Center For Autism and
Neurodevelopmental Disabilities
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ABOUT YOUR CHILD:

Today's Date_____

Child's Name_____ **Name child goes by**_____
Last *First* *Middle Initial*

Date of Birth_____**Age**_____**Sex:** ☐**M** ☐**F** **Birthplace:**_____

Person completing form_____ **Relationship to child**_____

Mailing address_____

City_____ **State**_____ **Zip**_____ **Phone #**_____

Father's Name_____ **Mother's Name**_____

WHAT ARE YOUR CONCERNS:

Current Concerns:

- ☐ **Developmental Delay**
- ☐ **Slow or late to talk**
- ☐ **Way your child moves, walks**
- ☐ **Poor attention/hyperactivity (ADHD)**
- ☐ **Possible Autism Spectrum Disorder**
- ☐ **School performance**
- ☐ **Behavioral problem**
- ☐ **Sensory Issue**
- ☐ **Sleep**
- ☐ **Social problems**
- ☐ **Other** _____

_____

Check previous or current diagnoses:

- ☐ **None**
- ☐ **ADHD**
- ☐ **Autism/ASD/Aspergers/PDD NOS**
- ☐ **Cerebral Palsy**
- ☐ **Conduct/Oppositional defiant disorder**
- ☐ **Epilepsy or seizure disorder**
- ☐ **Genetic disorder:** _____

_____

- ☐ **Intellectual disability**
- ☐ **Learning disorder**
- ☐ **Language disorder**
- ☐ **Psychiatric:** _____

_____

- ☐ **Tic disorder/Tourrettes**
- ☐ **Developmental delay**
- ☐ **Hearing loss/impairment**
- ☐ **Visual loss/blindness**
- ☐ **Other:** _____

_____

PAST MEDICAL HISTORY

PREGNANCY HISTORY

Note: **This information relates to birth (biological) parent.**

Mother's age when child was born? _____ What number of pregnancy for mother? _____

Complications/illnesses during pregnancy?_____
_____

During pregnancy used? ☐ Alcohol ☐ Tobacco ☐ Drugs ☐ Medications ☐ Other:_____

Type of delivery? ☐ Natural (Vaginal) ☐ Forceps/Vacuum ☐ Cesarean

Baby was born at? _____weeks Birth weight? _____

Complications during delivery?_____
_____

Length of stay in ☐ Nursery ☐ Neonatal Intensive Care (NICU):_____

Were there any problems while the baby was in the hospital?
☐ Jaundice ☐ Breathing ☐ Infections ☐ Feeding problems ☐ Episodes of apnea (not breathing) ☐ Surgery
☐Other: _____

POSTNATAL HEALTH

In the first 12 months, did baby have any of the following? (check): ☐Yes ☐ No

- ☐ **Excessively quiet/ sleepy**
- ☐ **Excessively hyperactive or irritable**
- ☐ **Colicky**
- ☐ **Difficult to feed (poor suck, spitting up)**
- ☐ **Floppy muscle tone**
- ☐ **Stiff muscle tone**
- ☐ **Other problems/ concerns (explain):**

  _____
  _____

- ☐ **Sleep problems**
- ☐ **Poor head control**
- ☐ **Poor eye contact**
- ☐ **Didn't like to be held or cuddled**
- ☐ **Difficult to calm down or comfort**
- ☐ **Abnormal response/ interactions with people**

Baby was ☐ breast fed until_____(age) ☐ bottle fed
Did parents have any problems adjusting to new baby? ☐ Yes ☐ No

Serious injuries/accidents (drowning, calls to poison control, motor vehicle accidents):_____
_____

If your child has had any of the following:

Review of Health Systems	Yes	No		Yes	No
Dental problems			Kidney/Urinary/Genital problems		
Does your child see a dentist			Chronic ear problems		
Birth defects			Long term use of antibiotics		
Heart problems			Easy bruising/bleeding/anemia		
Lung or breathing problems			Endocrine problems(e.g. thyroid)		
Constipation			Skeletal/Bone problems (e.g. scoliosis)		
Diarrhea			Environmental allergies		
Nausea/vomiting			Skin problems (rash, eczema)		
Stomache ache/pain/reflux			Sleep problems		
Tics			Migraines		
Tremors			Toe walking		
Hypotonia (low muscle tone/floppy)			Staring spells		
Hypertonia (tight muscles)			Seizures		

Hospitalizations (since birth):

Reason	Age	Date	Hospital

Surgeries:

Reason	Age	Date	Hospital

Medications child is taking at this time:

Medication	Amount (mg or volume)

Past Medications taken:

Medication	Period of time taken	Helpful (yes or no)

