History Form for Parent/Guardian of Adult Client *(age 18 and older)*

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

ADULT CLIENT 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 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)*: _____

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?

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

Is client his/her own guardian? ☐ Yes ☐ No

In North Carolina, all persons over 18 years of age who have not had their rights to manage their money and medical care legally transferred to someone else by a judge are their own guardians.

During the day, the adult client currently:

Occupation: _____ Place of employment:_____

Goes to school, Name of School: _____

Attends a day program, Name of day program: _____

☐ Is Unemployed?

☐ Other, please specify:

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 Adult: _____

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

Occupation: _____

Place of Employment:_____ Phone: _____

2nd PARENT / LEGAL GUARDIAN INFORMATION

First Name: _____Middle Name: _____ Last Name: _____

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

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

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: _____

SIBLING INFORMATION

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

OTHER CAREGIVER INFORMATION

First Name: _____Middle Name: _____ Last Name: _____

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

Street or Mailing Address: _____Suite or Apt #:_____

City: _____State: _____Zip Code: _____County:_____

Email: _____Primary Phone: _____

Phone 1: _____ 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 son/daughter received?

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

If yes, 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 son/daughter have (check any that apply): ☐ IEP ☐ 504 Plan

☐ Son/daughter not currently enrolled in school

PREVIOUS SCHOOL EXPERIENCE

Name of School	City/State	Special Education Services Received	Grades
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

Has your son/daughter had difficulties (past or present) 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)?* ☐ Yes ☐ No
If yes, please specify:

ADULT CLIENT BIRTH HISTORY

Hospital where client was born:_____Birth weight: _____ lbs. oz. _____

Weeks of gestation: _____ City/State:_____

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.

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*

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) *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 your son/daughter has been given over the years regardless 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 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:	

FAMILY TREE

If any of your son or daughter's biological relatives have had any of the following conditions, please write the person's *Relationship to your Child (client)* 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 *specify:*		
Psychosis disorder *specify:*		
Attention Deficit Hyperactivity Disorder (ADHD)		
Depression		
Bipolar disorder		
Mood disorder		
Alcoholism/Substance abuse or dependency		
Autoimmune disorders (thyroid, MS, lupus) *specify:*		
Other *specify:*		

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 your son or daughter'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

REFERRAL INFORMATION

Why did the referring person think you should contact TEACCH?

What are your main concerns at present for your son/daughter?

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

Describe any other concerns or information you feel we should 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 Autism Spectrum Disorder, 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 client: _____ Date: _____

---Please mail completed form to the local TEACCH Center---