

Client ID: _____
Today's Date: _____

Virginia Tech Autism Clinic
3110 Prices Fork Road
Blacksburg, VA 24060
Email: autism@vt.edu
(540) 231-6914

Child Information Form

CHILD'S NAME: _____

Date of Birth: _____ Age: _____ Gender: M _____ F _____

Place of Birth: _____

Race: Asian: _____ Black: _____ Hispanic: _____ White: _____ Other: _____

Phone Number: (Home) _____ (Cell) _____ (Work) _____

Address: _____

Form completed by: _____ Relationship to child: _____

Address (if different from above): _____

Phone Number: (Home) _____ (Cell) _____ (Work) _____

Email address: _____

Who referred you to our clinic? _____

- Would you like to be added to our Autism Clinic email list to receive information about local autism events as they arise? If so, please provide your email address: _____
- May we contact you about opportunities for participation in future research projects we conduct through the clinic? We would contact you simply to inform you about new studies; you or your child would be under no obligation to participate.
____ Yes, you may contact me about future studies.
____ No, please do not contact me about research.

BACKGROUND INFORMATION

Please list all individuals who live in the home and their relationship to your child:

Name: _____ **Relationship:** _____ **Age:** _____ **Gender:** _____

If both biological parents are not living in the home, please explain: _____

If child is adopted, please describe circumstances of adoption, age of adoption, and provide any information regarding the biological parents: _____

MOTHER'S NAME: _____ Date of Birth: _____ Social Security #: _____

Biological mother: ___ Stepmother: ___ Adoptive Mother: ___ Foster Mother: ___ Other: _____

Education: ___ Completed 7th grade or less
 ___ Completed some high school
 ___ Graduated from high school
 ___ Graduated from trade school, business school or specialized training program
 ___ Completed an Associate degree
 ___ Graduated from college
 ___ Completed graduate school

Employment: Is mother/caregiver employed outside the home? Yes _____ No _____

If yes, what is her job title? _____

Company's Name: _____

Work schedule: _____ No. of Hrs/Week: _____

Work Telephone: _____ May we call her there? Yes _____ No _____

FATHER'S NAME: _____ Date of Birth: _____ Social Security #: _____

Biological father: ___ Stepmother: ___ Adoptive Father: ___ Foster Father: ___ Other: _____

Education: ___ Completed 7th grade or less
 ___ Completed some high school
 ___ Graduated from high school
 ___ Graduated from trade school, business school or specialized training program
 ___ Completed an Associate degree
 ___ Graduated from college
 ___ Completed graduate school

Employment: Is father/caregiver employed outside the home? Yes _____ No _____

If yes, what is his job title? _____

Company's Name: _____

Work schedule: _____ No. of Hrs/Week: _____

Cell/Work Telephone: _____ May we call him there? Yes _____ No _____

Income: What is your estimated gross family income? _____

Insurance Company: _____ Insurance No: _____

CHILD DEVELOPMENTAL HISTORY

Note: If your child is adopted or in your foster care, please complete the following section to the best of your knowledge and leave unknown information blank.

Pregnancy and Prenatal Development: Was this pregnancy planned? Yes ___ No ___

Please indicate any illnesses or complications experienced by the child's mother during pregnancy.

- Rash_____
- High blood pressure_____
- Headaches_____
- Bleeding_____
- Abdominal pain_____
- Blurred vision_____
- Dizzy spells_____
- Marked swelling of hands/feet_____
- Toxemia_____
- Measles_____
- Diabetes_____
- Very puffy face_____
- Convulsions_____
- High fever_____
- Toxemia_____
- Viral infection_____
- Excessive weight gain_____
- Excessive vomiting_____
- Kidney disease_____
- Thyroid condition_____
- Asthma_____
- Surgery_____

Any accidents during pregnancy: Yes_____ No _____
If yes, specify_____

Other problems during pregnancy: Yes_____ No _____

Please indicate below any special diet the mother had during pregnancy: _____

Please circle the trimester(s) during which the mother smoked during this pregnancy:

- Do not know Did Not First Second Third

Please circle the trimester(s) during which the mother drank alcohol during this pregnancy:

