

*Proposed Developmental, Medical, Family Information Form(Adult)*

**Date Form Completed: \_\_\_/\_\_\_/\_\_ Person completing form:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Mo Day Yr Name and relationship to person referred

**Name**: **Birth Date: \_\_\_/\_\_\_/\_\_\_ Age**:\_\_\_\_\_\_ Sex: **M / F** Mo Day Yr

**Address**:

Street City State Zip

**Phone:** Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other contact phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship (circle): neighbor, relative, family friend, other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_):

\*\*Please indicate how you would prefer to be contacted:  phone  mail  email fax

Have you received the diagnosis of an autism spectrum disorder?  **Yes**  **No**

If yes, in what year \_\_\_\_\_\_\_\_\_ and by whom \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***PRENATAL/BIRTH HISTORY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

Was this pregnancy full term?  **Yes**  **No** If premature, born \_\_\_\_\_\_\_\_ weeks before expected due date

Was this a multiple birth?  **Yes**  **No**  **UK** (unknown); if yes: **Twins** **Triplets** **Quadruplets**

Were the babies identical? **Yes**  **No**  **UK** (unknown)

List problems that occurred during pregnancy (e.g., poor weight gain, high blood pressure, infections): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  None  Unknown

List medications taken during pregnancy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list problems during labor or delivery: fever/infection  excessive bleeding meconium  Cesarean Prolonged labor  Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth weight lbs oz; Head circumference \_\_\_\_\_\_ in. (if known)

Apgar Scores (if known): \_\_\_\_\_\_ at 1 min \_\_\_\_\_\_ at 5 min

Was the child healthy?  **Yes  No;** If not, describe problems/treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were birth defects or injury present?:  Yes  No If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did the child require treatment in a newborn intensive care unit?  No  Yes (for \_\_\_\_\_\_\_\_\_ days)

**Developmental History\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** (If you are uncertain, estimate as best as you can. Please record the ages in months. (**N/A: not yet achieved**)

Smiled in response to others \_\_\_\_ months  N/A First words (other than mama/dada) \_\_\_\_ months  N/A

Sat without support \_\_\_\_ months  N/A 3-word phrases \_\_\_\_ months  N/A

Walked independently \_\_\_\_ months  N/A Full sentences months  N/A

Age (in months) at which problems were first observed in:

Social development \_\_\_\_\_\_\_\_\_\_\_ months

Speech and language \_\_\_\_\_\_\_\_\_\_\_ months

Problem solving \_\_\_\_\_\_\_\_\_\_\_ months

Behavior \_\_\_\_\_\_\_\_\_\_\_ months

**Medical/Psychiatric History\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date** | Age | **Diagnosis/Illness** | **Past** | **Now** | **Date** | Age | **Diagnosis/Illness** | **Past** | **Now** |
|  |  | **Serious Injuries** |  |  |  |  | **Lung/breathing Problem (any)** |  |  |
|  |  | Serious head injury |  |  |  |  | Asthma |  |  |
|  |  | Loss of consciousness |  |  |  |  | Pneumonia |  |  |
|  |  | Other serious injury |  |  |  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |  | **Sleep Problems (any)** |  |  |  |  | **Stomach/intestinal Problems (any)** |  |  |
|  |  | Difficulty falling asleep |  |  |  |  | Ulcers |  |  |
|  |  | Difficulty staying asleep |  |  |  |  | Reflux |  |  |
|  |  | Early morning awakening |  |  |  |  | Chronic abdominal pain |  |  |
|  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  | Chronic diarrhea |  |  |
|  |  | **Neurological Problems** |  |  |  |  | Chronic constipation |  |  |
|  |  | Birth abnormality |  |  |  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |  | Seizures (any type) |  |  |  |  | **Kidney/Bladder Pblm -any** |  |  |
|  |  | Intellectual disability |  |  |  |  | Abnormalities at birth |  |  |
|  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  | Kidney/bladder infections |  |  |
|  |  | **Vision Problem (any)** |  |  |  |  | Reduced kidney functioning |  |  |
|  |  | Vision problems at birth |  |  |  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |  | Wears corrective lenses |  |  |  |  | **Muscle/bone/joint) Problem-any** |  |  |
|  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  | Abnormalities at birth |  |  |
|  |  | **Hearing** **Problem (any)** |  |  |  |  | Scoliosis or spinal curvature |  |  |
|  |  | Hearing problems at birth |  |  |  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |  | Hearing loss |  |  |  |  | **Circulatory Problem (any)** |  |  |
|  |  | **Dental Problem (any)** |  |  |  |  | Anemia |  |  |
|  |  | Dental abnormalities at birth |  |  |  |  | Sickle cell disease |  |  |
|  |  | Serious dental problems |  |  |  |  | Chronic low platelet count |  |  |
|  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  | Bleeding /bruising problem |  |  |
|  |  | **Hormone Problem (any)** |  |  |  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |  | Overactive thyroid |  |  |  |  | **Skin Problem (any)** |  |  |
|  |  | Underactive thyroid |  |  |  |  | Eczema |  |  |
|  |  | Sugar diabetes |  |  |  |  | Skin picking |  |  |
|  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |  | **Weight Problem (any)** |  |  |  |  | **Neuropsychiatric problem (any)** |  |  |
|  |  | Underweight |  |  |  |  | ADHD |  |  |
|  |  | Obesity |  |  |  |  |  |  |  |
|  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  | Anxiety disorder |  |  |
|  |  | **Heart Problem (any)** |  |  |  |  | Obsessive-compulsive disorder |  |  |
|  |  | Heart problems at birth |  |  |  |  | Depression |  |  |
|  |  | High blood pressure |  |  |  |  | Bipolar disorder (manic-depressive) |  |  |
|  |  | Heart rhythm abnormalities |  |  |  |  | Schizophrenia/psychotic disorder |  |  |
|  |  | Heart attacks |  |  |  |  | Tic disorder (e.g., Tourette) |  |  |
|  |  | Heart surgery |  |  |  |  | Eating disorder (e.g.,  anorexia) |  |  |
|  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |  | **Allergies** |  |  |  |  |  |  |  |
|  |  | Food allergy |  |  |  |  |  |  |  |
|  |  | Medication allergy |  |  |  |  |  |  |  |
|  |  | Hay fever/ respiratory allergy |  |  |  |  |  |  |  |
|  |  | Allergic skin rashes |  |  |  |  |  |  |  |

