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 married  Date: **\_\_\_\_\_** 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  No  Dates 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. |  | |

**Physician Information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Client’s Pediatrician or Physician:** | | Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Last Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Current Medication(s)** | **Prescriber** | | **Dose** | **Reason for Medication** |
| |  | | --- | |  | |  | |  | |  | | | | | |
| **Past Medication(s)** | **Prescriber** | | **Dose** | **When/Why Stopped** |
|  | | | | |
| |  | | --- | |  | |  | |  |   **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.   |  | | --- | |  | |  | |  | | | | | |

**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 |