History Form for Client

To be completed by TEACCH Center					
Center:		County:		Case #:	
UNC Hospital Unit # (*if available*):				Referral Date:	

CLIENT INFORMATION				Date Form Completed:	
First Name:		Preferred Name:		Middle Name:	
Last Name:		Suffix:	Jr. / Sr. / III / IV	Birth Date:	
Sex assigned at birth:	Male / Female / Uncertain	Pronouns:	He/him / She/her / They/them	Other:	
Gender Identity:	Male / Female / Transgender	Other:			

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 an updated assessment to maintain services			
Have an ASD diagnosis and need treatment services					
Race of Client:	African American or Black	American Indian/Alaska Native	Asian	Other Pacific Islander	More than one race
White	Native Hawaiian	Other (specify):	Ethnicity:	Hispanic or Latinx	Not Hispanic or Latinx
Is the client their own guardian?	Yes	No	Religious Affiliation (optional):		

Mailing Address:				Suite or Apt #:	
City:		State:	Zip	County	
Email:				Home Phone:	
Cell Phone:				Work Phone:	

Client's Marital Status:	Single	Married	Separated	Divorced	Divorced, Remarried	Living with Life Partner
Will anyone be accompanying you to TEACCH appointments?	Yes	No				
If yes, Name:		Relationship:				
Currently lives	Independently alone	with spouse/ partner	independently with friends/housemates	with both biological parents		
with biological father	with biological mother	with biological father & non-bio partner	with biological mother & non-bio partner			
with adoptive parent(s)	with foster parent(s)	in a group home	in supervised apartment	with other, who?		
Language Spoken at home:		Will an interpreter be needed?	Yes	No	If yes, what language?	

INSURANCE INFORMATION ***Please complete the following and send us a copy of insurance card front and back*					
Name of Primary Insurance Company:				Group #:	
Policy Holder Name:		Policy holder Birthdate:		Relationship to client:	
Policy Number + suffix:		Effective Date of Policy:			
Primary Care Provider Name (required):		Primary Care Practice Name			
Insurance Claims Address:				Customer Service Phone Number:	
SECONDARY INSURANCE INFORMATION ***Please complete the following and send us a copy of insurance card front and back*					
Name of Secondary Insurance Company:				Group #:	
Policy Holder Name:		Policy holder Birthdate:		Relationship to client:	
Policy Number + suffix:		Effective Date of Policy:			
Primary Care Provider Name (required):		Primary Care Practice Name			
Insurance Claims Address:				Customer Service Phone Number:	
Is there a 3rd Insurance policy?	Yes	No			

VOCATIONAL INFORMATION ***(for clients who are adults):***							
During the day, the adult client currently:		Is Unemployed		Goes to School	Name of School:		
Occupation:		Place of Employment:			Length of time at job:		
	Attends a day program	Name of day program:			Other (specify):		

1st PARENT/LEGAL GUARDIAN INFORMATION		Is this parent/caregiver a legal guardian?		Yes		No				
First Name:		Middle Name:		Last Name:						
Suffix:		Jr.		Sr.		III		IV	Relationship to client:	
Mailing Address:						Suite or Apt #:				
City:			State:		Zip		County			
Email:				Home Phone:						
Cell Phone:				Work Phone:						
Birthdate:		**Ethnicity:**		Hispanic or Latinx		Not Hispanic or Latinx				
Race:		African American or Black		American Indian/Alaska Native		Asian		Other Pacific Islander		
	White		Native Hawaiian		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	
Place of Employment:										

2nd PARENT/LEGAL GUARDIAN INFORMATION		Is this parent/caregiver a legal guardian?		Yes		No				
First Name:		Middle Name:		Last Name:						
Suffix:		Jr.		Sr.		III		IV	Relationship to client:	
Mailing Address:						Suite or Apt #:				
City:			State:		Zip		County			
Email:				Home Phone:						
Cell Phone:				Work Phone:						
Birthdate:		**Ethnicity:**		Hispanic or Latinx		Not Hispanic or Latinx				
Race:		African American or Black		American Indian/Alaska Native		Asian		Other Pacific Islander		
	White		Native Hawaiian		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	
Place of Employment:										

PARENT MARITAL STATUS	Are parents married to each other?		Yes		No	Date of marriage:		
Are parents separated or divorced?		Separated		Divorced		Widowed	Date of separation or divorce:	
If divorced or separated, please indicate custody arrangements:		Joint		Sole	Which parent?			
Please be prepared to share documentation of custody arrangement	Other (describe):							

OTHER CAREGIVER INFORMATION		Is this caregiver a legal guardian?		Yes		No				
First Name:		Middle Name:		Last Name:						
Suffix:		Jr.		Sr.		III		IV	Relationship to client:	
Mailing Address:						Suite or Apt #:				
City:			State:		Zip		County			
Email:				Home Phone:						
Cell Phone:		Work Phone:		Birthdate:						

