History Form for Adult Client *(age 18 and older and own guardian)*

To be completed by TEACCH Center

Center: _____ Case #:_____

UNC Hospital Unit# *(if available)*:_____ Referral Date: _____

Who referred you to TEACCH? ☐ Self ☐ Other, please specify: _____

Reason for Referral:

☐ Need a Diagnostic Evaluation for Autism Spectrum Disorder

☐ Have an ASD diagnosis and need Treatment Services

CLIENT INFORMATION

Date Form Completed:_____

First Name: _____ Last Name: _____ Suffix: ☐ Jr. ☐ Sr. ☐ III ☐ IV

Birth Date: _____ Sex: ☐ Male ☐ Female Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race of Client:

☐ African American or Black ☐ American Indian/Alaska Native ☐ Asian
☐ Other Pacific Islander ☐ More than one race ☐ Other (specify):
☐ White ☐ Native Hawaiian

Religious Affiliation (*optional*): _____

Street or Mailing Address: _____ Suite or Apt #:_____

City: _____ State: _____ Zip Code:_____ County:_____

Email: _____ Primary Phone: _____

Alternate Phone 1: _____ Alternate Phone 2: _____

Currently lives:

☐ independently alone ☐ with spouse or life partner ☐ independently with friends ☐ with both biological parents
☐ with biological father ☐ with biological mother ☐ with biological father and stepmother ☐ with biological mother and stepfather
☐ with adoptive parents ☐ with foster parents ☐ in a group home ☐ in supervised apartment
☐ with other, who?

Client's marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Divorced, Remarried ☐ Living with Life Partner

Will anyone be accompanying you to TEACCH appointments/sessions? ☐ Yes ☐ No

If yes, Name: _____ Relationship _____

Language Spoken at home: _____ Will an interpreter be needed? ☐ Yes ☐ No

INSURANCE INFORMATION

***Please complete the following and send a copy of insurance card front and back*

Name of Insurance Company:_____ Group #:_____

Policy Holder Name:_____ Policy Holder Birthdate: _____

Policy Number + suffix: _____

Primary Care Provider Name: _____

Insurance Claims Address: _____

Customer Service Phone Number: _____ Effective Date of Policy: _____

EDUCATIONAL/VOCATIONAL INFORMATION

Client Education (*check highest level completed*):

☐ Graduate/Professional degree ☐ BA, BS or 4-year degree ☐ Technical school degree

☐ Associates degree ☐ High School graduate ☐ GED diploma

☐ 1-3 years of high school ☐ Completed up to ninth grade ☐ Completed less than ninth grade

Did you receive special assistance in school? ☐ Yes ☐ No

If yes, please describe the type of extra academic assistance or special class placement:

During the day, do you currently:

Occupation: _____ Place of employment:_____

Go to school, Name of School: _____

Attend a day program, Name of day program: _____

Unemployed? ☐

Other, please specify:

BIOLOGICAL PARENT 1 INFORMATION

Please complete the following section to the best of your ability.

First Name: _____ Last Name:_____

Suffix: ☐ Jr. ☐ Sr. ☐ III ☐ IV Relationship to Client: _____

Street or Mailing Address: _____Suite or Apt #:_____

City: _____State: _____Zip Code: _____County:_____

Email: _____Primary Phone: _____

Phone 1: _____ Phone 2: _____

Birth date: _____ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race:

☐ African American or Black ☐ American Indian/Alaska Native ☐ Asian
☐ Other Pacific Islander ☐ More than one race ☐ Other (specify):
☐ White ☐ Native Hawaiian

Education (check highest level completed):

☐ Graduate/Professional degree ☐ BA, BS or 4-year degree ☐ Technical school degree
☐ Associates degree ☐ High School graduate ☐ GED diploma
☐ 1-3 years of high school ☐ Completed up to ninth grade ☐ Completed less than ninth grade

This parent knows about my early history (birth to age five): ☐ Yes ☐ No

This parent is currently involved in my life and serves a support person for me: ☐ Yes ☐ No

BIOLOGICAL PARENT 2 INFORMATION

Please complete the following section to the best of your ability

First Name: _____ Last Name:_____

Suffix: ☐ Jr. ☐ Sr. ☐ III ☐ IV Relationship to Client: _____

Street or Mailing Address: _____Suite or Apt #:_____

City: _____State: _____Zip Code: _____County:_____

Email: _____Primary Phone: _____

Phone 1: _____ Phone 2: _____

Birth date: _____ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race:

☐ African American or Black ☐ American Indian/Alaska Native ☐ Asian
☐ Other Pacific Islander ☐ More than one race ☐ Other (specify):
☐ White ☐ Native Hawaiian

