Thank you for your recent inquiry about the Greenwood Interprofessional Autism Center. Attached is our Greenwood Intake Packet as well as our Developmental History Form for Autism Spectrum Disorder. Please fill out both packets and return them with all required documents. In order to make sure that all information is current, it is our policy that the intake packet, developmental history form and all required documents must be returned within 90 days to place you/your child on our waitlist and/or scheduling you/your child for an Initial visit. You will not be placed on our waitlist or scheduled until all documents are received by Greenwood.

There are three Authorization of Release of Information (HIPAA) Forms at the end of the Greenwood Intake Packet. Please fill out one form for Medical, one form for School, and one for Therapy(s). If you/your child is currently enrolled in more than one Therapy, please print off an additional Authorization of Release of Information form and fill out the form for the additional Therapy(s).

Please note that our email system limits the total size of an email to 20 MB. When sending an email that is larger than 20 MB, including attachments, please divide the email between more than one email.

Disclaimer: Truman's email is HIPAA compliant. Please exercise caution when emailing personal health information from an account outside of Truman's organization.

If you have any questions, or need assistance, please reach out and I would be glad to assist you.

Thank you,

Christopher J. Maglio, Ph.D.
Licensed Psychologist/Health Service Provider

Developmental History Form (adult)

Date Form Completed: _____________ **Person Completing the Form**: ______________________________
Name and relationship to client if not client

Client's Name: ____________________________________ **Sex**: M / F **Date of Birth**: ________________

Address: ____
Street City State Zip

Phone Number: _________________________ **Email Address**: _________________________________

REASONS FOR EVALUATION

Please list the reason(s) the client is being referred for the evaluation:

1. ____
____
2. ____
____
3. ____
____

When did these problems begin?

What are the client's goals for this evaluation?

Has the client ever received the diagnosis of an autism spectrum disorder? ☐ **Yes** ☐ **No**

If yes, in what month & year _________ and by whom ______________________________________

FAMILY INFORMATION

Mother/Guardian Name: ______________________________________ Education: _______________________

Occupation: ____ ☐ Full-time ☐ Part-time

Father/Guardian Name: ____ Education: ______________________

Occupation: ____ ☐ Full-time ☐ Part-time

Parents are:

- ☐ Married
- ☐ Unmarried, Living Together
- ☐ Never Married, Living Together
- ☐ Separated
- ☐ Divorced
- ☐ Mother Deceased
- ☐ Father Deceased

Sibling Information

Name of sibling	Sex	Age	Different Father?	Different Mother?	List any health/behavior/ learning problems	Lives with child?
			☐Y ☐N	☐Y ☐N		☐Y ☐N
			☐Y ☐N	☐Y ☐N		☐Y ☐N
			☐Y ☐N	☐Y ☐N		☐Y ☐N
			☐Y ☐N	☐Y ☐N		☐Y ☐N
			☐Y ☐N	☐Y ☐N		☐Y ☐N

How well does the client get along with his/her siblings?
☐ Very Well ☐ Good ☐ Average ☐ Fair ☐ Poor

Is English the client's primary speaking language: ☐ Yes ☐ No

If no, what is the client's primary language: ____

What is the client's secondary language: ____

Child Care and Discipline

Who was primarily responsible for the client's care? ☐ Mother ☐ Father ☐ Both ☐ Other:___________

Who was mainly in charge of discipline in the home? ☐ Mother ☐ Father ☐ Both ☐ Other:_________

Please describe discipline techniques: ____

____

FAMILY PSYCHIATRIC HISTORY

CONDITION/DISORDER	MOTHER	FATHER	BROTHER	SISTER	GRANDPARENT	AUNT/ UNCLE	OTHER CLOSE RELATIVES
Alcoholism							
Anxiety							
ADHD/ADD							
Autism Spectrum Disorder							
Bipolar Disorder							
Depression							
Epilepsy/Seizure Disorder							
Genetic Condition							
Hospitalized for Emotional Problems							
Intellectual disability							
Jail Time/Incarceration							
Language disorder							
Learning Disability							
Motor or Vocal Tics							
Psychosis or Schizophrenia							
Special Education							
Substance Abuse							
Suicidal Ideation/Attempt							