CLIENT SIBLING INFORMATION														
First Name Only	Birth Date	Gender *(Male, Female, Other)*			Relationship to Client					Does sibling have Autism Spectrum Disorder		Other Developmental or Health Disorder	Does sibling live in the home with client	
		M	F	O	Full	Step	Half (M)	Half (P)	Foster/ Adopted	Yes	No		Yes	No

BIOLOGICAL CHILDREN OF THE CLIENT ***(for clients who are adults):***									
First Name Only	Birth Date	Gender *(Male, Female, Other)*			Does child have Autism Spectrum Disorder		Other Developmental or Health Disorder	Does child currently live in the home with client	
		M	F	O	Yes	No		Yes	No

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

HISTORY OF CONCERNS – To be completed by Parents					
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 you child have a period of time in which he/she seemed to lose a great number of skills?	Yes		No	
At what age?		How long was this period?		

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)		toxemia
	other infectious diseases, flu		kidney and/or bladder infection		high blood pressure		alcohol use
	difficulty conceiving		anemia (low iron)		smoking		premature birth
	fertility treatment		in-vitro fertilization		RH incompatibility		emotional strain
	ultrasound		amniocentesis		hospitalization during pregnancy		accidents
	other prenatal diagnostic studies		medical problems unrelated to pregnancy		physical strain		
	regular doctor visits for prenatal care, first visit in month #:						
	prescription drugs (specify):						
	non-prescription drugs (specify):						
	other (please specify):						

		Yes		No
Were there any problems during other pregnancies *(include items listed above as well as difficulty conceiving, miscarriages, stillbirths, premature births)*? If yes, please specify below:				

CLIENT'S BIRTH HISTORY

Weeks of gestation:		Birth weight:		lbs.		oz.						
Hospital where child was born:		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 the <u>first month</u>.

	breathing problems		seizures/convulsions		cyanosis (skin blue)		excessive crying		jaundice (skin yellow)		feeding problems
	infections		sleeping problems		very inactive		received care in an intensive care nursery		breastfed		

Any other neonatal problems? Please specify:

MEDICAL HISTORY

	Please check any of the following with whom the client has had contact.				*Frequency*	*See currently*	*Seen in past*
	PEDIATRICIAN or PRIMARY CARE PHYSICIAN	*Name:*					
	EARLY INTERVENTIONIST or DEVELOPMENTAL THERAPIST	*Name:* *Through CDSA?* ☐ *Yes* ☐ *No*					
	SPEECH THERAPIST	*Name:*	*At School*	*In Community*			
	OCCUPATIONAL THERAPIST	*Name:*	*At School*	*In Community*			
	PHYSICAL THERAPIST	*Name:*					
	AUDIOLOGIST	*Name:*					
	ABA THERAPIST	*Name:*					
	PSYCHOLOGIST	*Name:*					
	PSYCHIATRIST	*Name:*					
	SOCIAL WORKER/ COUNSELOR	*Name:*					
	NEUROLOGIST	*Name:*					
	EAR, NOSE & THROAT	*Name:*					
	OPTHAMOLOGIST	*Name:*					
	OTHER (specify):	*Name:*					

Has the client had any of the following? Please indicate age

check	condition	age	check	condition	age
	Abuse or neglect			Genetic testing/chromosome study, *Give results:*	
	Accidents *specify:*			Headaches/Migraines, *specify:*	
	Allergies			Hearing loss	
	Asthma			Heart disease	
	Autoimmune disorder - thyroid, lupus, MS *specify:*			Irritable bowel syndrome	
	Bladder or kidney infection			Malnutrition	
	Cancer			Meningitis and/or encephalitis	
	Cerebral palsy			Obesity	
	Chicken pox, measles, mumps *specify:*			Poisoning	
				Seizures/convulsions	
	Chronic infection (TB, cytomegalovirus, herpes, HIV) *specify:*			Severe reaction to immunizations	
				Surgery, *specify:*	
	CNS brain studies (MRI, CT, EEG) *specify:*			Tonsillitis, recurrent	
				Whooping cough (pertussis)	
	Concussion, head injury *specify if lost consciousness: Yes No*			Hospitalization (for medical reasons)	
				Hospitalization (for behavioral or psychiatric reasons)	
	Diabetes			Threats and/or attempts to harm self	
	Diarrhea, severe with dehydration			Threats and/or attempts to harm others	
	Ear infections, recurrent			Other trauma experiences, *specify:*	
	Eye and/or vision problems				
	Encopresis			Other, specify:	
	Enuresis				
	Fainting spells				

