The Behaviour Change Clinic
Autism Intake Form

CHILD'S PERSONAL INFORMATION

Today's Date: _____

Child's Name: _____ ◯ Male ◯ Female Age: _____ Birthdate: _____

Address: _____

City: _____ Postcode: _____ Country: _____ Phone: _____

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
- ☐ Motor skills
- ☐ Inappropriate sexual behavior
- ☐ 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?

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 MOTHER to the best of your ability, *even if you are not the child's biological parent.*

Biological Mother's Name: _____ Age: _____ Birthdate: _____

Ocupation: _____ Ethnic / Cultural Background: _____

Work Phone: _____ Home Phone: _____ Mobile Phone: _____

Complete the following for the child's BIOLOGICAL FATHER to the best of your ability, *even if you are not the child's biological parent.*

Biological Father's Name: _____ Age: _____ Birthdate: _____

Ocupation: _____ Ethnic / Cultural Background: _____

Work Phone: _____ Home Phone: _____ Mobile Phone: _____

If child does not live with BOTH biological parents, who has legal custody of the child? Type below!

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
☐ Parent's partner ☐ Other, describe: _____

Ocupation: _____ Ethnic / Cultural Background: _____

Work Phone: _____ Home Phone: _____ Mobile Phone: _____

Parent / Caretaker Two's Name: _____ Age: _____ Birthdate: _____

☐ Relationship to child: ☐ Adoptive Parent ☐ Step-Parent ☐ Foster Parent
☐ Parent's partner ☐ Other, describe: _____

Ocupation: _____ Ethnic / Cultural Background: _____

Work Phone: _____ Home Phone: _____ Mobile Phone: _____

If child is with ADOPTIVE parent, age child was first in home: _____ Date of legal 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: _____

Ocupation: _____ Ethnic / Cultural Background: _____

Relationship to Child: _____

Siblings: (please list whether the siblings live in the child's home or not)

Name: _____ Age: _____ ☐ Male ☐ Female Full/Step/Half? _____

Name: _____ Age: _____ ☐ Male ☐ Female Full/Step/Half? _____

Name: _____ Age: _____ ☐ Male ☐ Female Full/Step/Half? _____

Other occupants of child's residence NOT listed above. Describe below ...

What languages does the child use (List PRIMARY language first)

What other languages is your child exposed to?

DEVELOPMENTAL HISTORY

Prenatal / Pregnancy

Did the biological mother have any of the following immediately before/after or during pregnancy?

☐ Maternal injury

Describe: _____

☐ Hospitalization during pregnancy. Reason: Type below!

Describe: _____

☐ X-rays during pregnancy. What month of pregnancy?

Describe: _____

Did the biological mother have any of the following during pregnancy? (continue on the next page)

☐ Emotional problems ☐ Infections ☐ Premature Labor

☐ Rashes ☐ 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
- [ ] Urinary problems
- [ ] Other virus, describe: _____
- [ ] Special diet, describe: _____
- [ ] Meds: _____
- [ ] Other: _____

Mother's age at conception: _____

Did the mother have previous pregnancies? ◯ No ☐ Yes

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: _____ Apgars: at 5 minute: _____

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 If Yes - How long? _____
- [ ] Feeding problems
- [ ] Flu
- [ ] High blood pressure
- [ ] Kidney disease
- [ ] 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: _____

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: ☐ Normal ☐ Drooling ☐ Gagging ☐ Difficulty swallowing

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 SKILS

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:

If other, describe below;

Who is mainly in charge of discipline?

What do you find most difficult about raising your child?

MEDICAL HISTORY

Has your child ever had:

Head injury Age _____ Describe _____

Loss of consciousness Age _____ How long? _____

Describe below

Allergies to food / medication List: (list below)

Surgery - Age _____ Reason _____

Describe below;

Ear Infections: Age _____

Describe

Ear grommits? ◯ Yes ◯ No

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:

If suspected seizures, describe:

If seizures diagnosed, type:

☐ Genetics – Date: .....

Diagnosis:

☐ Psychiatry – Date: .....

Diagnosis:

☐ Psychology – 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 (Genetics) – Date:

Results:

☐ Other Describe:

MEDICATION HISTORY

CURRENT medications(continue on next page!)