PREGNANCY AND BIRTH HISTORY

Parental ages when client was born: Mom ____________ Dad ____________

Was this pregnancy full term? ☐ **Yes** ☐ **No** If not, how many weeks before or after the expected due date was the client born? _____ weeks ☐ **BEFORE** ☐ **AFTER** due date

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

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

Please describe any problems that occurred during previous pregnancies (e.g., miscarriage, premature labor and delivery, etc.): ____

Mother's health during pregnancy:

☐ No health problems during pregnancy
☐ Poor weight gain
☐ Seizures
☐ High blood pressure
☐ Other (specify)______________________
☐ Health during pregnancy not known
☐ Severe nausea {☐ with dehydration}
☐ Infections (Flu, measles, CMV)
☐ Eclampsia/Toxemia
☐ Rh (blood group) incompatibility

List medications taken during this pregnancy (if known):

____

Did the mother consume more than 2 glasses of alcohol a day during this pregnancy? ☐ Yes ☐ No

Did the mother smoke during pregnancy? ☐ Yes ☐ No

Did the mother consume illegal substances during the pregnancy? ☐ Yes ☐ No

Labor and Delivery:

☐ No problems during labor and delivery ☐ Not known

Please note whether any problems occurred during labor or delivery (☐ all that apply):

☐ Excessive bleeding
☐ Meconium staining
☐ Fever or infection of mother
☐ Placenta previa or abruption
☐ Other (specify): ___________________________________
☐ Forceps Used
☐ Umbilical cord around baby's neck
☐ Breathing difficulties of child
☐ Placenta (bag of water) broke more than 1 day before delivery

Baby was born ☐ head first ☐ breech (feet first) ☐ vaginal ☐ Cesarean (Why? ________________

Birth weight ______ lbs ______ oz Length ______ in. (if known) Head circumference ______ in. (if known)

Apgar Scores (if known): ______ at 1 min ______ at 5 min

Newborn period:

Was the client healthy as a newborn? ☐ **Yes** ☐ **No** If not, please describe the problems and treatment:

____

____

Was the client born with any birth defects? ☐ Yes ☐ No If yes, explain: ___________________________

____

____

Did the client require treatment in a newborn intensive care unit? ☐ Yes (for _________ days) ☐ No

Did the baby require any special care immediately after birth? ☐ Yes ☐ No

If yes, √ all that apply

- ☐ Breathing problems (requiring ☐ oxygen ☐ ventilator *(with a tube in windpipe)*
- ☐ Placement in an incubator
- ☐ Blood transfusions
- ☐ Significant muscle weakness or paralysis
- ☐ Poor muscle tone
- ☐ Seizures
- ☐ Feeding difficulties
- ☐ Excessive sensitivity to noise/stimulation
- ☐ Jaundice treated with lights
- ☐ Infection
- ☐ Surgery (describe): ____

DEVELOPMENTAL HISTORY

Social Development

Did the client have any delays in his/her social development? ☐ Yes ☐ No

As an infant, did the client:

Enjoying cuddling? ☐ Yes ☐ No ______________________________

Tend to be fussy/irritable? ☐ Yes ☐ No ______________________________

Make appropriate eye contact? ☐ Yes ☐ No ______________________________

Respond to his/her name? ☐ Yes ☐ No ______________________________

In the first four years of life, were any special problems noted in the following areas?
If yes, please describe below:

Temper Tantrums ☐ Yes ☐ No ______________________________

Separating from parents ☐ Yes ☐ No ______________________________

Excessive crying ☐ Yes ☐ No ______________________________

Playing with other children ☐ Yes ☐ No ______________________________

Speech and Language Development

Did the client have any delays in his/her language development? ☐ Yes ☐ No

If yes, please specify: ____

Did the following milestones develop on time? Please specify age (year/month).