**Specialized neurological or genetic tests:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ** If done** | **Date (if known)**  **Month/Year** | **Test** | **Normal**  **Result** | **Abnormal**  **Result** | **Unknown**  **Result** |
|  | / | EEG (brain wave test) |  |  |  |
|  | / | CT scan |  |  |  |
|  | / | MRI scan |  |  |  |
|  | / | Chromosomal analysis (karyotype) |  |  |  |
|  | / | DNA testing for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
|  | / | Other (specify): |  |  |  |

**List all hospitalizations and surgeries (medical or behavioral)**

|  |  |  |
| --- | --- | --- |
| **Reason for hospitalization/surgery** | **Age** | **Length of stay** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Allergies** (to medications, foods, environmental antigens, etc.)

|  |  |
| --- | --- |
| **Source (medication, food, etc.)** | **Nature of reaction (hives, trouble breathing, etc.)** |
|  |  |
|  |  |
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**Current Medications**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Medication** | **Dosage** | **Age at start** | **Reason for medication** | **Improved** | |
|  |  |  |  | **Y** | **N** |
|  |  |  |  | **Y** | **N** |
|  |  |  |  | **Y** | **N** |
|  |  |  |  | **Y** | **N** |

**Past Medication**

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication** | **Dates (month/year)** | **Reasons for prescription** | **Response to medication**  **(positive & negative)** |
|  | / to / |  |  |
|  | / to / |  |  |
|  | / to / |  |  |
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|  | / to / |  |  |

**RESOURCES**: Please ****current resources/services

Case Management Services (Agency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Vocational/employment services (Agency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Psychiatry services  Behavioral therapy  Family therapy  Group therapy

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY/SOCIAL HISORY:**

**SIBLINGS**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name of sibling** | **Sex** | **Age** | **Full** | **Half** | **Step** | **List any health/behavior/ learning problems** |
|  |  |  |  |  |  |  |
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**EXTENDED MEDICAL HISTORY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Please check if family members have experienced the following conditions:*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Condition/Disorder** | **Mo** | **FA** | **BR** | **SIS** | **MGM** | **MGF** | **MA** | **MU** | **MC** | **PGM** | **PGF** | **PA** | **PU** | **PC** |
| Autistic Disorder |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Autism spectrum disorder or Pervasive developmental dis. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Asperger syndrome |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Fragile X syndrome |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Tuberous sclerosis |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Other genetic disorders |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Intellectual disability |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Learning disability |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Language disorder |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Attention deficit disorder |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Tourette’s syndrome |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Seizure disorder (epilepsy) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Obsessive compulsive dis |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Other anxiety disorders |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Condition/Disorder** | **Mo** | **FA** | **BR** | **SIS** | **MGM** | **MGF** | **MA** | **MU** | **MC** | **PGM** | **PGF** | **PA** | **PU** | **PC** |
| Bipolar disorder |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Schizophrenia |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Alcoholism |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Drug addiction |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Birth defects (e.g. cleft lip, club foot, heart defect) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Gland/endocrine ex thyroid, diabetes, delayed puberty |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Immune disorders (e.g. arthritis, lupus) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Mo** = mother, **Fa** = father, **Br** = brother, **Sis** = sister, **MGM** = maternal grandmother, **MGF** =maternal grandfather, **MA** = maternal aunt, **MU** = maternal uncle, **MC** = maternal cousin, **PGM** = paternal GM, **PGF** = paternal GF, **PA** = paternal aunt, **PU** = paternal uncle, **PC** = paternal cousin

**EDUCATIONAL HISTORY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

School name: Phone:

Grade in school: (ever repeat a grade? Yes / No)

Teacher (or best contact): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ IEP □ 504 Plan □ Special Ed □ Services: OT/PT/SLT

What best describes your child’s current educational program?

Full time in a regular class

Regular class supplemented by resource room/learning lab time

Time split between regular and special education classes

Special education class in a neighborhood school

Aide/Paraprofessional or extra help

Specialized school

Home schooled

**EMPLOYMENT HISTORY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Yes, I am currently working  No, I am not currently working  I volunteer**

**If yes, where are you working/volunteering?**

**Name of job:**  \_\_\_\_\_\_\_\_\_\_\_\_ **Address**:

**Phone number:**   **Supervisor’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**List job responsibilities:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Yes, I currently have a job coach  No; I do not have a job coach**

**If Yes:**

**Name of agency employing your job coach:**

**Focus/skills of job training:**

**If you had a job coach in the past please include:**

**Name of agency employing your job coach:**

**Focus/skills of job training:**

**In the space below please explain your work and job training history:**