Form Completed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

## Client’s Information

|  |
| --- |
| Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_What name does he/she go by? \_\_\_\_\_\_\_\_\_\_\_\_ |
|

|  |  |
| --- | --- |
| Race/Ethnicity[ ]  American Indian or Alaskan Native[ ]  Asian or Asian-American[ ]  Black or African-American | [ ]  Pacific Islander[ ]  White or Caucasian[ ]  Hispanic or Latino  |

 | Gender[ ]  Male[ ]  Female |

## Family Information

|  |
| --- |
| **Home Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Street) (City) (Zip Code) |
| **Father:** | Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Age: \_\_\_\_\_\_ | Education: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Business Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Email Address (Optional): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Mother:** | Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Age: \_\_\_\_\_\_ | Education: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Business Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Email Address (Optional): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Parents Are:** [ ]  Married [ ]  Divorced [ ]  Separated [ ]  Widowed [ ]  Single, never marriedDate: **\_\_\_\_\_** Date: **\_\_\_\_\_** Date: **\_\_\_\_\_** Date: **\_\_\_\_\_**  [ ]  Other: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** (Please explain) |
| **Client’s Legal Guardian:**[ ]  Both Birth Parents [ ]  Birth Mother [ ]  Birth Father [ ]  Adoptive Parents [ ]  Department of Human Resources (DHR) [ ]  Other Legal Guardian |
| List all the individuals and their relationship to the client (including parents) who are currently living in the home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| List information about all of the client’s siblings below:  |
|

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Age | Full/Half/Step/Adopted | Learning or Medical Diagnosis |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

 |
| Is this a foster home placement? [ ]  Yes [ ]  No If yes, age at placement? \_\_\_\_\_\_\_\_ |
| Adopted? [ ]  Yes [ ]  No If yes, age at placement? \_\_\_\_\_\_\_\_ |
| Are there any custody issues? [ ]  Yes [ ]  No If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If applicable, what are the custody or visitation arrangements? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Has the Department of Human Resources (DHR) ever been involved with this client? [ ]  Yes [ ]  NoDates of DHR involvement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reason(s) for DHR involvement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

## Referral Information & Primary Concerns

|  |
| --- |
| Who referred you to the University of Alabama Autism Clinic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| What is their phone number? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|

|  |  |
| --- | --- |
| **Chief problems as you see them** | **When did this problem begin?** |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |
| 5. |  |

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**Physician Information**

|  |  |
| --- | --- |
| **Client’s Pediatrician or Physician:** | Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Current Medication(s)** | **Prescriber** | **Dose** | **Reason for Medication** |
|

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 |
| **Past Medication(s)** | **Prescriber** | **Dose** | **When/Why Stopped** |
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**Current Weight**: \_\_\_\_\_\_\_\_\_ |

## Client’s Medical History

|  |
| --- |
| **Mark “yes” for any illness the client has had.** |
| Meningitis | [ ]  Yes [ ]  No  |  | Sleep Problems | [ ]  Yes [ ]  No |
| Encephalitis | [ ]  Yes [ ]  No  |  | Draining Ear(s) | [ ]  Yes [ ]  No |
| Hay Fever | [ ]  Yes [ ]  No  |  | Asthma | [ ]  Yes [ ]  No |
| Frequent Ear Infections | [ ]  Yes [ ]  No  |  | Growth Problems | [ ]  Yes [ ]  No |
| Allergies  | [ ]  Yes [ ]  No  |  | Other injuries | [ ]  Yes [ ]  No |
| Convulsions/Seizures | [ ]  Yes [ ]  No  |  | Other illness(es) | [ ]  Yes [ ]  No |
| Head Injury | [ ]  Yes [ ]  No  |  | Hospitalizations | [ ]  Yes [ ]  No |
| Pneumonia | [ ]  Yes [ ]  No  |  | Operations/Surgeries | [ ]  Yes [ ]  No |
| Tonsillitis | [ ]  Yes [ ]  No  |  |  |  |
| In the space below, describe each illness marked “yes” (e.g., when it occurred, the client’s age, did it require hospitalization, etc.) and any other specific **medical diagnosis** or **significant health problems** the client has.

