Great Plains Interdisciplinary Autism Diagnostic Clinic

Date: ____________________________

Referral Information:

Who referred you to this clinic? ____

Identifying Information:

Patient Name: _____________________________________

Patient Date of Birth: ______________________ Age: __________________ Gender: M or F

Address: ____

Home Phone#: ______________________________

Mother's Name: ___________________________________ Father's Name: _______________________

(If not parents, please indicate: ___ legal guardian* ___ foster parent __ other, whom_____________
(*Please provide copy of guardianship papers)

Parent's Address: ____

Mother's Daytime Phone: ___________________ Father's Daytime Phone #: _____________________

Email address: ____

Parents: Married Living together Separated Divorced

Person/Relationship to child completing this form: ____

Patient's Physician Name and Address: ____

Patient Attending Which School: ____

Presenting Concerns:

Describe as completely as possible your concerns about your child's language, behavioral, medical, feeding, hearing or motor skills. Also include the age of your child they presented:

____

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____

Does your child have difficulty going from one setting to another setting or one activity to another activity? (If yes, Please explain): ____

____

Does your child have difficulty feeding himself or difficulty at meal times? (If yes, Please explain):

____

____

Does your child take naps? _________________ If so, how long does he/she sleep? ________________

Does your child have a bedtime routine? ____________ How many hours of sleep per night __________

Does your child have difficulty in public settings (restaurants, shopping, church, school)? ____________

If so, please explain ____

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Developmental History:

Pregnancy and Birth History

Age of Mother at child's birth: _______________ Age of Father at child's birth: _______________

Was this pregnancy planned? Yes or No Was your child exposed to any drugs during pregnancy (prescription or recreational)?__________ If yes, please list and duration __________________

____

Was your child exposed to alcohol during pregnancy? Yes or No

Was this pregnancy full term or premature? __________ If premature, gestational weeks_____

Was this pregnancy normal or complicated? _______________ List complications if any _______

____

Length of labor: ______________ Delivery method: Caesarean or vaginal Forceps: Yes or No

Medications used during labor and/or delivery? ______________Child's Birth Weight _________

Were there any problems at birth? ______________ If yes, please explain: ___________________

____Did your child require oxygen at birth: Yes or No

Was your child "blue" or jaundiced at birth? ____

Were there any problems immediately following the birth or during the first two weeks of your child's life (health, swallowing, sucking, feeding, sleeping, others)? If so, please describe:

____

____

____

Developmental History:

At what age did the following occur?

Held head erect while lying on stomach	______________________________________
Rolled over alone	______________________________________
Sat alone unsupported	______________________________________
Crawled	______________________________________
Stood alone	______________________________________
Walk unaided	______________________________________
Fed self with spoon	______________________________________
Toilet trained	Bladder ______daytime _________nighttime Bowel _______daytime _________nighttime
Dressed and undressed self	______________________________________

What hand does your child prefer? Right or Left or Ambidextrous

How would you describe your child's current physical development: _______________________

____

Behavioral History:

Please check as they apply:

During the first three years of life of the child:	Frequently	Sometimes	Rarely
Enjoyed being held			
Was alert to what was happening around him/her			
Explored the surrounding environment			
Was active			
Interacted with adults			
Interacted with other children			
Was predictable in terms of sleep/waking patterns			
Was predictable in bowel and bladder patterns			
Was predictable in terms of hunger patterns			

Please check as they apply:

During the 2nd and 3rd years of life of the child:	Frequently	Sometimes	Rarely
Had temper tantrums			
Had extreme mood changes			
Was afraid of new faces or places			
Was distractible			
Was unresponsive to discipline			
Was destructive			
Engaged in self-hurting or injuring behavior (rocked or banged head)			
Very quiet			
Did not like to be held/touched			
Preferred toys to contact with people			
Cried a lot			

Please check as they apply:

Presently	Yes	No
Is your child difficult to manage?		
Does your child have difficulty concentrating?		
Can your child stay with an activity?		
Is your child overactive?		
Is your child underactive?		
Is your child excitable?		
Is your child happy?		
Does your child cry a lot?		
Is your child irritable?		

Please check as they apply:

Regarding your child's interactions with others	Yes	No	Is it a problem?
Does your child prefer to be alone?			
Does your child make friends easily?			

Does your child prefer younger children?			
Does your child prefer adults?			
Does your child have acting out behaviors with adults?			
Does your child have acting out behaviors with peers?			
Does your child have acting out behaviors with siblings?			
Does your child usually enjoy being swung, bounced on your knee, etc?			

Does your child separate from his/her parents without crying or fussing? Yes or No If he/she has difficulty please explain: ____

____

How do you discipline your child? ____

____

What are your child's favorite play activities? ____

____

____

Speech, Language and Hearing History:

How much did your child babble and coo during their first six months? ____________________

At what age did he/she speak their first words? ____

What were your child's first few words? ____

How many words was your child speaking at 1 ½ yrs? __________________________________

At what age did he/she speak two to three word phrases/sentences? _____________________

Does your child make sounds incorrectly? ________________ If so, which ones? ____________

How well can your child be understood when talking to:

Parents: ____

Siblings: ____

Peers: ____

Relatives: ____

Strangers: ____

Does your child imitate words but not use them? ____________________________________

Did the development of your child's speech ever slow down or did he/she ever stop talking?

