BOLD Pediatric Therapy Center – Autism Evaluation Intake

Please complete this form for the 2 part diagnosis process. 1) ADOS Test ,OT & Speech 2) MD visit:

Child's Name:_____Nickname:_____

Date of Birth:_____Gender- identify as: male☐ female☐ other _____

Form completed by:_____Today's date:_____

Child lives with:_____

Language(s) spoken at home:_____

Cultural/ religious preferences you want us to know about: _____

MEDICAL HISTORY

Current medications/ supplements and reason for taking: _____

_____

Are immunizations current?☐ yes☐ no

Allergic to or reactions to (i.e., medication, vaccines, food, environmental): _____

Symptoms: _____

Difficulties with conception? (i.e., IVF, donated egg/sperm, surrogacy)☐ yes ☐ no

Complications/ illnesses/ accidents during pregnancy: _____

Prescription/non-prescription drugs taken during pregnancy: _____

Known substance exposures with pregnancy:☐ cigarettes☐ alcohol☐ drugs☐ environment toxins.

Length of pregnancy (in weeks): _____ Birth weight: _____ Length of hospital stay after birth: _____

Birth injuries or complications during labor or delivery: _____

Type of delivery: ☐ vaginal☐ C-section ☐ forceps used☐ vacuum used.

Was child in NICU?☐ yes☐ no, If yes, how long? _____ Breast fed☐ yes☐ no, Bottle☐ yes☐ no

Describe your child as an infant: _____

Describe your initial bonding experience with your child: _____

Medical, feeding, or developmental challenges as an infant: _____

_____

Serious/ chronic illnesses, injuries, surgeries, or hospitalizations that have occurred: _____

_____

CHILD'S GENERAL HEALTH – Please check any that are of concern:

☐ poor appetite ☐ excessive appetite ☐ excessive thirst ☐ overweight ☐ underweight ☐ difficulty sleeping ☐ excessive sleeping ☐ confusion ☐ fevers ☐ loss of memory ☐ excessive energy ☐ no energy ☐ behavior problems.

EYES/ EARS/ NOSE/ THROAT/ MOUTH

☐ eye pain ☐ blurred vision ☐ crossed eyes ☐ eye itching ☐ vision complaints ☐ wears glasses

Date of most recent vision test: _____ Results: _____

☐ ear pain ☐ hearing loss ☐ ear infections ☐ loud snoring ☐ congestion ☐ sneezing ☐ sore throat ☐ bloody nose

Date of most recent hearing test: _____ Results: _____

Have PE tubes been placed? ☐ no ☐ yes Date(s): _____

☐ tooth pain ☐ chronic colds ☐ difficulty swallowing ☐ tonsillitis ☐ Adenoidectomy ☐ tongue structure abnormality ☐ jaw structure abnormality ☐ cleft palate/lip ☐ tongue tie/lip tie ☐ ear structure abnormality

RESPIRATORY/ CARDIOVASCULAR

☐ hoarseness ☐ persistent cough ☐ wheezing ☐ difficulty breathing ☐ exercise/ activity intolerance.

☐ fatigue ☐ chest pain ☐ palpitations ☐ heart murmur ☐ blue spells ☐ fainting spells

GASTROINTESTINAL/ URINARY

☐ abdominal pain ☐ nausea ☐ vomiting ☐ diarrhea ☐ blood in stool ☐ constipation ☐ stool in underwear ☐ pain after eating ☐ challenges with toilet training ☐ abnormal urine stream ☐ painful urination ☐ burning with urination ☐ frequent urination ☐ daytime wetting ☐ bed wetting ☐ unusually foul odor to stools.

SKELETAL/ NEUROMUSCULAR/ SKIN

☐ bone pain ☐ joint pain ☐ muscle pain ☐ weakness ☐ back pain ☐ swollen joints ☐ frequent bone fractures/ breaks ☐ headache ☐ migraine ☐ numbness ☐ loss of coordination ☐ dizziness ☐ loss of balance ☐ seizure ☐ jerks ☐ unexplained movements ☐ tics/motor habits ☐ repetitive movements

☐ rash/acne ☐ unexplained bruising ☐ birth marks ☐ itchy skin

EMOTIONAL/ COGNITIVE/ PSYCH

☐ explosive ☐ defiant ☐ anxious ☐ temper tantrums ☐ phobias/ fears ☐ easily frustrated ☐ bites ☐ hits ☐ clingy/needy ☐ boundary issues ☐ hyperactive ☐ under active ☐ difficulty following directions ☐ memory challenges ☐ obsessions ☐ compulsions ☐ hallucinations ☐ delusions ☐ depression ☐ suicidal ☐ grandiose ideation ☐ hyper-sexual ☐ sexual identity issues.

DATE OF LAST WELL CHILD EXAM: _____ with DOCTOR: _____

PARENT/ GUARDIAN CONCERNS

What are your main concerns? _____

What are you seeking from our service? _____

Please list what services your child has/ is receiving (OT, PT, speech therapy, psych/counseling, vision, audiology, ABA, other specialist/ MD), where, and dates of services:_____

_____

_____

Name of school and grade: _____ IFSP/IEP/504 in place ☐ yes ☐ no

CHILD'S DEVELOPMENT

Describe your child's personality: _____

Child attends: ☐ day care ☐ preschool ☐ school ☐ tutor services ☐ home school

other: _____

Developmental Concerns – mark with Y (yes) or N (no):

__ gross motor __ coordination __ falls easily/ bumps into objects __ fine motor __ speech __ language __ handwriting __ reading/ literacy __ social interactions __ play __ self-care skills __ avoids self-care activities (i.e., bath, brush teeth) __ toileting __ sleeping __ tolerance of daily routines __ cognition __ attention __ eating __ tolerance of touch/handling __ tolerance of tactile play/ tasks __ movement tolerance __ sound sensitivity __ visually protective __ visually avoidant __ smell sensitivity __ avoids movements __ easily distracted __ uses primarily one side of body __ challenges learning new tasks __ limited diet/accepted foods __ poor control of saliva __ swallowing challenges __ gag/ vomit episodes __ academic performance __ communicating needs/ wants

Milestones – At what age did your child do the following -mark in M (months) or Y (years):

Hold head steady:____ Roll over:____ Sit alone:____ Crawl:____ Stand:____ Walk alone:____ Use the stairs:____ Jump with two feet:____ Pedal a trike:____ Reach and grasp an object:____ Move object between hands:____ feed self with fingers:____ use spoon to eat:____ use fork to eat:____ drink from open cup:____ transition to solid foods:____ toilet trained:____ scribble:____ use scissors: ___exhibited hand dominance for- Right:____ Left:____ Babble:____ Use 1st word:____ Point at objects:____ Put 2 words together:____ Gesture (i.e., wave, clap):____ Follow simple directions:____

Regulation of state – check behaviors that describe your child:

☐ infant that cried/ fussed a lot ☐ infant that was "easy"/not demanding ☐ alert infant ☐ passive infant ☐ infant resisted being held ☐ "floppy" infant ☐ poor sleep patterns as infant ☐ mouthed toys/ objects as infant ☐ restless child ☐ over-reacts to non-threatening situations/ activities ☐ poor tolerance of changes in routines ☐ seeks spinning/ rocking ☐ seeks hugs/ squishing ☐ seeks a lot of movement/crashing ☐ flees from activities/ environments ☐ visually disengages from person/ activity ☐ aggressive to people ☐ needs to be in control ☐ difficulty with transitions ☐ impulsive

Home Routines – check the ones that you have established:

__mealtime routines__family meals __ bedtime routines__ self-care routines__ daily schedules for the week__ transition routines. Supports or objects include: _____

Hours per day on screens - virtual school: ___ games/ computer: ___ TV/show/you tube: ___ other:___

Sleep patterns – check if applicable:

child sleeps:__solo__ in room with others__ in sibling bed__in parent room__with parent bed __restlessly__ bad dreams__ night terrors__ poor calming to sleep__ wakes during night__ difficulty calming self back to sleep__talks/ cries in sleep__snoring/ irregular breathing__ must have supports/ objects to sleep (i.e., night light, weighted blanket) __ difficulty waking in am.

Average hours of sleep per night: ____ at naptime:____ , typical bedtime:_____ typical wake time:_____

COMMUNICATION – check the ones that are applicable:

My child:__Responds to their name __Responds to "no" __Recognizes names of familiar objects __Points to common pictures named __Answers "yes/no" questions__Follows 1 step directions.

My child's speech is repetitive with:__sounds__words__phrases heard on video/ TV.

My child:__babbles__makes sounds__uses single words__uses simple sentences__names objects __answers "wh" questions (what, where, who, when, why)

Approximate number of words used in my child's vocabulary: _____

How does your child let you know what they want/ need? _____

_____

How does your child show you they understand what you say? _____

_____

Is your child frustrated by communication challenges? How? _____

List 3 sample sentences/ phrases/ words your child currently uses: _____

_____

_____

What percent do you understand of what your child says?__0%__10% __30%__50%__75%__ 100%

What percent do unfamiliar listeners understand from your child?__0%__25%__50%__75%__ 100%

SOCIAL

Child's favorite play activities: _____

How does your child interact with others? _____

_____

What activities does your family enjoy doing together? _____

_____

What supports do you have? (ie family, friends, spiritual, community programs, etc) _____

_____

What are the major stressors for your family? _____

What do parent(s) do for work? _____

What else do you want to tell us about your child? _____

_____

_____

Thank you for taking the time to answer these questions so we can better understand your child and your family. This document will be included as an attachment on the final BOLD report. We look forward to supporting you at BOLD Pediatric Therapy Center.