CHATTANOOGA AUTISM CENTER

Name: _____

Initial Intake

ID #: _____

Patient's Preferred Name: Date

Patient Date of Birth:

Special Consumer Needs (ethnicity, language, cultural, age, disability) Circle: ☐ YES ☐NO

If Yes, Explain:

Person completing this form: Relationship to Patient:

Parent/Legal Guardian (if not informant):

Address:

Emergency Contact: Relationship: Daytime Phone:

Preferred hospital in case of emergency:

Referred By:

Primary Care Provider: Date of last physician visit:

Address: Phone: Fax:

Any known allergies. ☐No ☐Yes; please list.

Allergen	Reaction	Treatment

What information or services would you like to leave the Chattanooga Autism Center with?: _____

Specific Services Requested: ☐ Testing Only ☐ Testing and Treatment ☐ Treatment Only ☐ Caregiving/Advocacy Training

☐ Support Group ☐ Community Resources ☐ Don't know ☐ Other_____

Name: _____

ID #: _____

Birth History:

Birth Weight: Was Patient Born Premature? ☐N ☐Y: How many weeks/months?

How long did the patient stay in the hospital after birth?

Were there any problems with the pregnancy or birth? ☐N ☐Y If Yes, explain:

Did the baby go home with the mother? ☐Y ☐ N If No, explain:

Developmental History:

Please fill in the **age** the patient began these activities. If the information is not known, please check here ☐ and explain:

Sat Alone		Walked Alone		Fed Self at Table	
Said First Words		Used Word Phrases		Bladder Trained	
Bowel Trained		Tied Shoes		Rode tricycle/Big wheel	

Did the patient ever loose a skill that they previously had? ☐No ☐Yes, explain:

Have developmental delays been previously Diagnosed? ☐No ☐Yes, by: ☐ MD ☐School ☐Therapist ☐Other

Is patient now receiving or have they received early intervention services? ☐N ☐Yes, where? _____

Medical History:

Serious medical illnesses, conditions or injuries	Please check yes or no	Is the patient currently receiving treatment?	If currently receiving treatment, please provide the name and address of the provider.	Phone number
Head Injury	☐Y ☐N	☐Y ☐N		
Major/Chronic Illness	☐Y ☐N	☐Y ☐N		
Asthma	☐Y ☐N	☐Y ☐N		
Seizures	☐Y ☐N	☐Y ☐N		
PE Tubes (ear tubes)	☐Y ☐N	☐Y ☐N		
Dental Work	☐Y ☐N	☐Y ☐N		
Overnight Hospitalizations	☐Y ☐N	☐Y ☐N		
Major Surgeries	☐Y ☐ N	☐Y ☐N		
Other	☐Y ☐ N	☐Y ☐N		
Other	☐Y ☐N	☐Y ☐N		
Other	☐Y ☐N	☐Y ☐N		

Name: _____

ID #: _____

Are this patient's Immunizations up to date? ☐Y or ☐ N If no, explain:_____

Current medications: (add additional page as needed for listing)

Medication	Dosage	Reason	Side Effects/Allergies	Prescribed By

Substance Use: (N/A if patient is a child)

Alcohol ☐ Y ☐N Recreational Drugs ☐Y ☐N Prescription Medication ☐Y ☐ N
Nicotine ☐Y ☐N Caffeine ☐ Y ☐N

If yes, give additional information : _____

Hearing and Vision:

Does this patient have any hearing difficulty? ☐N or ☐Y
Does this patient have any vision difficulty? ☐Y or ☐N

If yes, explain and corrective procedures/devices:_____

***The Chattanooga Autism Center encourages documentation of hearing and vision results from PCP, Health Department, etc.**

Treatment History

	Please check yes or no	Is the patient currently receiving treatment?	Do you want us to exchange information with this provider?	Please provide dates of service, name and address of the provider.	Phone number
Speech/Language	☐Y ☐N	☐Y ☐N	☐Y ☐N		
Physical Therapy	☐Y ☐N	☐Y ☐N	☐Y ☐N		
Occupational Therapy	☐Y ☐N	☐Y ☐N	☐Y ☐N		
Psychological Testing	☐Y ☐N	☐Y ☐N	☐Y ☐N		
Counseling	☐Y ☐N	☐Y ☐N	☐Y ☐N		
Substance Abuse	☐Y ☐N	☐Y ☐N	☐Y ☐N		
Other	☐Y ☐N	☐Y ☐N	☐Y ☐N		
	☐Y ☐ N	☐Y ☐N			

Name: _____

ID #: _____

			☐Y ☐N		

If under school age:

Child stays with: ☐ Parent ☐Other Relative ☐Day Care ☐Other: _____

Learning or Behavior Problems in these settings? ☐Y ☐N

Explain: _____

Education: (Check one. If adult, how far did you go in school?):

Name of School:_____ Grade/Level:_____ Special Education: ☐No ☐Yes, type:_____

Current Grades: Reading _____ Spelling _____ Math _____ Other (list)_____

Grades Repeated: ☐No ☐Yes, list:_____

Learning Problems: (please check all that apply):