- Do not know Did Not First Second Third

Please circle the trimester(s) during which the mother drank coffee during this pregnancy:

- Do not know Did Not First Second Third

Please circle the trimester(s) during which the mother was exposed to x-ray during this pregnancy:

- Do not know Did Not First Second Third

Please indicate below any medications the mother took during pregnancy:

	<i>Started in what mo. of pregnancy:</i>	<i>For how long:</i>
Control Nausea		
Control Fluid Retention		
Help Sleep		
Help Stay Awake		
Help Relieve Anxiety		
Help Relieve Depression		
Help Control Allergies		
Other		
Other		
Other		

If the mother had severe emotional distress prior to this pregnancy, please explain:

If the mother had severe emotional distress during to this pregnancy, please explain:

If the mother had severe emotional distress after to this pregnancy, please explain:

Birth of Child: How long was pregnancy? _____ weeks

If the gestation period was abnormally short (e.g., the baby was born prematurely) or lengthy, please explain:

Birth weight of baby: _____ Length: _____ Apgar score: 1 minute: _____ 5 minutes: _____

If any medication was given to the mother during labor or delivery, please specify:

Local anesthesia (e.g., caudal, spinal, saddleblock) Yes___ No___ (If yes, specify:_____)

General anesthesia (e.g., ether, nitrous oxide) Yes___ No___ (If yes, specify:_____)

Pain medication (e.g., demoral, codeine) Yes___ No___ (If yes, specify:_____)

Other: _____

Please specify the type of delivery:

Vaginal _____ Normal _____ Induced _____ Forceps _____ Caesarian _____

If labor or delivery was abnormal in any way, please explain:

Please specify any special problems the infant had or special treatment the infant received after delivery:

Difficulty starting to breathe: Yes___ No___

Jaundice (yellowing of skin): Yes___ No___

Special feeding procedures: Yes___ No___ (Specify: _____)

Heart problems: Yes___ No___

Use of incubator: Yes ___ No ___ (If yes, how long? _____)

Oxygen: Yes___ No___ (If yes, how long? _____)

Convulsions: Yes___ No___ Epilepsy: Yes___ No___

Other: _____

Length of baby's stay in hospital after birth: _____

DEVELOPMENTAL & MEDICAL HISTORY

Please specify whether any of the following difficulties occurred during the baby's first few months at home:

Excessive crying: Yes ____ No ____ Unusual muscle activity: Yes ____ No ____
Feeding problems Yes ____ No ____ Sleeping problems: Yes ____ No ____
Dislike of normal handling: Yes ____ No ____ Stiffness, rigidity, floppiness: Yes ____ No ____
Other: _____ Please explain: _____

Please indicate in months when the following occurred and whether development was early, delay, or average:

	Early	Delay	Average
_____ Held head erect.....	_____	_____	_____
_____ Pulled self to sit.....	_____	_____	_____
_____ Rolled from back to stomach.....	_____	_____	_____
_____ Stood unsupported.....	_____	_____	_____
_____ Played with hands.....	_____	_____	_____
_____ Pulled self to stand.....	_____	_____	_____
_____ Reached for objects.....	_____	_____	_____
_____ Walked alone.....	_____	_____	_____
_____ Crawled.....	_____	_____	_____
_____ Fed self with spoon.....	_____	_____	_____
_____ Sat unsupported.....	_____	_____	_____
_____ Tied shoes.....	_____	_____	_____ NA _____
_____ Toilet trained.....	_____	_____	_____ NA _____
_____ Dressed self.....	_____	_____	_____ NA _____

Who is your child's medical doctor? _____ Phone number: _____

Physician's Address: _____

When was the last time your child saw the doctor? _____

Have you talked to your doctor about your concerns? Yes: _____ No: _____

What is your child's current height: _____ Current Weight: _____

Is your child: R-handed: ____ L-handed: ____ Mixed handedness: ____ D/K ____

Have there been any major changes for your child in the past year? (e.g., moved, new job, new school, new baby, death in family, etc.): _____

Medical Conditions: Please indicate whether your child has ever had any of the following:

Meningitis _____	Encephalitis _____	Asthma _____	Diabetes _____
Heart disease _____	Heart murmur _____	Hydrocephalus _____	Cerebral palsy _____
Seizures _____	Leukemia _____	Anemia _____	Arthritis _____
Bone disease _____	Muscle disease _____	Kidney problems _____	Tuberculosis _____
Cancer _____	Measles _____	Mumps _____	Chicken pox _____

If your child has ever been in an accident resulting in serious injury, please explain: _____

Hospitalizations: Has child ever had any medical hospitalizations: Yes____ No____

Age: Length of stay: Reason for hospitalization:

Has child previously been diagnosed (by anyone) with
Asperger's..... Yes____ No___ Date: _____
PDD..... Yes____ No___ Date: _____
Autism Spectrum Disorder..... Yes____ No___ Date: _____

Does child have any other psychiatric or medical diagnosis? Yes____ No___
If yes, please specify diagnosis:

Medications: If your child is currently taking any medications, please specify the name of the medication and the following:

ADHD medications	Dosage	Time of Day	Prescribed by
Anti-Depressant medications	Dosage	Time of Day	Prescribed by
Anti-Anxiety medications	Dosage	Time of Day	Prescribed by
Anti-Seizure medications	Dosage	Time of Day	Prescribed by
Allergy/Asthma medications	Dosage	Time of Day	Prescribed by
Other medications	Dosage	Time of Day	Prescribed by

Is your child on any special diet or has food restrictions? Yes___ No___

If yes, please specify: _____

Family Medical History:

Do any members of the family have a medical or psychological problem? Yes: _____ No: _____
If yes, list this person's name and describe briefly:

Name: _____ Concern: _____

Name: _____ Concern: _____

Name: _____ Concern: _____

Name: _____ Concern: _____

Hearing, Speech & Language History:

Has your child's hearing been screened? Yes___ No___ Date of the last hearing screening: _____

Please indicate if the testing was normal: Yes___ No___

If not, what was found? _____

Has your child's vision been screened? Yes___ No___ Date of last vision screening: _____

Please indicate if the testing was normal: Yes ___ No___

If not, what was found? _____

Is English the only language spoken in the home? Yes___ No___

If no, specify other languages: _____

Did your child have difficulty with any of the following: Yes___ No___

- ___sucking ___ nursing ___ regurgitation of liquids/solids
- ___chewing ___ choking/gagging ___ excessive time to drink bottle

If yes, please explain: _____

Please list ages (to the best of your memory) that your child did the following:

	Early	Delay	Average	N/A
___ Babbled and cooed.....	___	___	___	___
___ Responded to name.....	___	___	___	___
___ Pointed to objects.....	___	___	___	___
___ Said first word.....	___	___	___	___
___ Said two-word phrases.....	___	___	___	___
___ Made three-four word sentences....	___	___	___	___
___ Followed simple directions (e.g., "Give it to Mommy"?).	___	___	___	___
.....	___	___	___	___

Did your child's speech learning ever seem to stop for a period of time? Yes, ___ No ___

Please explain: _____

How does your child communicate his/her needs?

Gestures___ Sounds___ One or two words ___ phrases ___ sentences___ Sign language___

Other: _____

Do you question your child's ability to understand directions and conversations? Yes___ No___

If yes, please explain: _____

When your child speaks, can your child be understood by:

- Parents: Usually ___ Sometimes___ Rarely___ N/A___
- Siblings: Usually ___ Sometimes___ Rarely___ N/A___
- Grandparents: Usually ___ Sometimes___ Rarely___ N/A___
- Playmates: Usually ___ Sometimes___ Rarely___ N/A___
- Other adults: Usually ___ Sometimes___ Rarely___ N/A___

Does your child get 'stuck' on words and/or repeat sounds or words? Yes ___ No ___

If so, describe: _____

Does your child have any other language or communication difficulties not listed above? Yes ___ No ___

