Autism Evaluation Intake Form

CHILD'S PERSONAL INFORMATION

Today's Date: _____

Child's Name: _____ M F Age: _____ Birthdate: _____

Referred by: _____ Specialty: _____

Why do you want your child evaluated? _____

_____

CURRENT CONCERNS ABOUT YOUR CHILD

Please check all that apply:

☐ aggression	☐ has few friends	☐ has no friends
☐ overactivity	☐ language difficulties	☐ toilet training
☐ preoccupations	☐ temper tantrums	☐ biting
☐ hitting	☐ self-injury	☐ sleep problems
☐ sleeps in parents' bed	☐ has nightmares	☐ nervousness
☐ argumentative	☐ easily distracted	☐ self-help skills
☐ won't take baths	☐ appetite/food selections	☐ eats things that aren't food
☐ wets the bed	☐ pulls out own hair	☐ inattentive
☐ school adjustment	☐ cruel to animals	☐ inappropriate sexual behavior
☐ motor skills	☐ depressed or anxious	☐ muscle tone

☐ self-stimulatory behaviors: rocking, spinning, flapping hands, visual scrutiny

☐ Other: _____

Please provide detail for any items checked above: _____

_____

_____

What is the biggest problem?

How long has it been a problem?

What do you think caused it?

What seems to upset the child?

What seems to calm the child?

CHILD'S CURRENT LIVING SITUATION

With whom does the child currently reside? (please mark all that apply)

☐ Biological Mother ☐ Biological Father ☐ Step-mother ☐ Step-father
☐ Adoptive Mother ☐ Adoptive Father ☐ Foster Mother ☐ Foster Father
☐ Grandparent
☐ Other (describe: _____)

Complete the following for the child's BIOLOGICAL PARENTS to the best of your ability, *even if you are not the child's biological parent*.

Biological Mother's Name:_____ Age: _____ Birthdate:_____
Occupation:_____ Ethnic/Cultural Background: _____
Work Phone: _____ Home Phone: _____
Cell Phone: _____

Biological Father's Name:_____ Age: _____ Birthdate:_____
Occupation: _____ Ethnic/Cultural Background: _____
Work Phone: _____ Home Phone: _____
Cell Phone: _____

If child does not live with BOTH biological parents, who has legal custody of the child? _____

If the child currently resides with parents OTHER than biological parents, please describe them here.
Parent/Caretaker One's name:_____Age: _____ Birthdate:_____
Relationship to child: ☐ Adoptive Parent ☐ Step-Parent ☐ Foster Parent ☐ Grandparent
☐ Parent's partner ☐ Other:_____
Occupation: _____ Ethnic/Cultural Background:_____
Work Phone: _____ Home Phone: _____

Parent/Caretaker Two's name:_____Age: _____ Birthdate:_____
Relationship to child: ☐ Adoptive Parent ☐ Step-Parent ☐ Foster Parent ☐ Grandparent
☐ Parent's partner ☐ Other:_____
Occupation: _____ Ethnic/Cultural Background:_____
Work Phone: _____ Home Phone: _____

Highest level of education by each parent:

Biological Mother	Biological Father	Parent 1 (above, if app.)	Parent 2 (above, if app.)
☐ 11 grade or less	☐ 11 grade or less	☐ 11 grade or less	☐ 11 grade or less
☐ GED	☐ GED	☐ GED	☐ GED
☐ High school grad	☐ High school grad	☐ High school grad	☐ High school grad
☐ Associates Degree	☐ Associates Degree	☐ Associates Degree	☐ Associates Degree
☐ Bachelor's Degree	☐ Bachelor's Degree	☐ Bachelor's Degree	☐ Bachelor's Degree
☐ Graduate/Professional	☐ Graduate/Profess.	☐ Graduate/Profess.	☐ Graduate/Professional
☐ Vocational Certificate	☐ Vocational Cert.	☐ Vocational Cert.	☐ Vocational Certificate

