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 | | |

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

**Name:** _____

**ID #:** _____

## 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 CAC encourages documentation of hearing and vision results from PCP, Health Department, etc. Please provide this information prior to your first appointment, if possible.**

## 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 | ☐ Y ☐ N | | |

**Name:** _____

**ID #:** _____

## 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 | ☐ Does not complete homework | ☐ Acts out or is aggressive |
| ☐ Has difficulty retaining knowledge | ☐ Exhibits short attention span | ☐ Cries |
| ☐ Does not complete classwork | ☐ Daydreams | ☐ Disruptive in classroom |

☐ Other: _____

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 |

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 |

Social

| | | |
|---|---|---|
| Seeks attention | ☐ Y | ☐ N |
| Withdrawn | ☐ Y | ☐ N |
| Affectionate | ☐ Y | ☐ N |
| Lacks empathy | ☐ Y | ☐ N |
| Few friends | ☐ Y | ☐ N |
| Lies frequently | ☐ Y | ☐ N |
| Legal issues | ☐ Y | ☐ N |

Other

| | | |
|---|---|---|
| Short attention span | ☐ Y | ☐ N |
| Sensory sensitivity | ☐ Y | ☐ N |
| Repetitive behavior | ☐ Y | ☐ N |
| Unusual interest | ☐ Y | ☐ N |
| Sexuality concerns | ☐ Y | ☐ N |

**Name:** _____

**ID #:** _____

Quality of relationships with:

Parents: _____

Step-parents: _____

Siblings: _____

Peers: _____

Others: _____

Methods of Discipline: _____

**Recreational Activities**: _____

**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: _____

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

**Name:** _____

**ID #:** _____

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: _____

_____

_____