



TUCSON ALLIANCE FOR AUTISM
1002 N. Country Club
Tucson, Arizona 85716
Phone: 520-319-5857
Fax: 520-319-5979

BUSINESS INFORMATION FORM

CHILD'S NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY/STATE: _____ ZIP CODE: _____

CONTACT INFORMATION FOR HEALTH CARE:

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____

FATHER'S NAME: _____ SS#: _____

EMPLOYER: _____ WORK PHONE: _____

MOTHER'S NAME: _____ SS#: _____

EMPLOYER: _____ WORK PHONE: _____

EMERGENCY CONTACT: _____

(Name)

RELATIONSHIP: _____ PHONE: _____

PHYSICIAN'S NAME (child's primary): _____

ADDRESS: _____

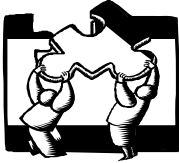
PHONE: _____ FAX: _____

Signature

Date

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CHILD HISTORY FORM

Please return completed form to the address above

Date of Evaluation: _____ - _____ - _____ Date of Form Completion: _____ - _____ - _____

Child's NAME: (first) _____ (middle) _____ (last) _____

Date of Birth: _____ - _____ - _____ Age: _____ yrs _____ mo Male _____ Female _____

Educational Program or Grade: _____ Regular or Special education? (circle one)

Current Services (hours/ week): Speech _____ OT _____ PT _____

Education Specialist _____ Other Therapies _____

Your Name: _____ Relationship to Child: _____

Referred by: _____

Primary Care Physician: _____

<u>Family Constellation:</u>	1 = Two Parent Household (Natural or step)	<u>Ethnicity:</u>	1 = Hispanic
	2 = Single Parent - Mother		2 = Non-minority (Caucasian)
	3 = Single Parent - Father		3 = African American
	4 = Guardian		4 = Asian
	5 = Other adult(s) in home _____ (Specify)		5 = Native American
			6 = Other Minority _____ (Specify)

Language spoken in home (if other than English): _____

DOES CHILD: Speak this language? Yes ___ No _____ Understand this language? Yes _____ No _____

Reasons for this Evaluation

1. What about your child concerns you the most? _____

2. What do you want to learn from us or to be done for your child? _____

3. Please describe your child's difficulty or current diagnosis: _____

4. When did you first notice these concerns? _____

5. What has already been done to treat these concerns? _____

6. What do you believe may be the reason or cause for your child's difficulties? _____

7. Indicate other concerns about your child: () Behavior () School () Family () Health () Anxiety () Mood

8. Please describe your child's strengths (characteristics, hobbies, abilities): _____

9. Describe your child's needs: _____

Birth History

1. During this child's pregnancy, did biological mother have: (Check all that apply) _____None
____Anemia ____Diabetes ____High blood pressure ____Excessive weight gain ____Pre-eclampsia
____Vaginal infections ____Other infections ____High fevers ____Kidney problems
____Amniocentesis ____No prenatal care ____Family stress ____Emotional problems
____Premature labor ____Exposure to toxins (metals, paint, solvents, toluene etc)

2. During the pregnancy, did the biological mother use: (Check all that apply)
____Alcohol ____Tobacco ____Medications ____Street drugs (specify): _____

3. Was labor induced? No____ Yes____ By what? _____

4. The delivery was: _____vaginal _____Caesarean section (C-section)

5. How long did the pregnancy last? _____months

6. How long was the labor? _____hours

7. What was this baby's birth weight? _____pounds _____ounces

8. How long did this baby stay in the hospital? _____days

9. Please describe any difficulties this baby may have had during the hospital stay: _____

10. Describe any other unusual conditions during pregnancy or immediately after birth of this baby: _____

11. Pregnancy history (biological mother): How many prior to this baby? _____live births? _____

12. Is this child your biological _____ or adopted child? _____At what age? _____

Health History

Describe your child's general health at present: _____

Please circle and describe any of the following health problems that your child may have had at any time during his/her life:

1. Sleep difficulties: Settling to sleep Staying asleep Teeth grinding Nightmares/terrors Snoring

2. Brain difficulties: Seizures Staring spells Confusion Head injury Fainting spells
Tics-vocal/motor Unusual movements/tremors Muscle weakness Coordination problems

3. Lung/breathing difficulties: Recurring cough Asthma/wheezing Bronchitis Pneumonia

4. Ear/nose problems: Ear infections Hearing loss PE tubes Chronic congestion

Has your child had a hearing test? ___No ___Yes If so, when was the last test? ___-___-___
Give location/person _____ Results available? N Y
Comments about your child's hearing: _____

5. Allergies: Seasonal _____ Environmental _____ Foods _____

6. Skin problems: Eczema Rashes Dry skin Acne Birth marks Hair loss

7. Eye problems: Poor vision? Y N Strabismus? Y N Surgery? _____ Wears glasses? Y N

8. Blood/heart problems: Anemia _____ Easy bruising/bleeding _____ Congenital heart _____

9. Muscle and bone problems: Spasticity _____ Low tone _____ Scoliosis _____

10. Urine/kidney problems: Bedwetting (>3years) _____ Infections _____ Reflux _____

11. Growth concerns: Slow gain (height/weight) _____ Overweight _____ Thyroid? Y N

12. Stomach and bowel problems: Diarrhea Constipation Mushy/sandy/runny stools Excess gas
Alternating diarrhea/constipation Vomiting/reflux Stomachaches Stool soiling

13. Feeding: How was baby fed after birth and for how long?
Breast _____ mos. Bottle _____ mos. Formula (kind) _____
Weaning to cup: Easy ___ Difficult _____ Age _____ mos.

Describe any early feeding problems: _____

Current feeding habits: Good eater (wide variety of table foods) _____ How much milk/liquids? _____/day
Picky eater (limited variety, amount and specific preferences or difficulties): Describe _____

List any food allergies and restrictions: _____

List current vitamins or supplements: _____

14. Describe any serious infections, illnesses, accidents, or surgery your child has had. (Give age at occurrence and relative severity): _____

15: Medications: List past and current, prescribed or over-the-counter medications used by your child on a regular basis: Dose Side effects/allergic reactions

Early Development

1. At about what age did your child first:	<u>Age</u> (months or years)	[Not sure, check one:]		
		<u>On time</u>	<u>Early</u>	<u>Late</u>
a. Sit alone?	_____	___	___	___
b. Crawl?	_____	___	___	___
c. Stand?	_____	___	___	___
d. Walk alone?	_____	___	___	___
e. Speak first real words?	_____	___	___	___
f. Feed self with utensils?	_____	___	___	___
g. Use two word sentences?	_____	___	___	___
h. Speak so that strangers could understand?	_____	___	___	___
i. Dress self (not buttoning or tying)	_____	___	___	___
j. Ride a tricycle?	_____	___	___	___
k. Ride a bicycle without training wheels?	_____	___	___	___
l. Tie own shoes?	_____	___	___	___
m. Become toilet trained?	_____	___	___	___

2. Do you have any of the following concerns about your child's motor development? (please circle)
 Muscle tone Gross motor Fine motor Handwriting Other

3. Has your child ever lost language or regressed: ___ No ___ Yes At what age? _____

4. Describe your child's current use of speech and language including conversational skills (speech sounds, words, and sentences, how the voice sounds, and the rhythm of speech): _____

5. Does your child use an augmentative alternative communication device? No _____ Yes _____ If so, name of system or device (e.g. sign language, communication/picture board, picture exchange communication system, verbal output device) _____

6. Did your child learn pre-academic skills (shapes, colors, numbers, and letters) at the same time as other children his/her age? Yes ___ No ___ Please explain: _____

7. Have you ever been told or been concerned that your child's development was behind other children his/her age? No ___ Yes ___ Please explain: _____

