Patient's History/Information

PLEASE NOTE: This form ideally should be completed by the patient's parents, even though the patient is an adult. However, if no parent is available or able to complete this form, the patient may do so to the best of his or her ability. We encourage you to review these areas with other family members, such as siblings or other individuals familiar with the patient's early history.

Patient's Name: _______________________________ M F Age: __________ Birthdate: _______________

Referred by: __________________________________ Specialty: _____________ Date: ____________

Person Completing this Form: _______________________________ Relationship to patient: _____________

Why are you seeking this evaluation? ____

____

Who is legally responsible for the patient: ____

CURRENT CONCERNS ABOUT THE CLIENT (*Please circle all that apply*)

aggression	peer relationships	school or work environment	over-activity
language abilities	toileting	preoccupations	temper tantrums
biting	hitting	self-injury	sleep problems
appetite/food selections	inattention	self-help (independence) skills	motor skills
depressed or anxious	medication	muscle tone	

self-stimulatory behaviors: rocking, spinning, flapping hands, close visual inspection

Other: ____

CLIENT'S CURRENT LIVING SITUATION

Marital Status: _____________

With whom does the patient currently reside? (Please circle all that apply)

Lives Independently   Spouse   Life Partner   Sibling(s)   Biological Mother   Biological Father

Step-mother   Step-father   Adoptive Mother   Adoptive Father   Group Home

Other (describe: ____)

Complete the following for the patient's BIOLOGICAL PARENTS to the best of your ability, even if the child/client was NOT raised by the biological parents.

Biological Mother's name: _______________________________ Age: ______

If deceased, age at time of death: ______ Cause of death: _________________________

Occupation: __________________________ Ethnic/Cultural Background: __________________________

Day Phone: _________________________________ Evening Phone: ____________________________

Biological Father's name: _______________________________ Age: ______

If deceased, age at time of death: ______ Cause of death: _________________________

Occupation: __________________________ Ethnic/Cultural Background: __________________________

Day Phone: _________________________________ Evening Phone: ____________________________

If the patient was raised by parents OTHER than biological parents, please describe them here.

Parent One's name: ____Gender: _____

Age: ______ If deceased, age at time of death: ______ Cause of death: _________________________

Relationship to patient: .. Adoptive Parent .. Step-Parent .. Foster Parent .. Other: ____________

Occupation: __________________________ Ethnic/Cultural Background: __________________________

Day Phone: _________________________________ Evening Phone: ____________________________

Parent Two's name: ____Gender: _____

Age: ______ If deceased, age at time of death: ______ Cause of death: _________________________

Relationship to patient: .. Adoptive Parent .. Step-Parent .. Foster Parent .. Other: ____________

Occupation: __________________________ Ethnic/Cultural Background: __________________________

Day Phone: _________________________________ Evening Phone: ____________________________

If the patient was ADOPTED, age patient was first in the home: ______ Age at time of adoption: ______

Are there any custody-related legal proceedings in progress or planned? Yes No

Other individuals living with client:

Name	Age	Sex	Relationship

What languages does the patient use (List PRIMARY language first): ___________________________

What other languages is the patient exposed to? ____

HISTORY (If re-evaluation, please skip to "Checklist" on page 5.)

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? (*Please circle all that apply*.)

Emotional problems	Infections	Anemia	Premature Labor
Rashes	Bed-rest	Toxemia	Difficulty in conception
Flu	Vaginal bleeding	Kidney disease	Gained more than 35 pounds
Excessive swelling	Measles/German measles	Headaches	High blood pressure
Strep Throat	Threatened miscarriage	Rh incompatibility	Excessive nausea/vomiting
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? Yes No

Please describe changes: ____

Delivery

Was infant born full-term? Yes No

If premature, how early? _________________________If overdue, how late? __________________________

Birth weight: Apgars: __________1 min __________5 min

Type of anesthetic used: None Spinal Local General

Length of active labor: __________ Describe any complications during delivery: _____________________

____

Circle 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? (*Circle all that apply*)

Breathing problems	Required oxygen	Required incubator	Feeding problems	Sleeping problems
Infection	Rash	Excessive crying	Sleeping problems	Seizures/convulsions
Bleeding into the brain				

Jaundice (Were Bilirubin lights used? No Yes – If yes, how long? __________________________)

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

Was child placed in the Neonatal Intensive Care Unit? No Yes -- If yes, why and for how long?