|  |
| --- |
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**Previous Evaluations**

|  |
| --- |
| Please provide the following information regarding specialists who might have evaluated the client. If “yes”, please provide additional information to the right:  |
| **Type of Service Provider** | **Agency/Provider’s Name and Full Address** | **Date(s) Seen** |
| Neurologist | [ ]  Yes [ ]  No |  |  |
| Psychiatrist | [ ]  Yes [ ]  No |  |  |
| Psychologist | [ ]  Yes [ ]  No |  |  |
| Eye Specialist | [ ]  Yes [ ]  No |  |  |
| Hearing Specialist | [ ]  Yes [ ]  No |  |  |
| Speech/Language Pathologist | [ ]  Yes [ ]  No |  |  |
| Occupational Therapist | [ ]  Yes [ ]  No |  |  |
| Physical Therapist | [ ]  Yes [ ]  No |  |  |
| Geneticist | [ ]  Yes [ ]  No |  |  |
| Other (specify): |  |  |
| Other (specify): |  |  |
| If the client had any previous psychological, psychiatric, neurological, CT, MRI, or EEG evaluations completed, please list the type of evaluation and the date of the evaluation below. Evaluation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_ Evaluation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_ Evaluation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_ Evaluation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_ Please indicate your understanding of the results from any previous testing listed above:

|  |  |  |
| --- | --- | --- |
| Has the client’s hearing been tested?  | [ ]  Yes [ ]  No | What were the results?  |
| Has the client’s vision been tested?  | [ ]  Yes [ ]  No | What were the results? |

P |

**Treatment History**

|  |  |  |
| --- | --- | --- |
| Is your child **currently** in counseling or therapy?  | [ ]  Yes [ ]  No | If yes, what is or was the focus of treatment?  |
| Has your child **ever** been in counseling or therapy? | [ ]  Yes [ ]  No |
| Has the client ever been hospitalized or placed in residential treatment for mental health or behavioral concerns? If yes: When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason(s) for admission: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Recommendation(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

## General Health & Adjustment

|  |
| --- |
| **Sleeping** |
| Typical Bedtime: \_\_\_\_\_\_\_\_\_\_\_ | Average Hours of Sleep Per Night: \_\_\_\_\_\_\_\_\_\_\_ |
| Any Problems: [ ]  Falling asleep [ ]  Waking up during the night [ ]  Waking up in the morning |
| Are there any nightmares or night terrors now or in the past? [ ]  Yes [ ]  No  |
| If yes, please explain:  |
| **Eating** |
| Is the client on a special diet?  | If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Does he/she take nutritional supplements? | If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Is he/she a “picky eater”? | If yes, what will he/she eat? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Please describe anything else about the client’s current eating habits:  |

## Has the client been given any of the following diagnoses?

|  |  |  |
| --- | --- | --- |
|  |  | If yes, when and by whom? |
| Autism Spectrum Disorder | [ ]  Yes [ ]  No |  |
| Asperger’s Disorder | [ ]  Yes [ ]  No |  |
| Fine Motor Delays | [ ]  Yes [ ]  No |  |
| Sensory Integration Disorder | [ ]  Yes [ ]  No |  |
| Articulation Delays | [ ]  Yes [ ]  No |  |
| Receptive or Expressive Language Disorder | [ ]  Yes [ ]  No |  |
| Social Pragmatic Communication Disorder  | [ ]  Yes [ ]  No |  |
| Intellectual Disability or Mental Retardation  | [ ]  Yes [ ]  No |  |
| Learning Disability | [ ]  Yes [ ]  No |  |
| Attention Deficit/Hyperactivity Disorder | [ ]  Yes [ ]  No |  |
| Anxiety or Excessive Worries or Fears | [ ]  Yes [ ]  No |  |
| Tics or Involuntary Movements | [ ]  Yes [ ]  No |  |
| Depression | [ ]  Yes [ ]  No |  |
| Obsessive-Compulsive Disorder | [ ]  Yes [ ]  No |  |
| Oppositional Defiant Disorder | [ ]  Yes [ ]  No |  |
| Disruptive Behavior Disorder | [ ]  Yes [ ]  No |  |
| Conduct Disorder | [ ]  Yes [ ]  No |  |
| Mania/Bipolar Disorder | [ ]  Yes [ ]  No |  |
| Psychosis/Schizophrenia | [ ]  Yes [ ]  No |  |