Name of medication:	Dose & Frequency	Date:
Name of medication:	Dose & Frequency	Date:

Name of medication:	Dose & Frequency	Date:
Name of medication:	Dose & Frequency	Date:
Name of medication:	Dose & Frequency	Date:

If more than 5 medications describe below:

Reason: (use one line per medication)	Effectiveness:	Who prescribes these medications?	Date of last visit:

CURRENT SKILLS

COMMUNICATION SKILLS

How does your child communicate his / her needs?:

ADAPTIVE / SELF - HELP SKILLS

Is your child able to:

Put a shirt on	☐ Yes	☐ No	☐ With help
Take a shirt off	☐ Yes	☐ No	☐ With help
Put trousers on	☐ Yes	☐ No	☐ With help
Take trousers off	☐ Yes	☐ No	☐ With help
Put socks on	☐ Yes	☐ No	☐ With help
Take socks off	☐ Yes	☐ No	☐ With help
Put shoes on	☐ Yes	☐ No	☐ With help

Take shoes off	☐ Yes	☐ No	☐ With help
Button shirts	☐ Yes	☐ No	☐ With help
Unbutton shirts	☐ Yes	☐ No	☐ With help
Put on coat	☐ Yes	☐ No	☐ With help
Take off coa	☐ Yes	☐ No	☐ With help
Zip coat	☐ Yes	☐ No	☐ With help
Unzip coat	☐ Yes	☐ No	☐ With help
Brush teeth	☐ Yes	☐ No	☐ With help
Wash face	☐ Yes	☐ No	☐ With help
Dry face	☐ Yes	☐ No	☐ With help
Brush hair	☐ Yes	☐ No	☐ With help
Wash hands	☐ Yes	☐ No	☐ With help
Dry hands	☐ Yes	☐ No	☐ With help
Blow nose	☐ Yes	☐ No	☐ With help

EATING

Can your child *independently*:

Eat finger foods	☐ Yes	☐ No
Use a fork	☐ Yes	☐ No
Use a spoon	☐ Yes	☐ No
Cut with a knife	☐ Yes	☐ No
Keep his eating area clean	☐ Yes	☐ No
Clean up after a meal	☐ Yes	☐ No
Drink from a cup	☐ Yes	☐ No
Drink from a straw	☐ Yes	☐ No
Pour liquid into a cup	☐ Yes	☐ No

Do you have any concerns about your child's diet or eating habits? If yes, please describe:

TOILETING

Is your child toilet trained? ◯ Yes ◯ No If no, please move on to next section.

Is your child: ◯ Day trained ◯ Night trained ◯ Bowel trained

How many accidents per week does your child have? _____

Does your child use unfamiliar/public toilets? ◯ Yes ◯ No

Do you have any concerns regarding toileting?

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
- ☐ Cerebral Palsy
- ☐ Kidney disease
- ☐ Physical handicap
- ☐ Tuberous Sclerosis
- ☐ Huntington' chorea
- ☐ Sickle-cell anemia
- ☐ Diabetes
- ☐ Alcohol / drug abuse
- ☐ Schizophrenia
- ☐ Autism / PDD
- ☐ Bipolar/manic-depressive disorder
- ☐ Antisocial Behavior(assaults, thefts, arrests)
- ☐ Cruel to animals
- ☐ School adjustment
- ☐ Chromosomal / genetic disorder
- ☐ Severe head injury
- ☐ Migraine headaches
- ☐ Nervousness / Anxiety
- ☐ Alzheimer' disease
- ☐ Muscular dystrophy
- ☐ Cancer
- ☐ Heart disease
- ☐ Depression
- ☐ Mental Retardation
- ☐ Reading problem
- ☐ Emotional disturbance/mental illness
- ☐ Tics / Tourette' syndrome
- ☐ Childhood behavior disorder (aggressive/defiant/ADHD)
- ☐ Other
- ☐ Overactivity
- ☐ High blood pressure
- ☐ Multiple Sclerosis
- ☐ Stroke
- ☐ Hemophilia
- ☐ Parkinson' disease
- ☐ Seizures/epilepsy
- ☐ Food allergies
- ☐ Physical / Sexual abuse
- ☐ Speech/language delay
- ☐ Other learning disability

If Other, please describe:

Has anyone in the family ever received special education services? ◯ Yes ◯ No

If 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
- ☐ Birth/Adoption of another child
- ☐ Separation
- ☐ Sibling conflict
- ☐ Divorce
- ☐ 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
- [ ] Sexual abuse
- [ ] Parental disagreement about child-rearing
- [ ] Involved with Social Services/Child Protective Services
- [ ] Other, if not listed describe below:

Describe:

SCHOOL HISTORY

If more space is necessary, please attach additional sheets or write on the back of this page.

Current school: _____

LEA _____

Year: _____

- [ ] Type of class
- [ ] Mainstream
- [ ] Special Ed
- [ ] Behavioural 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)? ◯ Yes ◯ No If Yes, for what reason?

SERVICES

Please list services your child has received.

Child's age when school services began: _____

Individual Education Plan (IEP) eligibility: _____

Which services is your child CURRENTLY receiving?

- [ ] Speech therapy How often? _____
- [ ] Occupational therapy How often? _____
- [ ] Physiotherapy How often? _____
- [ ] ABA How often? _____
- [ ] Other - describe: _____

TERMS and CONDITIONS

- [ ] **I agree with the terms and conditions set by The Behaviour Change Clinic.**