

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

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 _____
Date of Birth _____ Male Female
Educational Program or Daycare (please describe): _____
Grade _____ School _____

Today's Date _____
Filled out by _____

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?

- | | |
|---|---|
| <input type="checkbox"/> Biological Parents | <input type="checkbox"/> Other relative |
| <input type="checkbox"/> Mother only | <input type="checkbox"/> Foster care |
| <input type="checkbox"/> Father only | <input type="checkbox"/> Group home |
| <input type="checkbox"/> Joint custody | <input type="checkbox"/> Other |
| <input type="checkbox"/> Grandparent | |

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Math problem in school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Writing problems in school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Attention deficits/hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gifted/honors student	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kept back in school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Behavior Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Speech problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Language problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cerebral palsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neurologic condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Birth defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anxiety or panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Manic-depressive (bipolar)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol or substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vision impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Color blind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Left handed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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)

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

Please list any other pregnancy problems:

Newborn problems (check all that apply)

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

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