If so, describe: _____

Do you think your child hears adequately? Yes ___ No ___

If no, please explain: _____

Do you think his/her hearing is constant or does it vary? Yes ___ No ___

Please describe: _____

Does your child's voice seem normal to you? Yes ___ No ___

If no, please describe: _____

Does your child have difficulty with coordination? _____

Does your child lose balance or fall easily? _____

SOCIAL AND BEHAVIORAL HISTORY

Does your child tend to play alone or with other children? _____

Age of playmates: _____

How does your child get along with other children? _____

With adults? _____

Do you have any other children? Yes ___ No ___

If yes, how does your child get along with his/her brothers and sisters? (e.g., enjoys their company, argues or fights frequently, plays cooperatively, etc.) _____

Is it difficult to discipline your child? (Explain as fully as possible)

Would you describe your child as happy or unhappy? _____

Is your child unusually quiet? _____

Unusually active? _____

Has your child ever expressed suicidal tendencies or behaviors to harm self? Yes____ No____

If yes, please explain: _____

Has your child ever shown violent behavior? Yes____ No____

If yes, please explain: _____

List any sensory sensitivity that your child might have (e.g., becomes very upset if__, very preoccupied with__)

List any of your child's fears that you feel are excessive: _____

Does your child have difficulty concentrating? _____

Does your child have difficulty sleeping? _____

List any repetitive behaviors or intense preoccupations your child may have_____

List some of your child's favorite interests, hobbies or games:

Describe any other concerns you have about your child's behavior, including any current problems or concerns for which you would like help: _____

Please list professionals or clinics with whom you've consulted about the problem.

EDUCATIONAL HISTORY

Is your child currently attending day care, school or an educational program? Yes _____ No _____

School Name: _____

Date he/she started attending this school: _____ Current grade: _____

If Day Care, or preschooler, how many days per week? _____

Teacher's Name: _____

Teacher's Name: _____

May we contact his/her teacher if necessary? Yes _____ No _____

Has your child ever been retained in school? Yes ___ No ___ If so, what grades? _____

If applicable, what kinds of grades does your child make? _____

How does your child feel about school? _____

Has your child ever been evaluated psychoeducationally by a school or private consultant (include any diagnosis given)?

Yes ___ No ___

Date: _____ Evaluated by: _____ Outcome/Diagnosis: _____

PSYCHIATRIC/EMOTIONAL

If your child has ever been treated or received special help for learning or emotional problems not listed elsewhere on this form, please describe. Please also indicate any past diagnosis that has been given.

Date: _____ Evaluated by: _____ Outcome/Diagnosis: _____

SERVICES

Please circle any special programs in which your child is currently enrolled in school:

- A. None
- B. Counseling
Name: _____
- C. Learning disabled (LD) or resource
Areas: _____ Number of hrs/day _____
- D. Seriously emotionally disturbed (SED)
- E. Chapter 1 Reading
- F. Chapter 1 Math
- G. Other Health Impaired (OHI)
- H. Developmentally Delayed

Please complete the following for any therapies your child has received.

- A. Speech/Language Therapy:
Of hrs per week _____ Date it started: _____ Date it ended _____
Group _____ and/or Individual _____ / Private _____ and/or School system _____
Provider: _____
- B. Occupational Therapy:
Of hrs per week _____ Date it started: _____ Date it ended _____
Group _____ and/or Individual _____ / Private _____ and/or School system _____
Provider: _____
- C. Applied Behavioral Analysis:
Of hrs per week _____ Date it started: _____ Date it ended _____
Group _____ and/or Individual _____ / Private _____ and/or School system _____
Provider: _____
- D. Play Therapy:
Of hrs per week _____ Date it started: _____ Date it ended _____
Group _____ and/or Individual _____ / Private _____ and/or School system _____
Provider: _____
- E. Music Therapy:
Of hrs per week _____ Date it started: _____ Date it ended _____
Group _____ and/or Individual _____ / Private _____ and/or School system _____
Provider: _____
- F. Social Skills Therapy:
Of hrs per week _____ Date it started: _____ Date it ended _____
Group _____ and/or Individual _____ / Private _____ and/or School system _____
Provider: _____
- G. Individual Therapy:
Of hrs per week _____ Date it started: _____ Date it ended _____
Private _____ and/or School system _____
Provider: _____
- H. Other services: _____

- I. Other services: _____
