AUTISM INTAKE QUESTIONNAIRE

Please complete this form to the best of your ability. We recognize that you may not have the answers to all questions. If you feel that there is not enough room or that you would like to elaborate further about a particular topic, please feel free to include it at the space provided at the end of the form. All information requested in this form is important and will allow us to provide you with the most accurate diagnosis and optimal treatment and care plans. Thank you for taking the time to complete it.

Reasons for Evaluation/ Treatment:

What are your primary patient concerns? Please be specific.

_____

_____

_____

_____

_____

_____

_____

_____

_____

What do you hope to gain from the evaluation?

_____

_____

_____

_____

_____

_____

_____

Identifying Information

1. Patient's Name: _____ **2. Patient's Date of Birth:** _____

Address: _____

Address: _____

Phone:_____ **Email:**_____

Medical History

Has the patient ever had or been diagnosed with any of the following conditions?

	No	Yes		No	Yes
Hearing Loss	☐	☐	Seizures	☐	☐
Vision or Eye Problems	☐	☐	Sleep Problems	☐	☐
Birth Defects	☐	☐	Tics/ Movement Disorders	☐	☐
Chronic Stomach/Bowel Problems (ie: constipation, diarrhea, vomiting, reflux)	☐	☐	Genetic Disorders (e.g. Fragile X, Tuberous Sclerosis, Down syndrome, Rett Syndrome, Neurofibromatosis)	☐	☐
Allergies (environmental, seasonal)	☐	☐	Other Medical Conditions	☐	☐
Multiple Ear Infections	☐	☐	Autism/ASD	☐	☐
Frequent or Chronic Headaches	☐	☐	ADHD/ADD	☐	☐
Head Abnormalities	☐	☐	Depression	☐	☐
Chronic Heart Conditions/Disease	☐	☐	Mania / Bipolar Disorder	☐	☐
Lung Disease (Asthma, other)	☐	☐	Obsessive-Compulsive Disorder	☐	☐
Kidney/Bladder/Genital Problems	☐	☐	Anxiety	☐	☐
Chronic Skin Problems	☐	☐	Schizophrenia	☐	☐
Hormone/ Growth Problems	☐	☐	Other Psychiatric Illnesses	☐	☐

If you answered "**Yes**" to any of the above, please explain:

_____

_____

Prior Medical Evaluations

1. Has the patient had any of the following evaluations?

				If yes, results?:	
Evaluation	**No**	**Yes**	**Unsure**	**Normal**	**Abnormal**
Audiologic Evaluation	☐	☐	☐	☐	☐
Vision Evaluation	☐	☐	☐	☐	☐
Head Imaging (MRI, CT or Ultrasound)	☐	☐	☐	☐	☐
EEG	☐	☐	☐	☐	☐
Genetic Testing	☐	☐	☐	☐	☐
Other Evaluations, Procedures, or Results	☐	☐	☐	☐	☐

If any of the above were "**Abnormal**", please explain:

_____

_____

	No	Yes	If "Yes", provide date & explanation
2. Has the patient ever been hospitalized?	☐	☐	_____
3. Has the patient had any surgeries?	☐	☐	_____

4. Are the patient's immunizations up to date? ☐ **No** ☐ **Yes** ☐ **Unknown**

Medications & Biomedical Interventions

1. Is the patient currently taking any medications (prescribed or over the counter), vitamins, or supplements?

Medication, Vitamin, or Supplement Name	Purpose	Date Started	Side Effects

2. Does the patient follow any special diets or have special dietary needs? ☐ **No** ☐ **Yes**
If **Yes**, please explain: _____
_____

3. Please list any other biomedical interventions: _____
_____
_____

	None known	Yes	If "Yes", please explain.
4. Is the patient allergic to any medications?	☐	☐	_____
5. Is the patient allergic to any foods?	☐	☐	_____

Pregnancy & Birth History

1. How old were biological parents at time of the patient's birth? Biological mother: _____
Biological father: _____
2. How many times has biological mother been pregnant? _____
3. How many pregnancies have resulted in live births? _____

Pregnancy	No	Yes	Unknown
1. Were there fertility treatments to become pregnant with the patient?	☐	☐	☐
2. Was the patient part of a multiple birth pregnancy? (e.g., twins)	☐	☐	☐
3. Did the birth mother take any medications, vitamins or supplements during pregnancy? If **Yes**, please specify below.	☐	☐	☐
4. Did the birth mother use any alcohol, tobacco or recreational drugs during pregnancy? If **Yes**, please specify below.	☐	☐	☐
5. Were there any difficulties during pregnancy? (eg: bleeding, fever, infections, abdominal trauma, decrease in fetal movement)? If **Yes**, please specify below.	☐	☐	☐

If "**Yes**" to any of the above, please explain:
_____
_____

Labor & Delivery and Neonatal Course

1. Was Pitocin used to induce or augment this labor? ☐ **No** ☐ **Yes** ☐ **Unknown**
2. The delivery was: ☐ **Vaginal** ☐ **By C-section** ☐ **Unknown**
   If **C-Section**, reason performed: _____
3. Please provide the following information about the patient's birth measurements:
   Birth weight: _____ lbs. & oz. / grams (circle one)
   APGAR scores (if known): ____ at 1 minute ____ at 5 minutes

	No	Yes	Unknown
4. Was the patient born premature? If **Yes**, how many weeks premature? _____	☐	☐	☐
5. Were there complications during labor or delivery?	☐	☐	☐
6. Was any special resuscitation required or was the patient admitted to the NICU? If **Yes**, how old was the client when discharged? ____ days	☐	☐	☐
7. Did the patient experience any problems while still in the hospital? (e.g. feeding problems, breathing difficulties, infections, jaundice, seizures)	☐	☐	☐

If "**Yes**" to any of the above, please explain: _____
_____

Family History

1. Please indicate if anyone in the patient's biological family ever had any of these conditions (if so, please specify which family member, such as "mother", "maternal grandmother", "paternal uncle").