____

Length of stay in hospital: Mother __________ Infant __________

Developmental History

During this child's first 3 years, were any special problems noted in the following areas? (*Circle all that apply*.)

Irritability	Breathing problems	Colic	Difficulty sleeping
Eating problems	Temper tantrums	Failure to thrive	Excessive crying
Withdrawn behavior	Poor eye contact	Early learning problem	Destructive behavior
Convulsions/Seizures	Unable to separate from parent		

Other ____

Developmental Milestones

Indicate age when child:

_________sat unaided	_________walked	_________started solid foods
_________bladder trained – day	_________bladder trained – night	_________bowel trained
_________rides tricycle	_________rides bike	

Can patient be described as clumsy/uncoordinated? Yes No

Having fine motor delay? Yes No

Which hand does the patient 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 patient 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

Adaptive Skills

Feeds self	No	Yes	Helps with household chores	No	Yes
Dresses self	No	Yes	Knows phone number and address	No	Yes
Bathes self	No	Yes	Tells time accurately	No	Yes

Has the patient ever lost skills, which at one time he/she was able to perform No Yes

If yes, please explain ____

If applicable, how is the patient's misbehavior managed? ____

Family Changes and Stressors

What are the major family stresses the family and/or patient is currently experiencing or has experienced within the last year? (*Circle all that apply*)

Marital discord/fighting	Separation/Divorce	Birth/Adoption of a child	Parent-Patient conflict
Parent/sibling death	Patient-child conflict	Financial problems	Involved in court
Family deployed extensively	Move/Relocation	Physical abuse	Sexual abuse
Family emotionally/mentally ill	Family substance abuse	Loss of job	
Involved with Social Services/Protective Services		Other: _____________________	

Checklist

Please mark any of the following that describe the patient currently or in the past:

Speech

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

Relating with other people

Current	Past		Current	Past	
_____	_____	not cuddly as baby	_____	_____	prefers to be by self
_____	_____	"in a world of his/her own"	_____	_____	aloof, distant
_____	_____	"clings" to people	_____	_____	doesn't recognize parent
_____	_____	very fearful of strangers	_____	_____	likes to be held

Imitation

Current	Past	
_____	_____	doesn't imitate waving "bye-bye", "patty cake", etc. (physical imitation)
_____	_____	doesn't repeat words said to him

