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	Non-binary	Choose not to disclose	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 treatment services	Have an ASD diagnosis and need an updated assessment to maintain services															
Race of Client:	American Indian/Alaska Native	Asian Indian	Black/African American	Chinese	Filipino	Guamanian											
Japanese	Korean	Native Hawaiian	Other Asian	Other Pacific Islander	Other Race:												
Prefer Not to Answer	Samoan	Unknown	Vietnamese	White													
Ethnicity:	Another Hispanic, Latino/a, or Spanish Origin	Not Hispanic, Latino/a, or Spanish Origin	Cuban														
Mexican, Mexicano American, Chicano/a	Puerto Rican	Prefer not to answer	Unknown														
Is the client their own guardian?	Yes	No	Religious Affiliation (optional):														
ADA Accommodations:	Hard of Hearing	No	Yes	Unable to obtain	Sight Impaired	No	Yes	Unable to obtain									
Deaf	No	Yes	Unable to obtain	Blind	No	Yes	Unable to obtain	Physically Impaired	No	Yes							
Unable to obtain	Speech Impaired	No	Yes	Unable to obtain	Memory Impaired	No	Yes	Unable to obtain									

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		Primary Care			

Name (required):		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: Another Hispanic, Latino/a, or Spanish Origin	Not Hispanic, Latino/a, or Spanish Origin	Cuban			
Mexican, Mexicano American, Chicano/a	Prefer Not to Answer	Puerto Rican	Unknown		
Race: American Indian/Alaskan Native	Asian American	Black/African American	Chinese	Filipino	
Guamanian	Japanese	Korean	Native Hawaiian	Other Asian	Other Pacific Islander	Samoan
Prefer Not to Answer	Unknown	Vietnamese	White	Other Race	
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: Another Hispanic, Latino/a, or Spanish Origin	Not Hispanic, Latino/a, or Spanish Origin	Cuban			
Mexican, Mexicano American, Chicano/a	Prefer Not to Answer	Puerto Rican	Unknown		
Race: African Indian/Alaskan Native	Asian American	Black/African American	Chinese	Filipino	
Guamanian	Japanese	Korean	Native Hawaiian	Other Asian	Other Pacific Islander	Samoan
Prefer Not to Answer	Unknown	Vietnamese	White	Other Race	
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):						

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: ☐ Yes ☐ No

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 first month.				
☐ 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				
	Asthma				
	Autoimmune disorder - thyroid, lupus, MS *specify:*			Hearing loss	
				Heart disease	
				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			Hospitalization (for medical reasons)	
	specify if lost consciousness: ☐ *Yes* ☐ *No*			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	Mother	Father	Sister	Brother	G. Mother (M)	G. Father (M)	Aunt (M)	Uncle (M)	1st Cousin (M)	G. Mother (P)	G. Father (P)	Aunt (P)	Uncle (P)	1st Cousin (P)
					MATERNAL SIDE					PATERNAL SIDE				
	M	F	S	B	GM	GM	AM	UM	CM	GP	GP	AP	UP	CP
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 School:

Check any that apply below: 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		Grades
		Yes	No	

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---