School History

1. School and Address (current): _____

2. School Progress (prior to this year) - Placement and special services (if any):

Any grades repeated? _____
Any school problems? _____

3. Child's attitude toward school: _____

4. What is your impression of your child's learning potential? (please circle)
Slow Average Above Average Gifted

5. Do you feel your child is performing up to his/her potential in school? Yes ___ No ___ If no:
Please explain: _____

6. Previous evaluations and/or treatment (When, where, by whom): [Provide a copy of results]

7. Is homework any area of concern? No ___ Yes _____. If so, please explain: _____

Social

1. Describe your child's general behavior and personality (check those that apply):

- | | |
|---|---|
| <input type="checkbox"/> Easy going, generally happy | <input type="checkbox"/> Makes friends easily |
| <input type="checkbox"/> Shy | <input type="checkbox"/> Has difficulty with other children |
| <input type="checkbox"/> Prone to temper tantrums | <input type="checkbox"/> Very distractible |
| <input type="checkbox"/> Good attention to tasks | <input type="checkbox"/> Prefers to play alone |
| <input type="checkbox"/> Plays well with other children | <input type="checkbox"/> Shares easily |
| <input type="checkbox"/> Fights more than others | <input type="checkbox"/> Prefers adults over peers |
| <input type="checkbox"/> Easily influenced by others | <input type="checkbox"/> Has a best friend |
| <input type="checkbox"/> Handles change easily | <input type="checkbox"/> Gives up easily |
| <input type="checkbox"/> Has a hard time recovering from upsets | <input type="checkbox"/> Stands up for self |
| <input type="checkbox"/> Recognizes own strengths | <input type="checkbox"/> Has self-confidence |

2. Does your child's activity level or temperament interfere in his/her own or family's life in any way?
No ___ Yes ___ Please explain: _____

3. Does your child have unusual or repetitive behaviors? No ___ Yes ___ Please explain: _____

4. Does your child have difficulty with sensations – touch, light, noise, movement? No ___ Yes ___
Please explain: _____

5. What are some of his/her favorite activities? _____

6. What are your child's dislikes? _____

7. Please give any other information you believe will help us understand your child's problem: _____

8. Will your child work with us independent of you? (Will he/she separate from you during the evaluation?) _____ Yes _____ No _____ Maybe

Family History

1. Please list names, ages and occupation of parents or guardians: Living in same home?
Name Age (yrs) Occupation Y N
 _____ _____ _____ Y N
 _____ _____ _____ Y N

2. List names, ages and concerns for all children living/visiting regularly in this child's home:
Name Age (yrs) Health/developmental concerns Biological? _
 _____ _____ _____ Y N
 _____ _____ _____ Y N
 _____ _____ _____ Y N
 _____ _____ _____ Y N
 _____ _____ _____ Y N

3. List biological family history difficulties for this child: Mother's family Father's family

- Health (allergies, asthma, hay fever, migraines, bowel problems)
 (heart disease/stroke, cancer, diabetes, arthritis)
- Mental/emotional (depression, bipolar, schizophrenia, suicide)
- Educational (learning difficulties, dyslexia, drop-out)
- Developmental (ADHD, late to talk, speech or hearing delay)
 (language disorders, autism, social withdrawal)
- Abuse - Substances (alcohol, street drugs),
 - Emotional, physical, sexual
- Social-legal difficulties (school expulsion, trouble with law)

TUCSON ALLIANCE FOR AUTISM

Clinic Staff, Therapist, Volunteers and Client/Patient Confidentiality Policy

All medical, clinical, and personal information of clients/patients is confidential. Confidentiality of client/patient information is mandated by federal law and is the policy of Tucson Alliance for Autism. Severe sanctions exist for individuals and institutions that violate the privacy and confidentiality of client/patient information. Client/patient information is confidential and must not be repeated or released to anyone except Tucson Alliance for Autism personnel, when needed. The importance of client/patient confidentiality has been explained to me and I have reviewed the ***Notice of Health Information Practices***. I am also aware that as an observer in clinic, I will be privy to personal health information of our clients/patients. I will only be exposed to the "minimum necessary" personal health information and will not have access to any patient files while involved in observations in Tucson Alliance for Autism.

I have been informed of the HIPAA standards for privacy of individual identifiable health information. I agree to comply with the rules for protecting confidentiality of client/patients by not discussing their personal health information outside of the clinical setting.

Signature _____ Date _____

Print Name _____

Witness _____ Date _____