_____ _____ doesn't repeat words generally, but usually does what he is asked to do

_____ _____ doesn't use common gestures

Response to Sounds, Speech

Current Past

_____ _____ often ignores sounds

_____ _____ afraid of certain sounds

_____ _____ often ignores what is said to him/her (speech)

_____ _____ seems to hear distant or soft sounds that most other people don't hear or notice

_____ _____ really likes certain sounds (music, motors, etc.)

_____ _____ unpredictable response to sounds (sometimes reacts, sometimes doesn't)

_____ _____ responds to speech and sounds like other people of the same age

Visual Response

Current Past

_____ _____ stares vacantly around room

_____ _____ likes to look at self in mirror

_____ _____ stares at parts of his/her body (e.g. hands)

_____ _____ is distracted by lights – stares at certain lights

_____ _____ very interested in small parts of an object

_____ _____ seems to look at things out of the corner of his/her eye and not by looking directly at them

_____ _____ often avoids looking at people when they are talking to him

Current Past

_____ _____ often doesn't look at anything

_____ _____ likes to look at shiny objects

_____ _____ turns lights on and off repeatedly

Other Senses

Current Past

_____ _____ puts many objects in mouth

_____ _____ overreacts to pain

_____ _____ doesn't notice pain as much as most people

_____ _____ smells objects not usually smelled or smells unfamiliar objects

_____ _____ tries to chew or eat objects that are not supposed to be eaten (for example, clay)

Current Past

_____ _____ licks objects

_____ _____ likes vibrations

Emotional Responses

Current Past

Current Past

_____ _____ temper tantrums

_____ _____ over-responds to situations

_____ _____ cries/seems sad for no reason

_____ _____ laughs/smiles for no reason

_____ _____ moods change very quickly, sometimes for no apparent reason

_____ _____ often has a blank expression on face – little response to what is happening around

Medical History

Has the patient ever had:

Head injury Yes No If yes, age experienced head injury and description of head injury:

____

Loss of consciousness (LOC) Yes No If yes, age experienced LOC and description of LOC:

____

Allergies to food/medication List: ____

Surgery Age _____ Reason ______________ Describe _______________________________

____

Doctors seen now or in the past (check all that apply)

General Physician – Date of last visit: _________ Diagnosis: ______________________________

Neurologist – Date: __________ Diagnosis: ____

suspected seizures, describe: ____

seizures diagnosed, type: ____

Genetics – Date: _______ Diagnosis: ____

Psychiatry – Date: ________ Diagnosis: ____

Gastroenterology – Date: ________ Diagnosis: ____

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 (Genetic) – Date: ________ Results: __________________________

Other; Describe: ____

Medication history

CURRENT medications (PLEASE NOTE: Patient SHOULD TAKE regularly scheduled medications, if any, on the day of appointment)

Name of medication   Dose & Frequency   Date Started   Reason   Effectiveness

____

____

____

____

Who prescribes these medications? ______________________________ Date of last visit: ________________

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

Name of medication   Date Started   Reason   Effectiveness

____

____

____

____

____

Who prescribed past medications? ______________________________

Family History

Have any members of the biological mother's or biological father's families had any of the following problems or disorders (*Please circle 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	Intellectual Disability	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, etc.)

Childhood behavior disorder (aggressive/defiant/ADHD)

Other: ____

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

____

School History

Patient's Highest Level of Education (*Please circle applicable response*.)

11th grade or less High school graduate Bachelor's Degree GED

Vocational Certificate Associates Degree Graduate/Professional

Did the patient have special education testing in school?

Psychological/Cognitive – Date: __________ .. Academic – Date: ____________________

Speech/Language – Date: _______________ .. Other: _______________ Date: _________

Was/Is the patient on an IEP (Individual Education Plan)? _____ For what reason? ________________

(If patient is no longer in school, please skip to Work History.)

Current school: School district:__________________ Grade level: _____

Type of placement/class (Circle all that apply) General Education Content Mastery Resource

Self-contained Behavior adjustment class

SERVICES

School District (Please bring copies of the most recent Individual Education Plan (IEP))

Patient's age when school services began: __________ Age when discontinued: __________

Individual Education Plan (IEP) eligibility category(ies): ______________________

Which services is the patient CURRENTLY receiving through the SCHOOL DISTRICT? (Circle all that apply)

Speech therapy Occupational therapy Physical therapy

Adaptive Physical Education Discrete Trial Training(DTT/ABA) Social Skills

Other; describe: ____

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

Private Services (Please bring copies of relevant reports to your first appointment.)

Speech therapy Provided by: ___________________________ Age when began: ______________

Occupational therapy Provided by: ______________________ Age when began: _____________

Physical therapy Provided by: __________________________ Age when began: ______________

Social Skills Provided by: _____________________________ Age when began: ______________

Vocational Assistance, Provided by: _____________________ Age when began: ______________

Psychotherapy, Provided by: ___________________________ Age when began: ______________

Other; describe: ____

Please provide copies of your most recent Individual Education Plan (IEP), ECI assessment or Individual Family Service Plan (IFSP), and any other relevant reports prior to your first scheduled appointment.