Dietary/Nutrition/Metabolic	Yes	No		Yes	No
Picky eater			Difficulty with solids		
Does child drink milk			Difficulty with liquids		
Eating/craving non-food items			Special diet		
Avoids specific food groups			Dehydration needing hospitalization		
Reaction to specific foods			Anorexia/Bulemia		
Feeding issues in infancy					

DEVELOPMENTAL HISTORY

Have you ever been worried that your child has lost skills that he/she used to have? ☐ Yes ☐ No
If yes, explain:

MOTOR	Age	Early	Normal	Late	NA
Crawled on hands and knees					
Walked with no help					
Pedaled a Tricycle					
Rode a 2 wheeled bicycle					
USE OF HANDS/DAILY LIVING SKILLS					
Buttoned clothing					
Tied shoelaces					
Dressing/Undressing					
Toilet training					
Handwriting					
RECEPTIVE LANGUAGE					
Smiled					
Understood name and/ or the word "no"					
Followed a simple command					
Pointed to body parts (1-4)					
EXPRESSIVE LANGUAGE					
Babbled with repetitive vowels/ consonants					
Said first word					
Spoke in two word sentences					
Asked questions					

SCHOOL HISTORY

Current School:

Grade: **School Phone Number:**

Teacher (Main Classroom):

Special Ed or Resource Room teacher:

Type of class: ☐ Regular ☐ Special education ☐ 504 Accommodation Plan

Does your child receive any of the following services? If so, how many times and minutes per week? (e.g., 1X/ day - 30 min per week)

☐ Speech therapy: At School? _____ In Community? _____

☐ Occupational therapy: At School? _____ In Community? _____

☐ Physical therapy: At School? _____ In Community? _____

☐ Counseling: At School? _____ In Community? _____

Has child ever been retained a grade or held back?
☐ No ☐ Yes (explain)

YOUR CHILD'S BEHAVIOR

Does your child have any of the following problems?

- ☐ **Attention/focus**
- ☐ **Crying/sadness**
- ☐ **Fears/worries**
- ☐ **Fighting**
- ☐ **Impulsiveness**
- ☐ **Mood**
- ☐ **Obsessions/compulsions**
- ☐ **Substance abuse**
- ☐ **Talk of suicide**
- ☐ **Severe tantrums**
- ☐ **Unusual/repetitive body movement**
- ☐ **Aggression to others:**

  _____

  _____

- ☐ **Self injury: Type:**

  _____

  _____

FAMILY HISTORY

Are the birth mother and father related in any way (1st cousins, 2nd cousins, etc.)? ☐No ☐Yes
If so, how?

Does anyone in the family have any of the following? Check all that apply, past or present.

Condition	Mother	Father	Sibling	Mother's Family	Father's Family
Intellectual disability					
Learning disability					
Attention/ hyperactivity					
Depression					
Bipolar disorder					
Anxiety/OCD/ panic					
Schizophrenia					
Legal problems					
Alcohol or drug abuse					
Tics or Tourettes					
Autism					
Seizures/ epilepsy					
Genetic syndrome					
Cerebral palsy					
Cardiac problems					

SOCIAL HISTORY

PARENTS

Mother's name_____ **Birthdate**_____ **Age**_____
Occupation_____ **Religion**_____
Highest grade completed_____ **Highest diploma**_____
Marital status_____ **Number of previous marriages**_____
Check which applies: ☐ **Biological/birth** ☐ **Adoptive** ☐ **Step** ☐ **Foster** ☐ **Other**_____

Father's name_____ **Birthdate**_____ **Age**_____
Occupation_____ **Religion**_____
Highest grade completed_____ **Highest diploma**_____
Marital status_____ **Number of previous marriages**_____
Check which applies: ☐ **Biological/birth** ☐ **Adoptive** ☐ **Step** ☐ **Foster** ☐ **Other**_____

Family members' names and ages (mother, father, siblings)

Name	Age	Relationship to patient	Living with patient

Please check any of the boxes below that apply to the patient:

☐ **Foster care**
☐ **Abuse (please circle type) physical sexual**
☐ **Neglect**
☐ **Legal problems (arrested or legal charges placed)**
☐ **Death of parent or grandparent (How old was patient?)**_____
☐ **Multiple moves**
☐ **Separation from primary care giver? How long?**_____
☐ **Divorce (How old was patient?)** _____
☐ **Homelessness. (How long?)**_____
☐ **Chronic medical condition**
☐ **Lack of transportation**
☐ **Witness to violence**
☐ **Fighting between parents** ☐ **verbal** ☐**physical**
☐ **Abandonment by one parent**
☐ **Litigation over custody/visitation**
☐ **Mental health diagnosis in one parent**
☐ **Little support from family**
☐ **Economic hardship**
☐ **Unsafe living conditions**

Please list custody arrangments if divorced. **Please list any pending custody litigation:**