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?
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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
☐ Rash  ☐ 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 __________________________

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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? __________________________

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**MEDICAL HISTORY**

Has your child ever had:

- Head injury  Age _____  Describe __________________________
- Loss of consciousness  Age _____  How long? __________________________
- Describe __________________________
- Allergies to food/medication  List: __________________________
Autism Evaluation Intake

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:

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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

- slow speech development
- unusual tone or pitch
- difficult to understand speech
- seldom speaks unless prompted
- has language of his/her own (may sound like foreign language/jargon)

Past   Current

- doesn’t understand without gestures
- repeats words/phrases over and over
- repeats questions, instead of answering them
- repeats dialogue from movies/songs verbatim

Relating with other people

Past   Current

- prefers to be by self
- aloof, distant
- fearful of strangers
- doesn’t like to be held
- doesn’t play with other children
- prefers playing with younger or older children

Past   Current

- “in a world of his/her own”
- clings to people
- not cuddly as baby
- doesn’t recognize parent

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

- often ignores sounds
- afraid of certain sounds
- 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

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### Other Senses

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### Emotional Responses

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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
- □ Parental disagreement about child-rearing
- □ 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.