How often does the other biological parent see this child? _____

Number of years married/together: _____ Approximate date of divorce/separation: _____
Number of times married: Mother _____ Father _____
If child is with ADOPTIVE parent, age child was first in home: _____ Date of legal adoption: ___
What has the child been told about the adoption? _____

If your child spends a significant amount of time with a caregiver other than someone described above (i.e., spends more than 4 hours/day) EXCLUDING school personnel, please complete the following information for that person here:
Name:_____ Age: _____ Birthdate:_____
Relationship to Child: _____ Ethnic/Cultural Background: _____
Occupation: _____ Highest Level of Education: _____

Siblings: (please list whether the siblings live in the child's home or not)

Name	Age	M/F	Full/Step/Half?	Grade	In child's home?

Other occupants of child's residence NOT listed above: _____
What languages does the child use (List PRIMARY language first): _____
What other languages is your child exposed to? _____

DEVELOPMENTAL HISTORY
(If re-evaluation, please skip to "Medical History" on page 5 and add any updates.)

Prenatal/Pregnancy
Did the biological mother have any of the following immediately before/after or during pregnancy?
☐ Maternal injury. Describe: _____
☐ Hospitalization during pregnancy. Reason: _____
☐ X-rays during pregnancy. What month of pregnancy? _____

Did the biological mother have any of the following during pregnancy?

☐ Emotional problems	☐ Infections	☐ Premature Labor
☐ Rashes	☐ Bed-rest	☐ Toxemia
☐ Difficulty in conception	☐ Anemia	☐ Gained more than 35 pounds
☐ Excessive swelling	☐ Vaginal bleeding	☐ Measles/German measles
☐ Excessive nausea/vomiting	☐ Flu	☐ High blood pressure
☐ Kidney disease	☐ Strep Throat	☐ Threatened miscarriage
☐ Rh incompatibility	☐ Headaches	☐ Severe cold
☐ Urinary problems	☐ Other virus	
☐ Special diet, describe: _____		☐ Meds: _____
☐ Other: _____		

Mother's age at conception: _____
Did the mother have previous pregnancies? ☐ No ☐ Yes--how many, including miscarriages? _____
Did mother receive prenatal care during this pregnancy? ☐ No ☐ Yes--beginning at month ____
During the pregnancy, was the baby: ☐ Very active ☐ Average ☐ Rather quiet
Were there any unusual changes in the baby's activity level during pregnancy? ☐ No ☐ Yes

Delivery
Was infant born full-term? ☐ Yes ☐ No
If premature, how early? _____ If overdue, how late? _____
Birth weight: _____ Apgars: at 1 minute _____ at 5 minutes _____
Type of anesthetic used: ☐ None ☐ Spinal ☐ Local ☐ General
Length of active labor: _____ Describe any complications during delivery: _____
_____

Check all of the following that applied to the delivery:
- ☐ Spontaneous ☐ Breech ☐ Forceps
- ☐ Head first ☐ Multiple births ☐ Cord around neck
- ☐ Induced; Reason: _____
- ☐ Cesarean; Reason: _____

Which of the following applied to the infant? (check all that apply)
- ☐ Breathing problems ☐ Required oxygen ☐ Required incubator
- ☐ Jaundice (Were Bilirubin lights used? ☐ No ☐ Yes – How long? _____)
- ☐ Feeding problems ☐ Sleeping problems ☐ Infection
- ☐ Rash ☐ Excessive crying ☐ Seizures/convulsions
- ☐ Unusual appearance, describe: _____
- ☐ Bleeding into the brain

Did the infant require: ☐ X-Rays ☐ CT scans ☐ Blood transfusions

☐ Placement in the NICU (If so, for how long? _____)
Length of stay in hospital: Mother _____ Infant _____

Early Childhood History
During this child's first three years, were any special problems noted in the following areas?
- ☐ Irritability ☐ Breathing problems ☐ Colic
- ☐ Difficulty sleeping ☐ Eating problems ☐ Temper tantrums
- ☐ Failure to thrive ☐ Excessive crying ☐ Withdrawn behavior
- ☐ Poor eye contact ☐ Early learning problems ☐ Destructive behavior
- ☐ Convulsions/Seizures ☐ Twitching ☐ Unable to separate from parent
- ☐ Other _____

