Return to: ALL CHILDREN'S HOSPITAL
501 6th AVENUE SOUTH
DEPT 7725
ST.PETERSBURG, FL 33701

AUTISM CENTER
History Form

A Note to Parents
We are pleased you are interested in having your child seen at the Autism Center. This form helps with planning your visit, so we can make better use of time in the office. It is helpful in making a diagnosis and preparing a complete report that covers all of your child's needs and strengths.

Please include **medical records, developmental and therapy reports, school psychological evaluations**, **Response to Intervention reports, behavior improvement plans, functional behavior analysis reports, Individual Education Plans**, and other materials that might be helpful in understanding your child and your family. Please be as complete as possible, and let us know if you need help completing this form.

Let us know in advance if you or your child needs any special accommodations such as a translator.

Child's Name _____ Today's Date _____
Date of Birth _____ ☐ Male ☐ Female Filled out by_____
Educational Program or Daycare (please describe):_____

Grade _____ School _____

Mother's Name _____
Mother's Age_____
Mother's Occupation _____
Grade completed _____
Emergency Contact _____
Emergency Phone __(_____)_____

Father's Name _____
Father's Age_____
Father's Occupation _____
Grade completed _____
Emergency Contact _____
Emergency Phone __(_____)_____

Child's Brothers (please give names and ages)

_____ _____
_____ _____
_____ _____

Child's Sisters (please give names and ages)

_____ _____
_____ _____
_____ _____

What are your main concerns and goals for your child's visit?

_____ _____
_____ _____
_____ _____

Child's Likes ex: (favorite toys/favorite activities)

_____
_____
_____
_____

Child's Dislikes

_____
_____
_____
_____

Patient Label

Child's Strengths

_____
_____
_____
_____

Family Strengths

_____
_____
_____
_____

Who does your child live with?

- ☐ Biological Parents
- ☐ Mother only
- ☐ Father only
- ☐ Joint custody
- ☐ Grandparent
- ☐ Other relative
- ☐ Foster care
- ☐ Group home
- ☐ Other

Parents are: ☐Married ☐Divorced ☐Separated ☐Widowed ☐Other_____

Family History

	Child's Mother	**Child's Father**	**Child's Sister(s)**	**Child's Brother(s)**	**Relative** (grandparent, aunt, etc.)
Reading problem in school	☐	☐	☐	☐	
Math problem in school	☐	☐	☐	☐	
Writing problems in school	☐	☐	☐	☐	
Attention deficits/hyperactivity	☐	☐	☐	☐	
Gifted/honors student	☐	☐	☐	☐	
Kept back in school	☐	☐	☐	☐	
Behavior Problems	☐	☐	☐	☐	
Speech problems	☐	☐	☐	☐	
Language problems	☐	☐	☐	☐	
Autism	☐	☐	☐	☐	
Mental retardation	☐	☐	☐	☐	
Cerebral palsy	☐	☐	☐	☐	
Neurologic condition	☐	☐	☐	☐	
Birth defect	☐	☐	☐	☐	
Depression	☐	☐	☐	☐	
Anxiety or panic attacks	☐	☐	☐	☐	
Manic-depressive (bipolar)	☐	☐	☐	☐	
Schizophrenia	☐	☐	☐	☐	
Alcohol or substance abuse	☐	☐	☐	☐	
Vision impairment	☐	☐	☐	☐	
Hearing impairment	☐	☐	☐	☐	
Color blind	☐	☐	☐	☐	
Left handed	☐	☐	☐	☐	

Explain if necessary: ☐**adopted**

Pregnancy and Birth

Name and location of hospital _____

Birthweight _____lbs. _____oz. Length of pregnancy ☐Full term ☐_____wks

Pregnancy (check all that apply)

☐	Had bleeding during first three months	☐	Had previous miscarriages
☐	Had bleeding during second three months	☐	Had previous premature baby(ies)
☐	Had bleeding during last three months	☐	Had an infection
☐	Gained 30 or more pounds (specify____)	☐	Had diabetes
☐	Had toxemia or pre-eclampsia	☐	Smoked one for more packs of cigarettes a day
☐	Had to take medications	☐	Had preterm labor
☐	Vomited often	☐	Labor lasted longer than 12 hours (specify_____)
☐	Got hurt or injured	☐	Labor lasted less than two hours
☐	Gained less than 15 pounds (specify____)	☐	Had a cesarean section
☐	Used street drugs (specify_____)	☐	Was put to sleep for delivery
☐	Drank alcohol (specify_____)	☐	Was born at full term

Please list any other pregnancy problems:

Newborn problems (check all that apply)

☐	Born with cord around neck	☐	Had a transfusion
☐	Injured during birth	☐	Was in hospital more than seven days
☐	Had trouble breathing		Length of hospital stay_____
☐	Turned yellow (jaundice)	☐	Had seizures (fits, convulsions)
☐	Turned blue (cyanosis)	☐	Gagged often
☐	Was a twin or triplet	☐	Vomited often
☐	Had an infection	☐	Born with heart defect
☐	Was given medications	☐	Born with other defect(s)
☐	Had diarrhea	☐	Had trouble sucking
☐	Needed oxygen	☐	Had skin problems
☐	Was on ventilator ____ days	☐	Was very jittery

Please list any other problems your child experienced as a newborn:

Health Problems (please indicate when they started and bring copies of medical records)

☐	Asthma	☐	Orthopedic problem	☐	Heart problem
☐	Allergies (including drugs)	☐	Joint problems	☐	Skin problem
☐	Sneezing or runny nose	☐	Arthritis	☐	Problems eating (too little or too much)
☐	Cough	☐	Numbness or tingling	☐	Seizures
☐	Ear infections	☐	Kidney problem	☐	Head injury
☐	Nausea or vomiting	☐	Wets bed	☐	Headaches
☐	Diarrhea	☐	Urinates too frequently	☐	Gets tired easily
☐	Constipation	☐	Irregular menstrual periods	☐	Had surgery
☐	Stomachaches	☐	Anemia	☐	Was hospitalized
☐	Has bowel accidents	☐	Other blood disease	☐	Vision problem
☐	Weight or growth problem	☐	Immune deficiency	☐	Hearing problem

Sleep Concerns

About how many hours of sleep does your child get each day (including naps)? _____

Does your child sleep through the night? Yes No Does your child fall asleep in about 20 minutes? Yes No

Does your child sleep too little? Yes No Does your child wake up during the night? Yes No

Current Medications (bring current medications and list of previous medications to visit)

Medication	Dose	Frequency	Reason

Developmental Milestones (check the age in months at which your child achieved each milestone)

	2 m	**4 m**	**6 m**	**9 m**	**12 m**	**15 m**	**18 m**	**2 y**	**3 y**	**4 y**	**5 y**	**6y**	**Not yet**
Sat without help													
Rolled over													
Crawled													
Walked alone (10-15 steps)													
Walked up stairs													
Rode a tricycle													
Caught a big ball													
Spoke first words													
Put words together													
Spoke 2-3 word sentences													
Spoke clearly													
Used fingers to feed self													
Used a spoon													
Fully bowel trained													
Fully bladder trained													
Able to dress self													
Able to tie shoe laces													
Able to separate easily from mother (for school, play, etc.)													

Comments: