _____

Clinic Name: _____

Clinic Address: _____

Is the child currently enrolled in 0-3 services, speech therapy, motor therapy, etc.? ☐ No ☐ Yes

Clinic Name: _____

1. Has the child ever experienced or been diagnosed with any of the following conditions?

	No	Yes		No	Yes
Hearing Loss	☐	☐	Seizures	☐	☐
Vision or Eye Problems	☐	☐	Sleep Problems	☐	☐
Birth Defects	☐	☐	Tics/ Movement Disorders	☐	☐

Chronic Stomach/Bowel Problems (ie: constipation, diarrhea, vomiting, reflux)	☐	☐	Genetic Disorders (e.g. Fragile X, Tuberous Sclerosis, Down syndrome, Rett Syndrome, Neurofibromatosis)	☐	☐
Allergies (environmental, seasonal)	☐	☐	Autism/ASD	☐	☐
Multiple Ear Infections	☐	☐	Other Medical Conditions	☐	☐
Head Abnormalities	☐	☐	_____		
			_____		
			_____		
Hormone/ Growth Problems	☐	☐	_____		

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

Medication, Vitamin, or Supplement Name	Purpose

Family History

1. Please indicate if anyone in the child'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)
Genetic Disorders		Learning Difficulties	
Intellectual Disability		Speech & Language Delays	
ASD (including autism, Asperger syndrome, & PDD-NOS)		Obsessive-Compulsive Disorder	
Anxiety		Depression	
ADD/ADHD		Schizophrenia	
Bipolar Disorder		Other Chronic Illnesses (specify)	
Psychotic Episodes		Other Neurologic Disease or Mental Disorder (specify)	
Birth Defects			

Additional Comments

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