Milestones - Indicate age when child:

_____ sat unaided	_____ crawled	_____ walked
_____ started solid foods	_____ fed self with spoon	_____ gave up bottle
_____ bladder trained-day	_____ bladder trained-night	_____ bowel trained
_____ rides tricycle	_____ rides bike	

Can child be described as clumsy/uncoordinated? ☐ Yes ☐ No
Having fine motor delay? ☐ Yes ☐ No
Which hand does your child use for: Writing/drawing? _____Eating? _____Cutting? _____
Current eating behavior: ☐ Normal ☐ Picky ☐ Eats too much ☐ Weight loss/gain
Oral Motor concerns ☐ None ☐ Difficulty swallowing ☐ Drooling ☐ Gagging

Language development
Indicate age when child begin babbling, such as repeating syllables, in attempts to communicate:
_____
Using single words? _____ Using phrases/short sentences? _____

Have there been any hearing concerns? ☐ No ☐ Yes Hearing testing – date? _____

Adaptive Skills

Feeds self	☐ No	☐ Yes, beginning at age _____
Dresses self	☐No	☐ Yes, beginning at age _____
Bathes self	☐ No	☐ Yes, beginning at age _____
Helps with household chores	☐ No	☐ Yes, beginning at age _____
Knows first and last name	☐ No	☐ Yes, beginning at age _____
Says “please” and “thank you”	☐ No	☐ Yes, beginning at age _____
Able to walk up/down stairs	☐ No	☐ Yes, beginning at age _____

Has the child ever lost skills, which at one time he/she was able to perform? ☐ No ☐ Yes
If yes, please explain _____
When your child is disruptive or misbehaves, what steps are you likely to take to deal with the problem?
☐ Time out ☐ Loss of allowance/privileges ☐ Physical punishment ☐ Yelling
☐ Ignoring ☐ Grounding ☐ Other, describe _____
Who is mainly in charge of discipline? _____
What do you find most difficult about raising your child? _____
_____

MEDICAL HISTORY
Has your child ever had:

Head injury Age _____ Describe _____
Loss of consciousness Age ____ How long? _____
Describe_____
Allergies to food/medication List: _____
_____

Surgery - Age_____ Reason _____
Describe_____
(if more than one surgery, please list on back)

Ear Infections: Age ____ Describe _____
Ear tubes? ☐ No ☐ Yes Date of surgery _____
Is the child up to date on immunizations? ☐ Yes ☐ No, Why not? _____

Doctors seen (check all that apply)

☐ Pediatrician – Date of last visit: _____ Diagnosis: _____
_____
☐ Developmental Pediatrician – Date: _____ Diagnosis: _____

☐ Neurologist – Date: _____ Diagnosis: _____
suspected seizures, describe: _____
seizures diagnosed, type: _____
☐ Genetics – Date: _____ Diagnosis: _____
☐ Psychiatry – Date: _____ Diagnosis: _____
☐ Psychology – Date: _____ Diagnosis: _____
☐ Gastroenterology – Date: _____ Diagnosis: _____
stomach/intestinal problems, type: _____
☐ Endocrinology – Date: _____ Diagnosis: _____

Diagnostic Testing (check all that apply)

☐ EEG (brain wave test) – Date: _____ Results: _____
☐ MRI – Date: _____ Results: _____
☐ CT Scan – Date: _____ Results: _____
☐ Ophthalmology Evaluation – Date: _____ Results: _____
☐ Chromosomal/DNA testing (Genetics) – Date: _____ Results: _____
☐ Other - Describe: _____

Medication history

CURRENT medications **(PLEASE NOTE: DO ADMINISTER child's regularly scheduled medications, if any, on the day of your appointment.)**

Name of medication Dose & Frequency Date Started Reason Effectiveness

_____
_____
_____

Who prescribes these medications? _____ Date of last visit: _____

Please also list any medications your child has been on in the PAST:

Name of medication Dose & Frequency Date Started/Ended Reason Effectiveness

_____

_____

_____

Who prescribed past medications?

