

Einstein Pediatrics Autism Intake Form

Instructions:

Please complete this form to provide us with detailed information about your child's developmental history, medical background, and current concerns. Not all questions may apply to your child—please fill out as much as possible.

Once completed, please return this form. Our staff will review the intake, and someone will contact you to schedule an initial visit if appropriate. Please provide 5 business days to hear from us.

Child's Information

- **Child's Name:** _____
- **Date of Birth:** _____
- **Referred By:** _____

1. Current Concerns About Your Child

Please check all that apply and provide details where needed:

- Delayed speech/language development
- Limited eye contact
- Repetitive behaviors (e.g., hand-flapping, rocking)
- Sensory sensitivities (e.g., textures, sounds)
- Difficulty with social interactions
- Limited interests or fixations on specific topics
- Aggressive or self-injurious behavior
- Difficulty with transitions or routine changes
- Other (please describe): _____

2. Delivery & Past Medical History (PMH)

Delivery History:

- Was your child born full-term? **Yes** **No** If premature, how many weeks? _____

- If overdue, how many weeks? _____
- **Birth weight:** _____ lbs _____ oz
- **Apgar scores:**
 - **At 1 minute:** _____
 - **At 5 minutes:** _____
- Any complications during pregnancy or delivery? **Yes** **No**
 - If yes, describe: _____

Medical History:

Has your child ever had any of the following?

- **Head injury:** **Yes** **No**
 - If yes, age: _____ Describe: _____
- **Loss of consciousness:** **Yes** **No**
 - If yes, age: _____ Duration: _____
- **Allergies to food/medications?** **Yes** **No**
 - If yes, list: _____
- **Surgeries?** **Yes** **No**
 - If yes, age: _____ Reason: _____
- **Frequent ear infections?** **Yes** **No**
 - If yes, describe: _____
- **Ear tubes placed?** **Yes** **No**
 - If yes, age: _____
- **Up to date on vaccines?** **Yes** **No**
 - If no, explain: _____
- **Current medications (name, dose, frequency, reason):**

3. Prior Testing & Evaluations

Has your child had any of the following tests? (Check if applicable)

- EEG MRI CT Scan Genetic/Chromosomal Testing Eye Exam
 Other: _____

Has your child ever been evaluated or treated by any of the following specialists?
(Check all that apply and provide details.)

- Occupational Therapist (OT)
 Physical Therapist (PT)
 Speech Therapist
 Feeding Therapist
 Applied Behavior Analysis (ABA) Therapist
 Psychiatrist/Psychologist
 Other Mental Health Provider

If applicable, please provide the following details:

Provider	Specialty	Date	Purpose of Evaluation	Results/Diagnosis

4. Behavioral & Social History

1. Please describe any behavioral concerns you have:

2. Does your child make friends easily? Yes No

- If no, explain: _____

3. Are there concerns regarding your child's social skills or interests? Yes No

- If yes, explain: _____

4. Are there concerns regarding anxiety or mood? Yes No

- If yes, explain: _____

5. Concerns in the following areas? (Check all that apply and explain if needed):

Area	No	Yes	Explanation
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 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	<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 behaviors	<input type="checkbox"/>	<input type="checkbox"/>	
Repetitive behaviors	<input type="checkbox"/>	<input type="checkbox"/>	
Fixations	<input type="checkbox"/>	<input type="checkbox"/>	
Toileting issues	<input type="checkbox"/>	<input type="checkbox"/>	

6. What are your child's interests and hobbies?

7. What are some of your child's strengths?

5. Developmental History

Please indicate if your child has reached these milestones and at what age:

Milestone	No	Yes	Age Achieved
Smiling when smiled at	<input type="checkbox"/>	<input type="checkbox"/>	
Pointing with one finger	<input type="checkbox"/>	<input type="checkbox"/>	
Walking independently	<input type="checkbox"/>	<input type="checkbox"/>	
First words (besides 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"/>	

Has your child ever lost a previously learned skill? Yes No

- If yes, explain: _____

6. Social & Adaptive Skills

Adaptive Skill	No	Yes	Age Achieved
Feeds self	<input type="checkbox"/>	<input type="checkbox"/>	
Dresses self	<input type="checkbox"/>	<input type="checkbox"/>	
Bathes self	<input type="checkbox"/>	<input type="checkbox"/>	
Helps with chores	<input type="checkbox"/>	<input type="checkbox"/>	
Knows first and last name	<input type="checkbox"/>	<input type="checkbox"/>	

Says "please" and "thank you"	<input type="checkbox"/>	<input type="checkbox"/>	
Walks up/down stairs	<input type="checkbox"/>	<input type="checkbox"/>	

7. Life at Home

- Concerns about **sleep routine**? **Yes** **No**
- Concerns about **feeding routine**? **Yes** **No**
- Does your child eat the family diet? **Yes** **No**
- Sensory sensitivity to foods? **Yes** **No**
- History of failure to thrive or growth problems? **Yes** **No**
- Required tube feeding? **Yes** **No**

8. Educational History

- **School Name:** _____
- **Current Grade Level:** _____
- Special services (IEP, 504 Plan, speech, OT, etc.)? **Yes** **No**

Parent/Guardian Name: _____

Date: _____

Preferred Contact Information: _____

Patient/Family

Address: _____

Please note that evaluations occur over 3 visits:

1. Initial Evaluation (in person) – 1 hour
2. Testing via ADOS-2* (in person) – 45 minutes
3. Review results and discuss recommendations (in person or remote) – 30-45 minutes

**Insurance may not cover the ADOS-2 test. Einstein Pediatrics charges \$200 for conducting and scoring this test when not covered. Private providers in our community typically charge \$450-\$2300 for this test.*