Education (check highest level completed):

☐ Graduate/Professional degree ☐ BA, BS or 4-year degree ☐ Technical school degree
☐ Associates degree ☐ High School graduate ☐ GED diploma
☐ 1-3 years of high school ☐ Completed up to ninth grade ☐ Completed less than ninth grade

This parent knows about my early history (birth to age five): ☐ Yes ☐ No

This parent is currently involved in my life and serves a support person for me: ☐ Yes ☐ No

BIOLOGICAL CHILDREN OF THE CLIENT

Name *(first name only)*	Birth Date	Grade	Gender	Does child have Autism Spectrum Disorder	Other Developmental or Health Disorder	Does child currently live with client
			☐ M ☐ F	☐ Yes ☐ No		☐ Yes ☐ No
			☐ M ☐ F	☐ Yes ☐ No		☐ Yes ☐ No
			☐ M ☐ F	☐ Yes ☐ No		☐ Yes ☐ No
			☐ M ☐ F	☐ Yes ☐ No		☐ Yes ☐ No

Who else lives in the home with you? *(spouse, partner, children, friends, aunts, uncles, grandparents, etc.)*

Name	Relation to Client

SIBLING INFORMATION

First Name Only	Birth Date	Gender	Relationship	Does sibling have an Autism Spectrum Disorder	Other Developmental or Health Disorder
		☐ Male ☐ Female	☐ Full ☐ Step ☐ Half ☐ Foster	☐ Yes ☐ No	
		☐ Male ☐ Female	☐ Full ☐ Step ☐ Half ☐ Foster	☐ Yes ☐ No	
		☐ Male ☐ Female	☐ Full ☐ Step ☐ Half ☐ Foster	☐ Yes ☐ No	
		☐ Male ☐ Female	☐ Full ☐ Step ☐ Half ☐ Foster	☐ Yes ☐ No	

MEDICAL HISTORY

Please check any of the following professionals with whom you have had contact.

PRIMARY CARE PHYSICIAN *Name:*	☐ *See Currently*
City/State:	☐ *Seen in the past*
NEUROLOGIST *Name:*	☐ *See Currently*
City/State:	☐ *Seen in the past*
EAR, NOSE & THROAT SPECIALIST *Name:*	☐ *See Currently*
City/State:	☐ *Seen in the past*
OPHTHALMOLOGIST *Name:*	☐ *See Currently*
City/State:	☐ *Seen in the past*
SURGEON *Name:*	☐ *See Currently*
City/State:	☐ *Seen in the past*
DENTIST *Name:*	☐ *See Currently*
City/State:	☐ *Seen in the past*
PSYCHIATRIST *Name:*	☐ *See Currently*
City/State:	☐ *Seen in the past*
PSYCHOLOGIST *Name:*	☐ *See Currently*
City/State:	☐ *Seen in the past*
AUDIOLOGIST *Name:*	☐ *See Currently*
City/State:	☐ *Seen in the past*
SPEECH THERAPIST *Name:*	☐ *See Currently*
City/State:	☐ *Seen in the past*
OCCUPATIONAL THERAPIST *Name:*	☐ *See Currently*
City/State:	☐ *Seen in the past*
PHYSICAL THERAPIST *Name:*	☐ *See Currently*
City/State:	☐ *Seen in the past*
SOCIAL WORKER *Name:*	☐ *See Currently*
City/State:	☐ *Seen in the past*
DIETITIAN *Name:*	☐ *See Currently*
City/State:	☐ *Seen in the past*
OTHER (specify) *Name:*	☐ *See Currently*
City/State:	☐ *Seen in the past*

Have you had any of the following? Please indicate age.

check	condition	age	check	condition	age
☐	meningitis and/or encephalitis		☐	bladder and/or kidney infection	
☐	accident(s) *specify:*		☐	headaches and/or migraines	
☐	heart disease		☐	poisoning	
☐	convulsions and/or seizure disorders		☐	diabetes	
☐	measles		☐	head injuries	
☐	whooping cough (pertussis)		☐	mumps	
☐	recurrent ear infections		☐	german measles	
☐	chicken pox		☐	recurrent tonsillitis	
☐	EEG		☐	chronic infections (for example, TB, cytomegalovirus, herpes, HIV) *specify:*	
☐	fainting spells		☐	chromosome studies	
☐	eye and/or visual problems		☐	other genetic studies	
☐	severe diarrhea with dehydration		☐	hospitalization (for medical reasons)	
☐	allergies		☐	hospitalization (for behavioral or psychiatric reasons)	
☐	severe reaction to immunizations		☐	threats and/or attempts to harm self	
☐	CNS (brain) studies (e.g. MRI, CT) *specify:*		☐	threats and/or attempts to harm others	
			☐	experienced abuse and/or neglect	
☐	surgery *specify:*				
☐	other *specify:*				

Please check any of the following behavioral or psychiatric diagnoses that you have been given over the years regardless of whether you believe it currently applies.

Check off	Diagnoses	If yes, by whom	Check off	Diagnoses	If yes, by whom
☐	Alcoholism		☐	Anxiety Disorder	
☐	Attention Deficit Hyperactivity Disorder (ADHD)		☐	ASD, Autism, Asperger's, Pervasive Developmental Disorder (PDD-NOS)	
☐	Bipolar Disorder/Manic Depression		☐	Depression	
☐	Intellectual Disability (*formerly known as mental retardation*)		☐	Learning Disability	
☐	Obsessive Compulsive Disorder (OCD)		☐	Personality Disorder	
☐	Post Traumatic Stress Disorder (PTSD)		☐	Psychosis/Schizophrenia	

☐	Seizure Disorder		☐	Substance Abuse	
☐	Other (please specify):		☐	Other (please specify):	

What medication(s) and/or vitamins have you taken or are currently taking?

Medication:	Date(s):
Reason/Effectiveness:	
Medication:	Date(s):
Reason/Effectiveness:	
Medication:	Date(s):
Reason/Effectiveness:	
Medication:	Date(s):
Reason/Effectiveness:	

FAMILY TREE

If any of your biological relatives have had any of the following conditions, please write the person's *Relationship to You* next to the condition. (*By relatives, we mean grandparents, aunts, uncles, first cousins on both sides and your brothers, sisters and parents)*.

CONDITION	Biological Mother's Family	Biological Father's Family
Autism Spectrum Disorder, Asperger Syndrome, (PDD-NOS)		
Communication Disorder		
Convulsions, Seizures, Epilepsy		
Cerebral Palsy, muscular weakness		
Hearing loss		
Intellectual Disability (*formerly known as Mental Retardation*)		
School difficulties		
Severe visual impairment		
Developmental delay, Speech delay		

Reading difficulty		
Anxiety Disorder		
Psychosis Disorder		
Attention Deficit Hyperactivity Disorder (ADHD)		
Depression		
Bipolar disorder		
Mood Disorder		
Alcoholism/Substance abuse or dependency		
Autoimmune disorders (thyroid, MS, lupus) *specify:*		
Other *specify:*		

REFERRAL INFORMATION

Who referred you to TEACCH? ☐ Self ☐ Other, please specify: _____

Reason for Referral:

☐ Need a Diagnostic Evaluation for Autism Spectrum Disorder

☐ Have an ASD diagnosis and need Treatment Services

What are you hoping the TEACCH Center can provide to you?

Describe any concerns or information you think is important for us to know.

PREVIOUS DIAGNOSES AND REPORTS

To serve you as effectively and as quickly as possible, we request that you send us copies of previous evaluations. If you have any questions about this process or need assistance getting copies of reports, please do not hesitate to contact your local TEACCH Center. We need all previous evaluation reports before we will schedule an appointment

1) Have you ever received an evaluation for ASD, Asperger Syndrome, or PDD-NOS made by a school system, psychologist or medical doctor? ☐ Yes ☐ No

If yes, by whom: _____ City/State: _____ Date: _____

Please check one: ☐ Report(s) attached ☐ Report(s) will be sent in a separate mailing

2) Have you ever received any developmental, cognitive, achievement or IQ testing? ☐ Yes ☐ No

If yes, whom: _____ City/State: _____ Date: _____

Please check one: ☐ Report(s) attached ☐ Report(s) will be sent in a separate mailing

3) Have you ever received any behavioral or mental health evaluations? *(for concerns such as ADHD, depression, anxiety, psychosis, conduct, etc.)* ☐ Yes ☐ No

If yes, whom: _____ City/State: _____ Date: _____

Please check one: ☐ Report(s) attached ☐ Report(s) will be sent in a separate mailing

4) Have you ever received any other type of evaluation for other disabilities or concerns *(e.g. OT, Speech, medical evaluations)*? ☐ Yes ☐ No

If yes, whom: _____ City/State: _____ Date: _____

Please check one: ☐ Report(s) attached ☐ Report(s) will be sent in a separate mailing

Form completed by ☐ Self ☐ Other _____

If other, relationship to client: _____ Date: _____

----Please mail or fax the completed form to your local TEACCH Center----