Show interest in sound *(by 3 months)* ☐ Yes ☐ No ______________________________

Babbling *(by 4 to 6 months)* ☐ Yes ☐ No ______________________________

Understanding words *(by 6-11 months)* ☐ Yes ☐ No ______________________________

Speaking first words *(by 12 months)* ☐ Yes ☐ No ____________________

Speaking in short phrases *(by 24 months)* ☐ Yes ☐ No ____________________

Motor Development

Did the client have any delays in his/her motor development? ☐ Yes ☐ No

If yes, please specify: ____

Did the following milestones develop on time? *Please specify age (year/month).*

Turn over (by 6 months) ☐ Yes ☐ No ____________________

Sit alone (by 9-12 months) ☐ Yes ☐ No ____________________

Crawl (by 9-12months) ☐ Yes ☐ No ____________________

Stand alone (by 9-12 months) ☐ Yes ☐ No ____________________

Walk alone (by 12-18 months) ☐ Yes ☐ No ____________________

Walk upstairs (by 36 months) ☐ Yes ☐ No ____________________

Walk downstairs (by 48 months) ☐ Yes ☐ No ____________________

Running ☐ Yes ☐ No ____________________

Which hand does the client use for writing or drawing? ☐ Right ☐ Left ☐ Both

Eating? ☐ Right ☐ Left ☐ Both

Throwing? ☐ Right ☐ Left ☐ Both

Daily Living

When was the client toilet trained? Days: ______________ Nights:______________

Did bed-wetting occur after toilet training? ☐ Yes ☐ No If yes, until what age? ____________

Did bed-soiling occur after toilet training? ☐ Yes ☐ No If yes, until what age? ____________

Does the client have difficulty with sensory processing?

If yes, please describe below:

Tolerating Food Textures ☐ Yes ☐ No ____________________

Gagging or Vomiting ☐ Yes ☐ No ____________________

Tolerating Clothing ☐ Yes ☐ No ____________________

Tolerating Touch from Others ☐ Yes ☐ No ____________________

Does Not Notice Pain ☐ Yes ☐ No ____________________

Other (please list) ________________________________

Did the client, as a child, experience a significant LOSS of an acquired skill or skills (not just a delay)? For example, a child who was engaging in pretend play with other children for at least 4 to 6 months and then stopped and began just spinning, dropping, or throwing objects in his/her free time or speaking in full sentences for many months and then just stopped speaking altogether or began using only single words occasionally)

Social functioning ☐ Age of loss: ______ months; Explain: ____________________________________

____

Speech / language ☐ Age of loss: ______ months; Explain: ____________________________________

____

Problem solving ☐ Age of loss: ______ months; Explain: ____________________________________

____

Motor coordination ☐ Age of loss: ______ months; Explain: ____________________________________

____

Bladder/bowel control ☐ Age of loss: ______ months; Explain: ____________________________________

____

MEDICAL HISTORY

☐ No serious illnesses or injuries in the **past** ☐ No serious illnesses or injuries **now**

Date	Age	Diagnosis/Illness	Past	No	Date	Age	Diagnosis/Illness	Past	No
		Serious Injuries	☐	☐			**Lung/breathing Problems**	☐	☐
		Serious head injury	☐	☐			Asthma	☐	☐
		Other serious injury	☐	☐			Pneumonia	☐	☐
		Loss of consciousness	☐	☐			Apnea or irregular breathing	☐	☐
		Sleep Problems	☐	☐			Other: ________________	☐	☐
		Neurological Problems	☐	☐			**Stomach/bowel Problems**	☐	☐
		Birth abnormality	☐	☐			Swallowing problems	☐	☐
		Seizures (any type)	☐	☐			Gastroesphageal reflux	☐	☐
		Other: ________________					Chronic abdominal pain	☐	☐
		Vision Problem	☐	☐			Chronic diarrhea	☐	☐
		Vision problems at birth	☐	☐			Chronic constipation	☐	☐
		Requires glasses/contacts	☐	☐			Other: ________________	☐	☐
		Other: ________________	☐	☐			**Kidney/Bladder Problems**	☐	☐
		Hearing Problem	☐	☐			Abnormalities at birth	☐	☐
		Hearing problems at birth	☐	☐			Kidney/bladder infections	☐	☐
		Deafness	☐	☐			Other: ________________	☐	☐

		Chronic ear infections	☐	☐			**Muscle/bone/joint) Problems**		
		Ear tubes	☐	☐			Abnormalities at birth	☐	☐
		Other: ________________	☐	☐			Scoliosis or spinal curvature	☐	☐
Date	Age	**Diagnosis/Illness**	**Past**	**No**	**Date**	Age	**Diagnosis/Illness**	**Past**	**No**
		Dental Problem	☐	☐			**Circulatory Problem**	☐	☐
		Abnormally shaped/ missing teeth	☐	☐			Anemia	☐	☐
		Extractions/cavities	☐	☐			Sickle cell disease	☐	☐
		Dental braces	☐	☐			Chronic low platelet count	☐	☐
		Other: ________________	☐	☐			Bleeding /bruising problem	☐	☐
		Skin Problem	☐	☐			Other: ________________	☐	☐
		Eczema	☐	☐			**Hormone Problem**	☐	☐
		Ash leaf patches	☐	☐			Sugar diabetes	☐	☐
		Café-au-lait spots	☐	☐			Early puberty	☐	☐
		Other: ________________	☐	☐			Late or incomplete puberty	☐	☐
		Growth Problem	☐	☐			Other: ________________	☐	☐
		Failure to gain weight	☐	☐			**Mental Health problem**	☐	☐
		Obesity	☐	☐			ADHD	☐	☐
		Short stature	☐	☐			Oppositional defiant	☐	☐
		Tall stature	☐	☐			Anxiety disorder	☐	☐
		Other: ________________	☐	☐			Obsessive-compulsive	☐	☐
		Heart Problem	☐	☐			Depression	☐	☐
		Heart abnormalities at birth	☐	☐			Bipolar disorder (manic-depressive)	☐	☐
		Heart surgery	☐	☐			Schizophrenia	☐	☐
		Heart rhythm abnormalities	☐	☐			Tic disorder (e.g., Tourette)	☐	☐
		High blood pressure	☐	☐			Intellectual disability	☐	☐
		Other: ________________	☐	☐			Eating disorder (e.g., anorexia)	☐	☐
							Other: ________________	☐	☐

I have confirmed with the client's Primary Care physician that his/her immunizations are up to date. ☐ **Yes** ☐ **No**

If no, explain:____

Specialized neurological or genetic tests:

☐ No neurological or genetic testing has been done

☐ If done	Date (if known) Month/Year	Test	Normal Result	Abnormal Result	Unknown Result
☐		EEG (brain wave test)	☐	☐	☐
☐		CT scan	☐	☐	☐
☐		MRI scan	☐	☐	☐
☐		PET/SPECT/ scan	☐	☐	☐
☐		Other scan (specify):	☐	☐	☐
☐		Chromosomal microarray	☐	☐	☐
☐		Chromosomal analysis (karyotype)	☐	☐	☐
☐		DNA testing for fragile X syndrome	☐	☐	☐
☐		Other genetic test:	☐	☐	☐

List all hospitalizations and surgeries for the client, include overnight stays (medical or behavioral)

☐ No past hospitalizations or surgery

Reason for hospitalization/surgery	Age	Length of stay

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

☐ No past or current allergies

Allergy Source (medication, food, etc.)	Nature of reaction (hives, trouble breathing, etc.)

Current Medications

☐ No medications taken **now** ☐ Medications are being taken now, but the names are not known

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

Name of person prescribing the medications: ____

RESOURCES: Please indicate resources/services client receives **now:**

☐ No resources/services are being received now
☐ Speech/Language therapy
☐ Psychiatry services
☐ Individual mental health therapy/counseling
☐ Group therapy
☐ Physical therapy
☐ Occupational therapy
☐ Case management
☐ ABA
☐ Other: ______________________

EDUCATIONAL HISTORY

Highest Grade Completed: _____ Did the client ever repeat a grade? ☐ **Yes** ☐ **No**

Is the client currently enrolled in school? ☐ **Yes** ☐ **No**

If attending school, is the client currently on a formal education plan in school? ☐ **Yes** ☐ **No**

If yes, please check: □ IEP □ 504 Plan

When in school, was the client on a formal education plan? ☐ **Yes** ☐ **No**

If yes, please check: □ IEP □ 504 Plan

What best describes the client's current educational program if currently enrolled?

Full time in a regular class	☐
Time split between regular and special education classes	☐
Special education class	☐
Aide/Paraprofessional or extra help	☐
Specialized school	☐
Home schooled	☐

Please indicate the educational program in which the client participated during his/her school* years:

School Year	**Type of School**		**Type of Class**		*Any Special Services*		
	Regular*	Special	Regular*	Special*	Yes	No	Type
3-5 preschool							
Kindergarten							
1st							
2nd							
3rd							
4th							
5th							
6th							
7th							
8th							
9th							
10th							

11th							
12th							

*** REGULAR school applies to public or private schools for children without disabilities.**
SPECIAL school applies to any schools intended for children with disabilities

SOCIAL AND BEHAVIORAL FUNCTIONING

Peer Relationships
Please indicate how the client relates to peers:

- ☐ Has problems relating to others his/her age
- ☐ Has difficulty making friends
- ☐ Fights frequently with peers
- ☐ Prefers interacting with younger individuals
- ☐ Prefers interacting with older individuals
- ☐ Prefers to be alone
- ☐ Has a best friend

What role does the client take in his/her peer groups? ☐ Leader ☐ Follower ☐ Some of Each

How many friends does the client have? ___________________________

Recreational Interests
What does the client enjoy?

☐ Sports ____

☐ Hobbies____

☐ Other ____

What are the client's personal strengths?

What are the client's hopes for his/her future?

Additional Questions

CURRENT CONCERNS

1. What are your current concerns? (Why are you wanting this evaluation done?)

DEVELOPMENTAL HISTORY

1. Does the client's family have a history of developmental or learning issues?

2. When did the client first notice that his/her development seemed different from other children? Describe any concerns that have been shared with the client particularly about his/her development prior to age four.

3. Did the client ever stop talking? If yes, at what age? For how long?

4. Has the client had concerns about his/her vision? (general vision problems, eye contact, intense interest in mirrors/lights, holds objects close to eyes, stares off into space, unusual visual interest such as spinning or studying objects)

5. Has the client had any concerns about his/her hearing? (failed screening, ear fluid/infections, concern about hearing impairment/deafness, covers ears when hearing everyday sounds, seems to hear better on some days)

6. Has the client had any concerns regarding his/her motor skills? (awkward, delays in gross motor skills/ fine motor tasks, repetitive motor behaviors/spinning and finger posturing)

SOCIAL INTERACTION

1. Does the client currently have any concerns about his/her behavior or social skills? If yes, what are your concerns? At what age did the client first have concerns about his/her social skills?

2. How would the client describe his/her ability to interact with others his/her age?

3. Does the client believe he/she has **more** difficulty making and keeping friends when compared to others his/her age?

4. What types of activities does the client enjoy participating in? Does the client show an interest in being with others?

5. How does the client express his/her emotions and feelings? Does the client use a typical range of facial expressions that are appropriate for the situation?

6. What calms the client down? Does the client seek others out for comfort when tired, upset or sick?

COMMUNICATION

1. If the client is given one direction at a time, can he/she follow the direction? Can he/she follow a series of directions? Give examples.

2. Does the client initiate conversations with family members? With individuals his/her same age? With other older/younger than himself/herself?

3. Does the client appropriately carry on back-and-forth conversation with other people?

4. Does the client have difficulty understanding nonverbal cues such as facial expressions or changes in vocal tone? Give an example.

5. Does the client repeat phrases or sentences heard in the past that have little or no relationship to the current situation?

Does the client:

_____ greet others
_____ respond to greetings
_____ make requests,
_____ describe events
_____ comment on activities
_____ share information about thoughts/interests/feelings
_____ ask for help

RESTRICTED, REPETITIVE, OR STEREOTPYED BEHAVIOR/INTERESTS/ACTIVITIES:

1. Have you noticed differences in how the client responds to touch, sound, smells, or light? (licks, smells, sniffs inedible objects)

2. Do you have any concerns about the client's eating? (unusual cravings, picky eater, restricted preferences)?

3. Does the client exhibit any unusual behaviors that seem different from other individuals? (flapping arms, walking on tip-toes or in circles, rocking, rapid lunging, obsessed with routines, self-abusive behavior)

4. What is the client's favorite activities. What holds his/her attention? Does the client initiate these activities independently?

5. Does the client have concerns about his/her activity level or attention span?

6. How does the client react to changes in daily routine or schedule? (appears anxious, easily upset, adjust if prepared ahead of time, responds negatively or with tantrums when given commands/requests/directions)

7. Does the client appear overly concerned with order and routine in his/her daily activities? (i.e., lining things up, needing things in a certain order)

SKILL ACQUISITION:

1. Does the client have difficulty learning new skills?

2. Does the client demonstrate any unusual or seemingly advanced skills?

OTHER:

1. Is there any other information that might be helpful to share?

Source: Supplement to "Promising Practices for the Identification of Individuals with Autism Spectrum Disorders".