

Today's Date: _____

Virginia Tech Autism Clinic

3110 Prices Fork Road

Blacksburg, VA 24060

Email: autism@vt.edu

(540) 231-6914

Information Form

Client's Name: _____

Social Security Number: _____

Form completed by (if not completed by client): _____

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

Place of Birth: _____

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

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

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 would be under no obligation to participate.
____ Yes, you may contact me about future studies.
____ No, please do not contact me about research.

EDUCATION & EMPLOYMENT HISTORY

Are you currently attending school or an educational program? Yes: _____ No: _____

School Name: _____ Grade: _____

Have you ever been retained in school? Yes: _____ No: _____ If so, what grade(s)? _____

What kinds of grades do you make? _____

How do you feel about school and about your teachers? _____

If you have ever been evaluated psychoeducationally by a school or private consultant, please indicate below:

Date: _____ Evaluated by: _____ Outcome: _____

Please circle any special programs in which you are 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

I. Other: _____

Please indicate the highest grade that you have completed:

___ less than 7th grade

___ partial high school education (9th, 10th or 11th grade)

___ graduated from high school

___ graduated from trade school or business school

___ attended college or specialized training program

___ graduated from college

___ completed graduate school

Are you employed outside the home? Yes: _____ No: _____

If yes, what is your company's name? _____

What is your job title? _____

What is your work schedule: _____ Number of hours you work each week: _____

Work Telephone: _____ May we call you there (if necessary)? Yes: _____ No: _____

What is your estimated gross income? _____

Insurance Company: _____

Insurance No: _____

FAMILY INFORMATION

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

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

HEALTH/MEDICAL HISTORY

Who is your medical doctor? _____ Phone number: _____

Physician's Address: _____

When was the last time you saw your medical doctor? _____

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

What is your current height: _____ Current Weight: _____

Are you: R-handed: _____ L-handed: _____ Mixed handedness: _____

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

If you have ever been in an accident resulting in serious injury, please explain:

Medical Conditions: Please indicate whether you have 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 |

Hospitalizations: Please indicate if you have ever any medical hospitalizations:

Age: _____ Length of stay: _____ Reason for hospitalization: _____

Medications: Please indicate whether you are currently taking any medications, including 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
Other medications	Dosage	Time of Day	Prescribed by

Developmental History: In the following section, please report to the best of your ability information you know, otherwise, please leave blank.

Your birth weight: _____ Length: _____

Please specify the type of delivery:

_____ Vaginal _____ Normal _____ Induced _____ Forceps _____ Caesarian

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

What language(s) is/are spoken in your home? _____

Do you hear adequately? _____

Family Medical History:

Do any members of your 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: _____

PSYCHIATRIC/EMOTIONAL HISTORY

If you have ever been treated or received special help for learning or emotional problems outside not listed elsewhere on this form, please describe. Please also indicate any past diagnosis you have received.

Date: _____ Evaluated by: _____ Outcome: _____

SOCIAL HISTORY

How do you get along with other peers? _____

 With adults? _____

Would you describe yourself as happy or unhappy? _____

Are you unusually quiet? _____ Unusually active? _____

Have you tried to commit suicide or tried to harm yourself? Yes____ No____

If yes, please explain: _____

Do you find it difficult to control your emotions (e.g., anger)? Yes___ No____

If yes, please explain: _____

Have you ever been aggressive or violent toward others? Yes____ No____

If yes, please explain: _____

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

Do you have difficulty concentrating? _____

Difficulty sleeping? _____

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

List some of your favorite interests, hobbies or games:
