

History Form for Parent/Guardian of Children and Adolescents (through age 17)

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

CHILD INFORMATION

Date form completed: _____

First Name: _____ Preferred Name: _____ Middle Name: _____

Last Name: _____ Suffix: Jr. Sr. III IV Birth Date: _____

Gender: Male Female Ethnicity: Hispanic or Latino Not Hispanic or Latino

Race of child:

African American or Black

American Indian/Alaska Native

Asian

Other Pacific Islander

More than one race

Other (specify):

White

Native Hawaiian

Religious Affiliation (optional): _____

Currently lives:

with both biological parents

with biological father

with biological mother

with biological father and stepmother

with biological mother and stepfather

joint custody – 2 separate homes

with adoptive parents

with foster parents

with non-family care, who?

with relatives, who?

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: _____

1ST PARENT / LEGAL GUARDIAN INFORMATION

First Name: _____ Middle Name: _____ Last Name: _____

Suffix: Jr. Sr. III IV Relationship to Child: _____

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

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

Email: _____ Primary Phone: _____

Alternate Phone 1: _____ Alternate 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	

Highest Education 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

Occupation: _____

Place of Employment: _____ Phone: _____

2nd PARENT / LEGAL GUARDIAN INFORMATION

First Name: _____ Middle Name: _____ Last Name: _____

Suffix: Jr. Sr. III IV Relationship to Child: _____

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

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

Email: _____ Primary Phone: _____

Alternate Phone 1: _____ Alternate Phone 2: _____

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

Race:

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

Highest Education 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

Occupation: _____

Place of Employment: _____ Phone: _____

MARITAL STATUS

Are parents married to each other? Yes No Date of Marriage: _____

Are parents separated or divorced? Divorced Separated Date of Separation or Divorce: _____

If divorced or separated, please indicate custody arrangements: Joint Sole (which parent?) _____

Other (please describe): _____

SIBLING INFORMATION

First Name Only	Birth Date	Gender	Relationship	Does sibling have Autism Spectrum Disorder	Other Developmental or Health Disorder	Does sibling live in the home with client
		Male Female	Full Half Step Foster	Yes No		Yes No
		Male Female	Full Half Step Foster	Yes No		Yes No
		Male Female	Full Half Step Foster	Yes No		Yes No
		Male Female	Full Half Step Foster	Yes No		Yes No

OTHER CAREGIVER INFORMATION

First Name: _____ Last Name: _____

Suffix: Jr. Sr. III IV Relationship to Child: _____

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

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

Email: _____ Primary Phone: _____

Alternate Phone 1: _____ Alternate Phone 2: _____

Birth date: _____

HISTORY OF CONCERNS

When did you first have concerns about your child's development? Age in months: _____ or Age in years: _____

What were your concerns at the time?

When did it seem serious enough to seek professional help? (Age in months): _____ or (Age in years): _____

What professionals (if any) did you consult?

What did he/she say?

What diagnoses has your child received?

Did your child have a period of time in which he/she seemed to lose a great number of skills? Yes No

At what age? (Age in months): _____ or (Age in years): _____

How long was this period? (months): _____ or (years): _____

CURRENT SCHOOL PLACEMENT

School: _____ Teacher: _____

Classroom: Regular _____ grade Resource Support Self-contained special education

Does your child have (check any that apply): IFSP IEP 504 Plan

My child is not currently enrolled in school

PREVIOUS SCHOOL EXPERIENCE

Name of School	City	Special Education Services Received	Grades
		Yes No	
		Yes No	
		Yes No	
		Yes No	
		Yes No	

Has your son/daughter had past or current difficulties in school? Yes No *If yes, please describe below:*

PREGNANCY INFORMATION

Please check any of the following, which occurred during the pregnancy with this child:		
excessive nausea and vomiting	spotting and/or bleeding	german measles (rubella)
other infectious diseases, flu	kidney and/or bladder infection	high blood pressure
toxemia	anemia (low iron)	smoking
alcohol use	prescription drugs (specify):	RH incompatibility
premature birth	non-prescription drugs (specify):	hospitalization during pregnancy
difficulty conceiving	medical problems unrelated to pregnancy	physical strain
fertility treatment	emotional strain	accidents
in-vitro fertilization	regular doctor visits for prenatal care, first visit in month #:	
other prenatal diagnostic studies	other (please specify):	
ultrasound		
amniocentesis		

Were there any problems during other pregnancies (include items listed above as well as difficulty conceiving, miscarriages, stillbirths, premature births)? No Yes

If yes, please specify:

CHILD'S BIRTH HISTORY

Hospital where child was born: _____ Birth weight: _____ lbs. _____ oz.

City/State: _____ Weeks of gestation: _____

APGAR Scores: range 1-10

#1	#2

Delivery:

no complications	multiple births	breech
cesarean section	forceps	cord around neck
other birth complications, specify:		

NEONATAL HISTORY

Please check any of the following, which applied during first month.

breathing problems	seizures/convulsions	cyanosis (skin blue)
excessive crying	infections	jaundice (skin yellow)
sleeping problems	received care in an intensive care nursery	very inactive
feeding problems	breastfed	
any other neonatal problems? please specify:		

MEDICAL HISTORY

Please check any of the following with whom you have had contact concerning your son/daughter.

PEDIATRICIAN <i>Name:</i>	<i>See Currently</i>
<i>City/State:</i>	<i>Seen in the past</i>
PRIMARY CARE PHYSICIAN (if not pediatrician) <i>Name:</i>	<i>See Currently</i>
<i>City/State:</i>	<i>Seen in the past</i>
NEUROLOGIST <i>Name:</i>	<i>See Currently</i>
<i>City/State:</i>	<i>Seen in the past</i>
EAR, NOSE & THROAT SPECIALIST <i>Name:</i>	<i>See Currently</i>
<i>City/State:</i>	<i>Seen in the past</i>
OPHTHALMOLOGIST <i>Name:</i>	<i>See Currently</i>
<i>City/State:</i>	<i>Seen in the past</i>
SURGEON <i>Name:</i>	<i>See Currently</i>
<i>City/State:</i>	<i>Seen in the past</i>
DENTIST <i>Name:</i>	<i>See Currently</i>
<i>City/State:</i>	<i>Seen in the past</i>
PSYCHIATRIST <i>Name:</i>	<i>See Currently</i>
<i>City/State:</i>	<i>Seen in the past</i>
PSYCHOLOGIST <i>Name:</i>	<i>See Currently</i>
<i>City/State:</i>	<i>Seen in the past</i>

AUDIOLOGIST Name:	<i>See Currently</i>
<i>City/State:</i>	<i>Seen in the past</i>
SPEECH THERAPIST Name:	<i>See Currently</i>
<i>City/State:</i>	<i>Seen in the past</i>
OCCUPATIONAL THERAPIST Name:	<i>See Currently</i>
<i>City/State:</i>	<i>Seen in the past</i>
PHYSICAL THERAPIST Name:	<i>See Currently</i>
<i>City/State:</i>	<i>Seen in the past</i>
SOCIAL WORKER Name:	<i>See Currently</i>
<i>City/State:</i>	<i>Seen in the past</i>
DIETICIAN Name:	<i>See Currently</i>
<i>City/State:</i>	<i>Seen in the past</i>
EARLY INTERVENTION SPECIALIST (received services/interventions before the age of 3) Name:	<i>See Currently</i>
<i>City/State:</i>	<i>Seen in the past</i>
OTHER (specify): <i>Name:</i>	<i>See Currently</i>
<i>City/State:</i>	<i>Seen in the past</i>

Has your son/daughter 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) <i>specify:</i>			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) <i>specify:</i>	
	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) <i>specify:</i>			threats and/or attempts to harm others	
				experienced abuse and/or neglect	
	surgery <i>specify:</i>				
	other <i>specify:</i>				

FAMILY TREE

If any of your child's biological relatives have had any of the following conditions, please write the person's *Relationship to Your Child* next to the condition. (By relatives, we mean your son or daughter's grandparents, aunts, uncles, first cousins, siblings and or 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) <i>specify:</i>		
Other <i>specify:</i>		

DEVELOPMENTAL HISTORY

Milestones: As closely as you can recall, please indicate age when your child did the following things.

Milestone	age	Milestone	age
Eating		Motor	
gave up bottle		rolled over	
drank from cup without help		reached for objects	
started eating solids		sat without support	
fed self with spoon		crawled	
Toilet training		pulled to standing	
bladder trained – daytime		stood without support	
bladder trained – nighttime		walked using furniture as support	
bowel trained – daytime		walked alone	
bowel trained – nighttime		rode tricycle	
went to bathroom alone		Social Communication	
Dressing Skills		smiled	
undressed himself		followed with eyes	
dressed himself		made single sounds (babbling)	
buttoned clothes		said first word	
tied shoelaces		used words every day	
		combined words in short sentences	

Please estimate the child's present vocabulary size:

- No words
- 1 to 5 words
- 10 to 25 words
- 25 to 50 words
- 50 to 75 words
- 75 to 100 words
- over 100 words

What medication(s) and/or vitamins has your son/daughter taken or is currently taking?

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

REFERRAL INFORMATION

Why did the referral person think you should contact TEACCH?

What are your main concerns at present for your child?

What are you hoping the TEACCH Center can provide to your son/daughter and your family?

Describe any concerns you have about your child's communication development:

Describe any concerns you have about your child's social development:

Describe any concerns you have about your child's play skills, interests and activities:

Describe any concerns you have about your child's learning style and behavior:

Describe any other concerns or information you feel 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) Has your child ever received an evaluation for ASD, Autism, 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) Has your child ever received any developmental, cognitive, achievement or IQ testing? Yes No

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

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

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

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

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

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

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

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

Person completing this questionnaire: _____

Relationship to child: _____ **Date:** _____

---Please mail completed forms to your local TEACCH Center---