Condition:	Family Member(s)	Condition:	Family Member(s)
Vision Problems		Hearing Problems	
Epilepsy/Seizures		Tourette's Syndrome	
Genetic Disorders		Birth Defects	
Multiple Miscarriages or Stillbirths		Childhood Deaths	
Other Neurologic Disease		Other Chronic Illnesses	
Intellectual Disability		Learning Difficulties	
ASD (including autism, Asperger syndrome, & PDD-NOS)		Speech & Language Delays	
Anxiety		Obsessive-Compulsive Disorder	
ADD/ADHD		Depression	
Bipolar Disorder		Schizophrenia	
Psychotic Episodes		Suicide	
Child Abuse		Delinquency	
Other Conditions: _____		Other Conditions: _____	

Developmental History

1. Has the patient accomplished each of the following developmental milestones?

	No	Yes	If yes, approximate age (years)
Smile When Smiled At	☐	☐	
Pointing	☐	☐	
Walk (Independently)	☐	☐	
First Words other than Mama/Dada	☐	☐	
First 2-3 Word Phrases	☐	☐	
Toilet Training: Bladder	☐	☐	
Toilet Training: Bowel	☐	☐	
Toilet Training: Night	☐	☐	
Use of Spoon or Fork	☐	☐	

2. Has the patient ever had loss or regression of a previously learned skill? (e.g., language, motor, or social skill) ☐ **No** ☐ **Yes**
   If **Yes**, please explain: _____
   _____

Educational History

1. Is the patient currently enrolled in school? ☐ **No** ☐ **Yes**
   School Name: _____ School District: _____ Program or Grade level: _____

2. Is the patient receiving or has the patient received special services or accommodations at school? ☐ **No** ☐ **Yes**
   If **Yes**, please explain what type: (e.g. IEP, IFSP, 504 Plan) _____

3. Please list any school testing and/ or other evaluations of the patient's learning skills:
   A. Name of Provider / Agency: _____
   Type of Evaluation: _____ Date(s): _____
   Result: _____
   B. Name of Provider / Agency: _____
   Type of Evaluation: _____ Date(s): _____
   Result: _____

4. Has the patient experienced any challenges related to reading, math or writing ☐ **No** ☐ **Yes**
   If **Yes**, please explain: _____
   _____

5. Are there concerns around the patient's organization, flexibility or attention? ☐ **No** ☐ **Yes**
   If **Yes**, please explain: _____
   _____

Behavioral & Social History

1. Please describe any behavioral concerns you have at this time:

_____
_____
_____
_____

2. Does the patient make friends easily? ☐ **No** ☐ **Yes**

If "**No**", please explain: _____
_____
_____
_____

3. Are there any concerns regarding the patient's social skills or interests? ☐ **No** ☐ **Yes**

If "**Yes**", please explain: _____
_____
_____
_____

4. Are there any concerns regarding anxiety and/or depression? ☐ **No** ☐ **Yes**

If "**Yes**", please explain: _____
_____
_____
_____

5. Has the patient been exposed to any form of abuse, neglect or domestic violence? ☐ **No** ☐ **Yes**

If "**Yes**", please explain: _____
_____
_____
_____

6. Has the patient experienced any recent significant stressors (e.g. moves, losses)? ☐ **No** ☐ **Yes**

If "**Yes**", please explain: _____
_____
_____
_____

7. Are there concerns regarding any of the following areas?

	No	Yes	If "Yes", please explain
Responding to sound	☐	☐	
Responding to touch	☐	☐	
Responding to light	☐	☐	
Emotional reactions/regulation	☐	☐	
Aggression Towards Others	☐	☐	
Self-Injurious Behavior	☐	☐	
Difficulty with Transitions	☐	☐	
Understanding social cues (e.g. gestures, facial cues)	☐	☐	
Eye contact	☐	☐	
Inappropriate conversations	☐	☐	
Inappropriate Behavior	☐	☐	
Ritualistic behavior	☐	☐	
Repetitive behavior (e.g. hand flapping, rocking)	☐	☐	
Fixation (e.g. computers, certain TV program, watching spinning toy)	☐	☐	
Toileting	☐	☐	
Other Concerns	☐	☐	

8. What are the patient's interests and hobbies?

_____
_____
_____

9. What are some of the patient's strengths? _____
_____
_____
_____

Additional Evaluations and Interventions

1. Has the patient ever been seen by an Occupational Therapist, Speech and Language Therapist, Psychiatrist, Psychologist, or other mental health counselor? ☐ **No** ☐ **Yes** ☐ **Unknown**

If yes, please provide the following information:

A. Name: _____ Type of Specialist_____ Date of evaluation: _____
   Purpose of Evaluation / Services: _____
   Results of Evaluation: _____
B. Name: _____ Type of Specialist_____ Date of evaluation: _____
   Purpose of Evaluation/ Services:_____
   Results of Evaluation: _____
C. Name: _____ Type of Specialist_____ Date of evaluation: _____
   Purpose of Evaluation:_____
   Results of Evaluation: _____

Additional Comments

Please feel free to discuss any questions or concerns not covered above or to elaborate on anything in the space below:

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_____
_____
_____
_____