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: ☐ 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):			

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 <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	
☐	Chronic infection (TB, cytomegalovirus, herpes, HIV) *specify:*		☐	Seizures/convulsions	
☐	CNS brain studies (MRI, CT, EEG) *specify:*		☐	Severe reaction to immunizations	
☐	Concussion, head injury *specify if lost consciousness:* ☐ *Yes* ☐ *No*		☐	Surgery, *specify:*	
☐	Diabetes		☐	Tonsillitis, recurrent	
☐	Diarrhea, severe with dehydration		☐	Whooping cough (pertussis)	
☐	Ear infections, recurrent		☐	Hospitalization (for medical reasons)	
☐	Eye and/or vision problems		☐	Hospitalization (for behavioral or psychiatric reasons)	
☐	Encopresis		☐	Threats and/or attempts to harm self	
☐	Enuresis		☐	Threats and/or attempts to harm others	
☐	Fainting spells		☐	Other trauma experiences, *specify:*	
			☐	Other, specify:	

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 M	Father F	Sister S	Brother B	MATERNAL SIDE G. Mother (M) GM	G. Father (M) GM	Aunt (M) AM	Uncle (M) UM	1st Cousin (M) CM	PATERNAL SIDE G. Mother (P) GP	G. Father (P) GP	Aunt (P) AP	Uncle (P) UP	1st Cousin (P) 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 Yes	Special Education Services Received 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 submit completed forms to your local TEACCH Center---