_____

CHECKLIST: Please mark any of the following in each area that describe your child currently or in the past:

Speech

Past	Current		Past	Current	
☐	☐	slow speech development	☐	☐	doesn't understand without gestures
☐	☐	unusual tone or pitch	☐	☐	repeats words/phrases over and over
☐	☐	difficult to understand speech	☐	☐	repeats questions, instead of answering them
☐	☐	seldom speaks unless prompted	☐	☐	repeats dialogue from movies/songs verbatim
☐	☐	has language of his/her own (may sound like foreign language/jargon)			

Relating with other people

Past	Current		Past	Current	
☐	☐	prefers to be by self	☐	☐	"in a world of his/her own"
☐	☐	aloof, distant	☐	☐	clings to people
☐	☐	fearful of strangers	☐	☐	not cuddly as baby
☐	☐	doesn't like to be held	☐	☐	doesn't recognize parent
☐	☐	doesn't play with other children			
☐	☐	prefers playing with younger or older children			

Imitation

Past	Current	
☐	☐	doesn't imitate waving "bye-bye" or "patty cake" etc. (physical imitation)
☐	☐	doesn't repeat words/things said to him
☐	☐	doesn't repeat words generally**,** but usually did what he was asked to do

Response to Sounds, Speech

Past	Current		Past	Current	
☐	☐	often ignores sounds	☐	☐	often ignores what is said to him/her
☐	☐	afraid of certain sounds	☐	☐	really likes certain sounds (music, motors, etc.)
☐	☐	seems to hear distant or soft sounds that most other people don't hear or notice			
☐	☐	unpredictable response to sounds (sometimes reacts, sometimes doesn't)			
☐	☐	responds to speech and sounds like other children of the same age			

Visual Response

Past	Current		Past	Current	
☐	☐	stares vacantly around room	☐	☐	plays with turning lights on and off
☐	☐	often doesn't look at things	☐	☐	distracted by lights – stares at certain lights
☐	☐	likes to look at self in mirror	☐	☐	very interested in small parts of an object
☐	☐	likes to look at shiny objects	☐	☐	looks at things out of the corners of eyes
☐	☐	stares at parts of his/her body (e.g. hands)			
☐	☐	often avoids looking at people when they are talking to him			

Other Senses

Past	Current		Past	Current	
☐	☐	puts many objects in mouth	☐	☐	likes vibrations
☐	☐	licks objects	☐	☐	doesn't notice pain as much as most people
☐	☐	overreacts to pain	☐	☐	smells objects unusual or unfamiliar objects
☐	☐	chews or eats objects that are not supposed to be eaten			

Emotional Responses

Past	Current		Past	Current	
☐	☐	temper tantrums	☐	☐	laughs/smiles for no obvious reason
☐	☐	overly responds to situations	☐	☐	moods change quickly/for no apparent reason
☐	☐	cries/seems sad for no obvious reason	☐	☐	often has blank expression on face
☐	☐	little response to what is happening around him/her			

Name some GOOD things about the child:

1. _____
2. _____
3. _____
4. _____

FAMILY MEDICAl/PSYCHIATRIC HISTORY

Have any members of the biological mother's or biological father's families had any of the following problems or disorders (check all that apply):

☐ Birth Defect	☐Chromosomal/genetic disorder	☐ Obsessive Compulsive Disorder
☐ Cerebral Palsy	☐ Severe head injury	☐ High blood pressure
☐ Kidney disease	☐ Migraine headaches	☐ Multiple Sclerosis
☐ Physical handicap	☐ Nervousness/Anxiety	☐ Stroke
☐ Tuberous Sclerosis	☐ Alzheimer's disease	☐ Hemophilia
☐ Huntington's chorea	☐ Muscular dystrophy	☐ Parkinson's disease
☐ Sickle-cell anemia	☐ Cancer	☐ Seizures/epilepsy
☐ Diabetes	☐ Heart disease	☐ Food allergies
☐ Alcohol/drug abuse	☐ Depression	☐ Physical/Sexual abuse
☐ Schizophrenia	☐ Mental Retardation	☐ Speech/language delay
☐ Autism/PDD	☐ Reading problem	☐ Other learning disability
☐ Emotional disturbance/mental illness		☐ Bipolar/manic-depressive disorder
☐ Tics/Tourette's syndrome		☐ Antisocial Behavior(assaults, thefts, arrests)
☐Childhood behavior disorder (aggressive/defiant/ADHD)		
☐Other: _____		