Please check any of the following behavioral or psychiatric diagnoses the client has been given over the years regardless of whether you believe it currently applies and specify who made this diagnose(s).

check	Diagnoses	If yes, by whom?
	Autism Spectrum Disorder, Asperger Syndrome, (PDD-NOS)	
	Alcoholism	
	Anxiety Disorder/Obsessive Compulsive Disorder	
	Attention Deficit Hyperactivity Disorder (ADHD)	
	Bipolar disorder/ Manic Depression	
	Communication Disorder, Speech or language delay	
	Depression	
	Developmental delay	
	Genetic disorder specify:	
	Intellectual Disability (formerly known as Mental Retardation)	
	Learning Disability	
	Mood Disorder	
	Obsessive Compulsive Disorder (OCD)	
	Personality Disorder	
	Post-Traumatic Stress Disorder (PTSD)	
	Psychosis Disorder/ Schizophrenia	
	Reading difficulties	
	School difficulties	
	Substance abuse or dependency	
	Other, specify:	

What medication(s) and/or vitamins has the client taken or is currently taking?			
Medication:		Date(s):	
Reason/Effectiveness:		Who prescribed medicine?	
Medication:		Date(s):	
Reason/Effectiveness:		Who prescribed medicine?	
Medication:		Date(s):	
Reason/Effectiveness:		Who prescribed medicine?	
Medication:		Date(s):	
Reason/Effectiveness:		Who prescribed medicine?	

DEVELOPMENTAL HISTORY – *to be completed by Parent of client*

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

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

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			

FAMILY TREE

If any of the client's biological relatives have had any of the following conditions, please check the box that corresponds to person's relationship to the client next to the condition. (M) = Maternal (P) =Paternal

CONDITION	M (Mother)	F (Father)	S (Sister)	B (Brother)	MATERNAL SIDE: GM (G. Mother (M))	GM (G. Father (M))	AM (Aunt (M))	UM (Uncle (M))	CM (1st Cousin (M))	PATERNAL SIDE: GP (G. Mother (P))	GP (G. Father (P))	AP (Aunt (P))	UP (Uncle (P))	CP (1st Cousin (P))
Autism Spectrum Disorder, Asperger Syndrome, (PDD-NOS)														
Attention Deficit Hyperactivity Disorder (ADHD)														
Alcoholism														
Anxiety Disorder/Obsessive Compulsive Disorder														
Autoimmune disorders (thyroid, MS, lupus) *specify:*														
Bipolar disorder														
Cerebral Palsy, muscular weakness														
Communication Disorder														
Convulsions, Seizures, Epilepsy														
Depression														
Developmental delay, Speech delay														
Genetic disorder *specify:*														
Hearing loss														
Intellectual Disability (*formerly known as Mental Retardation*)														
Mood Disorder														
Psychotic Disorder														
Reading difficulties														
School difficulties														
Severe visual impairment														
Substance abuse or dependency														
Other *specify:*														

For Parent's of client to complete for clients who are children

CURRENT SCHOOL PLACEMENT

Check any that apply below:

School:

Grade: Teacher:

- [ ] Resource Support
- [ ] Self-contained special education
- [ ] Speech & Language
- [ ] Occupational Therapy
- [ ] Regular Classroom
- [ ] My child is not currently enrolled in school
- [ ] Homeschooled

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

If IEP, does child have educational label of autism? [ ] Yes [ ] No

PREVIOUS SCHOOL EXPERIENCE

Name of School/Preschool or Childcare	City	Special Education Services Received: Yes	No	Grades

Has your child had past or current difficulties in school? [ ] Yes [ ] No If yes, please describe below:

EDUCATIONAL/VOCATIONAL INFORMATION for Adult Client								
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
Did you receive special assistance in school?		Yes		No	If yes, please describe the type of extra academic assistance or special class placement:			

REFERRAL INFORMATION			
	This is a parent describing concerns about your child		**This is an adult client describing own concerns**
Why did the referral person think you should contact TEACCH?			
What are your main concerns at present?			
What are you hoping the TEACCH Center can provide to you/your family?			
Describe any concerns you have about the client’s communication skills and development:			
Describe any concerns you have about the client’s social skills and development:			
Describe any concerns you have about the client’s interests and activities (or play skills, if client is a child):			

Describe any concerns you have about the client's learning style and behavior:

For Adult Clients: Describe any concerns you have about the client's ability to maintain a job, function in community, or live independently:

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, Autism, Asperger Syndrome, or PDD-NOS by a school system, psychologist or medical doctor?		Yes		No
If yes, by whom? Name:		City/State:		
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, by whom? Name:		City/State:		
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, by whom? Name:		City/State:		
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, by whom? Name:		City/State:		
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 forms to your local TEACCH Center---