

*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.)** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**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 /  |  |  |
|  |  / to /  |  |  |
|  |  / to /  |  |  |
|  |  / to /  |  |  |
|  |  / to /  |  |  |
|  |  / to /  |  |  |
|  |  / 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** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

**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:**