Has anyone in the family ever received special education services? ☐ No ☐ Yes - for what reason?

_____

Family Changes and Stressors: Please indicate any major family stresses the family and/or child is currently experiencing or has experienced within the last year.

☐ Marital discord/fighting ☐ Separation ☐ Divorce
☐ Birth/Adoption of another child ☐ Sibling conflict ☐ Parent-Child conflict
☐ Custody disagreement ☐ Single-parent family ☐ Parent/sibling death
☐ Parent deployed extensively ☐ Parent emotionally/mentally ill
☐ Involved in juvenile court ☐ Abandonment by parent ☐ Financial problems
☐ Parent substance abuse ☐ Child Neglect ☐ Physical abuse
☐ Sexual abuse ☐ Parental disagreement about child-rearing
☐ Involved with Social Services/Child Protective Services
☐ Other, if not listed: _____

SCHOOL HISTORY

(If more space is necessary, please attach additional sheets or write on the back of this page.)
Current school:_____ School district: _____
Grade level: _____
Type of class: ☐ Regular Ed ☐ Special Ed ☐ Resource ☐ ED ☐ Behavioral unit
Current # of: Students ____ Teachers ____ Aides ____ Does your child have a 1:1 Aide? _____
Has your child had special education testing in school?
☐ Psychological/Cognitive – Date: _____ ☐ Academic – Date: _____
☐ Speech/Language – Date: _____ ☐ Other: _____ Date: _____
Is your child receiving any special education services at school? ☐ Yes ☐ No
Is your child on an IEP (Individual Education Plan)? ____ For what reason? _____
Please list all of the schools, including preschools, your child has attended:

Name of school	Age/grade attended	Hours per day	Days per week

SERVICES - Please list services your child has received.
(Please bring copies of your most recent Individual Education Plan (IEP))

Child's age when school services began: _____
Individual Education Plan (IEP) eligibility: _____
Which services is your child CURRENTLY receiving through the SCHOOL DISTRICT?
☐ Speech therapy ☐ Occupational therapy ☐ Physical therapy
☐ Adaptive Physical Education ☐ Discrete Trial Training (DTT/ABA) ☐ Social Skills
☐ Other - describe: _____

Early Childhood Intervention (ECI): **(Please bring copies of your most recent ECI, Individual Family Service Plan (IFSP), and relevant reports to your appointment.)**

Is your child currently a client of ECI? ☐ Yes ☐ No (skip to Private Services)
Which ECI Center: _____ Eligibility category: _____

Child's age when ECI services began: _____

Which services is your child CURRENTLY receiving through the REGIONAL CENTER?
☐ Speech therapy ☐ Occupational therapy ☐ Physical therapy
☐ Adaptive Physical Education ☐ Discrete Trial Training (DTT/ABA) ☐ Social Skills
☐ Other - describe: _____

Private Services (Please bring copies of relevant reports to your first appointment.)
Are you or your insurance company currently paying for services to address your child's needs? ☐ Yes ☐ No
☐ Speech therapy Provided by: _____ Age when began: _____
☐ Occupational therapy Provided by: _____ Age when began: _____
☐ Physical therapy Provided by: _____ Age when began: _____
☐ Adaptive Physical Education Provided by: _____ Age when began: _____
☐ Social Skills Provided by: _____ Age when began: _____
☐ Discrete Trial Training(DTT/ABA) Provided by: _____ Age when began: _____
☐ Other - describe: _____

Please bring this completed intake form to your first appointment.