☐Reverses letters/numbers
☐Has difficulty retaining knowledge
☐Does not complete classwork
☐Other: _____

☐Does not complete homework
☐Exhibits short attention span
☐Daydreams

☐Acts out or is aggressive
☐Cries
☐Disruptive in classroom

Relationships at school(please describe):

With Teachers:
With Peers:

Other Educational Concerns: _____

Vocational History (include sheltered workshops or community participation) ☐Does not apply

Current Job:

Previous Jobs:

Medical or behavioral factors affecting job performance:

Relationship with supervisors:

Relationships with coworkers:

Relationships with customers:

Additional comments concerning learning problems:

Name: _____

ID #: _____

Family Information:

With whom is patient residing? ☐Father ☐Mother ☐Stepfather ☐Stepmother ☐Other:_____

Please name all other individuals who live in the home:_____

	Birth Mother Name:	**Birth Father Name:**
Name		
Age		
Education		
Learning Problems		
Occupation		
Health		
Developmental Problems		
Date of marriage/divorce		

	Stepmother/Other Name:	**Stepfather/Other Name:**
Name		
Age		
Education		
Learning Problems		
Occupation		
Health		
Developmental Problems		
Date of marriage/divorce		

Siblings	1	2	3	4	5	6
Name						
Age						
Education						
Learning Problems						
Occupation						
Health						
Developmental Problems						
Live in same house as client? (Y or N)						
Relationship (E.g., ½, step, maternal)						

Behavior of patient at Home: (Check the characteristics that apply to behaviors in the *past 3 months only*)

Emotional

Sadness	☐ Y	☐N
Anxiety	☐Y	☐N
Anger	☐Y	☐N
Mood swings	☐Y	☐N
Physical complaints	☐Y	☐N
Legal issues	☐Y	☐N

Social

Withdrawn	☐Y	☐N
Affectionate	☐Y	☐N
Lacks empathy	☐Y	☐N

Behavior

Impulsive	☐Y	☐N
Hyperactive	☐Y	☐N
Opposition	☐Y	☐N
Aggression	☐Y	☐N
Self injury	☐Y	☐N
Breaks objects	☐Y	☐N
Sets fires	☐Y	☐N

Other

Short attention span	☐Y	☐ N
Sensory sensitivity	☐Y	☐N
Repetitive behavior	☐Y	☐N

Name: _____

ID #: _____

Few friends ☐Y ☐N Unusual interest ☐Y ☐N
Lies frequently ☐Y ☐N Sexuality concerns ☐Y ☐N

Quality of relationships with:
Parents: _____

Step-parents: _____

Siblings: _____

Peers:_____

Others: _____

Methods of Discipline:_____

Interests: _____

Strengths: _____

Eating Problems: ☐None ☐Pica (eating non-food items) ☐Chewing/Swallowing

☐Eating Ritual ☐Binge Eating/Purging ☐Food Intolerances ☐Texture Sensitivity

Current Motor Skills: ☐Clumsiness ☐Poor eye/hand coordination ☐Sensory Sensitivity

☐Fine motor delays ☐Gross Motor delays

Describe motor skills problems:_____

Speech and Language: (Check) Patient currently speaks in: ☐Words ☐Phrases ☐Sentences ☐Nonverbal

Please check all that apply to this patient's speech, both currently and in the past:

☐ Normal Development ☐Stuttering ☐Mispronunciations ☐Babbling

☐Odd Voice ☐No speech ☐Repetitive speech ☐Echolalia

☐Monotone ☐Unusual sounds ☐Off-topic responses

☐Trouble expressing needs ☐Responds slowly ☐ Trouble understanding others

☐Trouble following oral directions ☐ Trouble processing/organizing information

Sleeping Patterns:

Bedtime: _____ Wakes at what time? _____ Naps? ☐N ☐ Y How long are naps?

Sleeps through the night? ☐ Y ☐N Wakes easily? ☐ Y ☐N Falls asleep easily? ☐Y ☐ N

Requires sleep medication? ☐ Y ☐ N Name of medication:_____

Name: _____

ID #: _____

Are any of these sleep problems: ☐New? ☐Recurrent? ☐Episodic?

Describe history of any physical abuse, sexual abuse, or emotional trauma(s): _____

_____

Involvement with the Department of Children's Services? ☐Y ☐ N , If yes, how long? _____
Involvement with Adult Protective Services? ☐Y ☐N, If yes, How long _____

Family Medical History (report 3 generations) Check those that apply and Explain checked items below (e.g., type of mental illness)						
	Parents	Grandparents	Great Grandparents	Sibs	Uncle/ Aunt	Cousins
Congenital/birth problems						
Syndromes						
Special Education						
Slow Learner						
Mental Retardation						
Diagnosed Hyperactivity						
Mental Illness						
Speech/language problems						
Babies/Young Adult Deaths						
Consanguinity (children between close relatives)						
Seizure Disorder						
Illness (cancer, heart, diabetes)						
Other:						
Other:						
Other:						

Explain: _____

_____

_____