



**General Information**

Child's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Mother's Name: \_\_\_\_\_  
Mother's Age: \_\_\_\_\_  
Father's Name: \_\_\_\_\_  
Father's Age: \_\_\_\_\_  
Referred by: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Mother's Occupation: \_\_\_\_\_  
Business Phone: \_\_\_\_\_  
Father's Occupation: \_\_\_\_\_  
Business Phone: \_\_\_\_\_  
Referral Phone: \_\_\_\_\_

Form Completed by: \_\_\_\_\_  
Date Form Completed: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

**Child's Legal Guardian:**

- \_\_\_ Both Birth Parents
- \_\_\_ Birth Mother
- \_\_\_ Birth Father
- \_\_\_ Adoptive Parents
- \_\_\_ Department of Human Resources
- \_\_\_ Legal Guardian
- Other (please explain) \_\_\_\_\_

**Marital Status of Natural Parents:**

- \_\_\_ Not Married
- \_\_\_ Married
- \_\_\_ Separated
- \_\_\_ Divorced
- \_\_\_ Father remarried
- \_\_\_ Mother remarried

If parents are separated or divorced, who has primary legal custody of the child?  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE ATTACH COPY OF COURT ORDER REGARDING CUSTODY OF CHILD**

Are both parents involved in the care of the child? \_\_\_\_\_

Are there other adults involved in the regular care of the child? \_\_\_\_\_

Who will be attending the evaluation? \_\_\_\_\_

Do all parties involved in the care of the child agree on the need for an evaluation of this child?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Brother's & Sister's (include half-brothers/sisters)	Age	Learning &/or Medical Problems
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does your child have a diagnosis of Autism or Asperger's disorder or an Autism Spectrum Disorder? If so, who made the diagnosis and when was it made? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe the concerns you have that prompted your referral. For example, describe your child's behavior problems, problem solving skills, personal/social skills, and/or speech/language development.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

When did you first become concerned with your child's development? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What prompted your concerns about his or her development? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Did a regression of skills or a loss of skills ever occur in your child's development? \_\_\_\_\_ Yes \_\_\_\_\_ No

If Yes, when did this regression of skills or loss of skills occur? \_\_\_\_\_

If Yes, describe the regression of skills or loss of skills? \_\_\_\_\_

\_\_\_\_\_

Since you first noticed the delay in your child's development, how has your child's development changed?

\_\_\_\_\_

\_\_\_\_\_

**Family History**

Is there any family history of the following? Please specify who by using the following abbreviations:  
(m) mother (f) father (s) sibling (o) others – please specify

Speech or Language Impairment _____	Visual Impairments _____
Hearing Impairment _____	Drug or Alcohol Abuse _____
Learning Disabilities _____	Seizure Disorder _____
Behavior Problems _____	Chronic Illness _____
Emotional Difficulties _____	ADHD/ADD _____
Diabetes _____	Thyroid Problems _____
Tics or involuntary movements _____	
Autism Spectrum Disorders _____	
Other (please specify) _____	

**School and Educational History**

<b>Schools Attended</b>	<b>Address</b>	<b>Date Attended (mm/yy) to (mm/yy)</b>	<b>Services Received</b>



Please provide the following information regarding specialists (speech/language pathologists, physicians, psychologists, special education teachers, etc) who have evaluated your child?

<b>Type of Service Provider</b>	<b>Agency/Provider Name</b>	<b>Agency/Provider COMPLETE address</b>	<b>Date(s) Seen</b>
Hospitalizations:			
Pediatrician:			
Family Physician:			
Neurologist:			
Psychiatrist:			
Psychologist:			
Eye Specialist:			
Hearing Specialist:			
Speech Language Therapist:			
Occupational Therapist:			
Physical Therapist:			
Geneticist:			
Children's Rehab. Services:			
Public Health Dept.:			
Dept. of Human Resources:			
Others specify:			
Others specify:			
Others specify:			

**\*\*\* IF YOUR CHILD IS CURRENTLY INVOLVED IN ONGOING THERAPY OR HAS AN INDIVIDUALIZED EDUCATIONAL PLAN (IEP) WITH THE SCHOOL SYSTEM, PLEASE COPY AND ENCLOSE WITH THIS FORM**

## Prenatal and Birth History

Mother's general health during pregnancy (illness, accidents, medications, etc...) \_\_\_\_\_

\_\_\_\_\_

Length of Pregnancy \_\_\_\_\_

Length of Labor \_\_\_\_\_

General Condition \_\_\_\_\_

Birth Weight \_\_\_\_\_

Miscarriages \_\_\_\_\_

Type of Delivery

Head First

Feet First

Caesarian

Were there any unusual conditions that may have affected the pregnancy or birth?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Medical History

If applicable, please provide the approximate age at which your child had the following illnesses/ conditions:

Allergies \_\_\_\_\_

Asthma \_\_\_\_\_

Chicken Pox \_\_\_\_\_

Colds \_\_\_\_\_

Sleep Problems \_\_\_\_\_

Croup \_\_\_\_\_

Dizziness \_\_\_\_\_

Draining Ear \_\_\_\_\_

Ear Infections \_\_\_\_\_

Encephalitis \_\_\_\_\_

Feeding Problems \_\_\_\_\_

Headaches \_\_\_\_\_

High Fever \_\_\_\_\_

Influenza \_\_\_\_\_

Growth Problems \_\_\_\_\_

Measles \_\_\_\_\_

Meningitis \_\_\_\_\_

Mumps \_\_\_\_\_

Pneumonia \_\_\_\_\_

Seizures \_\_\_\_\_

Sinusitis \_\_\_\_\_

Tonsillitis \_\_\_\_\_

Other \_\_\_\_\_

Current Weight \_\_\_\_\_

Current Feeding Method (check all that apply) Bottle fed \_\_\_\_\_ Baby food \_\_\_\_\_

Table food \_\_\_\_\_ Special diet \_\_\_\_\_

Does your child have a specific medical diagnosis? Or a significant health problem?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has your child had any surgeries? If yes, what type and when? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe any major accidents or hospitalizations, including visits to the emergency room? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is your child taking any medications? If yes, please list the name of the medication, the dose and the frequency. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please describe all allergies your child has (medication, food, environmental). \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### Developmental History

Provide the approximate ages at which your child began to do the following activities: (you can use early, late, or on-time if age is unknown)

Smile	_____	Crawl	_____
Coo/Babble	_____	Stand Alone	_____
Roll Over	_____	Walk Alone	_____
Sit Alone	_____	Feeds Self	_____
Single Words	_____	Dresses Self	_____
Phases	_____	Toilet Trained	_____
Short Sentences	_____	Bowel	_____
		Bladder	_____

Your child communicates by which of the following (check all that apply)

Crying	_____	Sentences	_____
Playful Sounds	_____	Sign Language	_____
Pointing with Index finger	_____	Picture Communication	_____
Words	_____		
Phrases	_____		

How much of your child's speech is understandable to you? Some \_\_\_\_\_ Most \_\_\_\_\_ All \_\_\_\_\_  
How much of your child's speech is understandable to others? Some \_\_\_\_\_ Most \_\_\_\_\_ All \_\_\_\_\_

Does your child have any problems:

Understanding what someone says	Yes _____	No _____
Talking	Yes _____	No _____

Has your child's hearing been tested? Yes \_\_\_\_\_ No \_\_\_\_\_  
Was hearing loss reported? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, who tested? \_\_\_\_\_  
If yes, when tested? \_\_\_\_\_  
If yes, what were the results? \_\_\_\_\_

Has your child's vision been tested?  
Was vision loss reported?

Yes \_\_\_\_\_ No \_\_\_\_\_  
Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, who tested? \_\_\_\_\_  
If yes, when tested? \_\_\_\_\_  
If yes, what were the results? \_\_\_\_\_

Does your child have difficulty walking, running, or participating in other activities that require small or large muscle coordination? If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Hand Preference: Right \_\_\_\_\_ Left \_\_\_\_\_ Both \_\_\_\_\_ Not Sure \_\_\_\_\_

Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, etc...?) If yes, please describe. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is your child a picky eater? If so, what foods will he/she eat? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is your child on any special diet? Does he/she take any nutritional supplements? If yes, please describe. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe your child's response to sound (e.g., responds to all sounds, responds to loud sounds only, extremely sensitive to loud noises, etc...). \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child have outbursts or "meltdowns" due to anger, frustration, and/or sensory overload? If so, are there strategies that you have used that are helpful in correcting this behavior? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How would you describe your child?

- Usually very active
- Active sometimes, but can play quietly
- Usually not active
- Usually happy
- Can be moody
- Demands attention

- Aggressive towards self or others
- Difficulty attending to activities
- Prefers motor activities
- Prefers sit-down activities
- 

Please describe your child's play/social skills? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What does your child enjoy doing in his/her free time? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What are your child's special interests, likes and dislikes? What rewards or motivates your child? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Educational History**

Is your child currently participating in any early learning or day care program? \_\_\_\_\_  
 Where? \_\_\_\_\_

What are his/her strengths and needs?  
 \_\_\_\_\_  
 \_\_\_\_\_

Name of School: \_\_\_\_\_ Current Grade: \_\_\_\_\_  
 Current Class: \_\_\_\_\_ Teacher(s) Name: \_\_\_\_\_

If your child has received any of the following special services, please give age of child when services started and date services ended or current frequency of services.

Physical Therapy	_____	Vision Impaired	_____
Occupational Therapy	_____	Hearing Impaired	_____
Speech/language Therapy	_____		
Special Instruction	_____		
Other, specify	_____		
_____			

Other pertinent information: \_\_\_\_\_  
 \_\_\_\_\_

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Please name three social goals that you would like for your child to accomplish this year?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please name three academic goals that you would like for your child to accomplish this year?

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Please rate your current stress level on a scale of one to five.

1                      2                      3                      4                      5  
No Stress                      Moderate                      Severe Stress

If applicable, what percentage of your stress do you attribute to an Autism Spectrum Disorder?

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