____

Are there any other languages spoken in the home? _______ Which language? _____________

By whom and how often? ____

How well does your child understand what is said to him/her? ___________________________

____

How does your child's speech compare to that of his/her siblings at this age? _______________

____

Does/did your child have ear infections? __________ If so, how many? ____________________

Does your child hear adequately? ____

Does your child ever seem oversensitive to noise (e.g. plugging ears)? _____________________

Does his/her hearing appear to be constant or does it vary? ____________________________

Is his/her hearing poorer when he/she has a cold? ___________________________________

Has your child ever worn a hearing aid? _______ Which ear _______ At what age? __________

How many hours per day? ___________ Does it seem to help him/her? ___________________

Please check as they apply:

Does your child	Yes	No	Explain: Give ages if possible
Cry less than normal amount			
Laugh less than normal amount			
Yell and screech to attract attention or express annoyance			
Head banging and foot stomping			
Temper tantrums			

Does your child	Yes	No	Explain: Give ages if possible
Very alert to gesture, facial expression or movement			
Generally indifferent to sound			
Did not respond when spoken to			
Respond to noises (car horns, telephones) but not to speech			
Gags or chokes easily			
Constant throat clearing			

Vision History:

Does your child view objects up close (within six inches)? ________________________________

Does your child squint when looking at objects? _______________________________________

Do you have any concerns regarding your child's vision? If so, please explain _______________

____

Medical History:

Is your child currently under the care of a doctor? __________ If yes please explain: _________

____

Does your child currently take any medications (prescription or over the counter including vitamins or supplements)? _________ If yes, please list dosage and frequency ______________

____

____

Does your child have any allergies to medications or food? _________ If yes, please list _______

____

Are your child's immunizations up to date? _____________ If no, please explain: ___________

____

Has your child had any major medical problems? ___________ If yes, please explain _________

____

Has your child had any hospitalizations or surgeries? _______ If yes, please give dates and explain: ____

____

Has your child had any broken bones? _________ If yes, please explain ___________________

Has your child ever fallen or had a blow to the head? __________ If yes, did he/she lose consciousness? Yes or No; Did it cause a concussion? Yes or No

Did it cause any: Nausea: Yes or No; Vomiting: Yes or No; Drowsiness: Yes or No

Nutrition History:

Does your child experience any feeding problems? _____________ If yes, please explain: _____

____

Please describe your child's usual appetite? ____

Does your child take vitamins or other supplements? _________________________________

Does your child have any known or suspected food allergies? _______ If yes, please list: ______

____

Has your child lost or gained any weight recently? _____________________________________

What type of exercise does your child do regularly? ____________________________________

Have you tried a special diet for your child? _______ If so, what kind or which one: __________

____

Name some of your child's favorite foods: ____

Do family members eat together or at separate times? _________________________________

Please keep a 24 hour food diary for your child:

24 Hour Recall Form

Meal	Time	Food	Notes
Breakfast			
Snack			
Lunch			
Snack			
Supper			
Snack			

Educational History:

Does your child attend day care? Yes or No If yes, where: ________________________________
How many hours per week? __________________

Does your child attend nursery school? Yes or No If yes, where: __________________________
How many hours per week? __________________

Does your child attend kindergarten? ____________ If yes, where: _________________________

Does your child attend school (Grade 1-12)? ________ If yes, where: _______________________

What grade is your child in? ____________ Has your child failed a grade? __________ If yes, which one: ___________ Has your child skipped a grade? _________ If yes, which one: __________

What are your child's average grades? ____________ Favorite/Best subjects: ________________

Least favorite/poorest subjects: _____________________________

What is your impression of your child's learning abilities? _________________________________

____

Has anyone talked to you whether they believe your child may have a learning problem? If yes, who and what problem are they wanting to address: ____________________________________

____

How old was your child at the time: ________________________

Is your child on an IEP (Individualized Education Plan)? __________________________________

Has your child received any of the following services (through school or direct therapy) and if so where and how often:

Speech ____
Language ____
Hearing ____
Psychological ____
Special Education ____
Behavioral ____

How available are services for your child in your home community?

5) Very available
4) Somewhat available
3) Neutral
2) Somewhat unavailable
1) Very unavailable

How do you feel the community-based services were organized for your family's use?

5) Very easy to use
4) Easy to use
3) Neither easy nor difficult to use
2) Difficult to use
1) Very difficult to use

Please add any additional information you feel will help us in understanding your child:

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____

Does your child currently have medical insurance? Yes or No If yes, What company____

Social Security #: ______________________ (This is requested for reporting to Special Health Services – this diagnostic clinic is funded by them.)