## Birth History

|  |  |  |
| --- | --- | --- |
| Were you taking medication during pregnancy?  | [ ]  Yes [ ]  No | If yes, what medications: |
| Were you under anesthesia during delivery?  | [ ]  Yes [ ]  No |  |
| Delivery Method  | [ ]  Vaginal [ ]  C-Section |
| Was labor induced?  | [ ]  Yes [ ]  No | If induced, please explain:  |
| If yes, was the induction planned? | [ ]  Yes [ ]  No |
| Was the delivery unusual in any way?  | [ ]  Yes [ ]  No | If yes, please explain:  |
| Did you have twins?  | [ ]  Yes [ ]  No | If yes, who was born first: \_\_\_\_\_\_\_\_\_\_ |
| **Check any of the following that the baby experienced:**  |
| Breathing problems | [ ]  Yes [ ]  No [ ]  Don’t Know | If yes, please explain:  |
| Cord around neck?  | [ ]  Yes [ ]  No [ ]  Don’t Know | If yes, please explain: |
| Oxygen used for baby?  | [ ]  Yes [ ]  No [ ]  Don’t Know | If yes, please explain: |
| Born premature? | [ ]  Yes [ ]  No [ ]  Don’t Know | If yes, how much?  |
| In an incubator? | [ ]  Yes [ ]  No [ ]  Don’t Know | If yes, please explain: |
| Stay in the NICU? | [ ]  Yes [ ]  No [ ]  Don’t Know | If yes, please explain: |
| How much did the baby weigh? \_\_\_\_\_\_\_\_\_\_\_ | APGAR Score? \_\_\_\_\_\_\_\_\_ |

## Development

|  |
| --- |
| **At what age the client first:**  |
| Crawl: \_\_\_\_\_\_\_\_\_\_\_\_ | Use First Words: \_\_\_\_\_\_\_\_\_\_\_ | Bladder Trained: \_\_\_\_\_\_\_\_\_\_\_\_ |
| Stand Alone: \_\_\_\_\_\_\_\_\_\_\_\_ | Use Phrases: \_\_\_\_\_\_\_\_\_\_\_ | Bowel Trained: \_\_\_\_\_\_\_\_\_\_\_\_ |
| Walk: \_\_\_\_\_\_\_\_\_\_\_\_ | Use Short Sentences: \_\_\_\_\_\_\_\_\_ |  |
| Was there any regression in his/her development (e.g., loss of speech or other skills?) [ ]  Yes [ ]  No If yes, please explain:  |
| Were you ever concerned regarding any area of his/her development? [ ]  Yes [ ]  No If yes, how old was he/she when you first became concerned? **\_\_\_\_\_\_** Please describe your concerns at that time. |
| **Your child currently communicates by using which of the following** (Check all that apply): |
| [ ]  Crying  | [ ]  Playful Sounds  | [ ]  Pointing | [ ]  Words |
| [ ]  Phrases  | [ ]  Sentences  | [ ]  Sign Language | [ ]  Picture Communication  |

## Educational Information

|  |
| --- |
| School Attending: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Current Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_  | Has your child ever repeated a grade? [ ]  Yes [ ]  No If yes, which grade? \_\_\_\_\_\_\_\_ |
| **Current Placement in School:**  |
| [ ]  Regular Classroom | [ ]  Special Education Classroom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Resource Room | [ ]  Alternative School | [ ]  Homeschool |  [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Has your child been suspended this year? [ ]  Yes [ ]  No  | If yes, why?  |
| Have there been any recent changes in his/her school setting? [ ]  Yes [ ]  No  | If yes, please explain.  |
| **Has your child attended:**  |
| Nursery School/Daycare?  | [ ]  Yes [ ]  No  |
| Preschool? | [ ]  Yes [ ]  No  |
| Kindergarten? | [ ]  Yes [ ]  No  |
| Has your child been evaluated by his/her school? If so, what were the results?  |
| On average, how are his/her grades this year? |
| In what classes does he/she typically do well?  |
| In what classes does he/she typically struggle? |
| Have there been any significant changes in his/her grades recently? If so, please explain.  |

## School-Based Therapy Services

|  |  |  |  |
| --- | --- | --- | --- |
| Therapy Type | Grade/Age When Services Began | Date Services Ended **OR**Current Frequency of Services | Specific Goals Being Addressed |
| Physical Therapy |  |  |  |
| Occupational Therapy |  |  |  |
| Speech/Language Therapy |  |  |  |
| Special Instruction |  |  |  |
| Vision Impaired |  |  |  |
| Hearing Impaired |  |  |  |
| Psychologist/Counselor |  |  |  |
| Social Skills |  |  |  |

## Additional Comments (Please use other side if necessary):

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**Thank you for taking the time to complete these forms. The information you provided gives us a better understanding of your child’s needs, allowing us to best assist you all through the evaluation process.**

|  |  |
| --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parent/Guardian Signature  | \_\_\_\_\_\_\_\_\_\_\_Date |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parent/Guardian Signature  | \_\_\_\_\_\_\_\_\_\_\_Date |