THE CENTER FOR AUTISM
& NEURODEVELOPMENTAL DISORDERS

1202 Bristol St 2nd Floor
Costa Mesa CA 92626

Patient Sticker Here

Patient History Form

Date Form Completed: ___ /___ /___ (Mo Day Yr) **Person completing form:** _____ (Name)

_____ (Relationship to patient)

Patient's Name: _____ **Birth Date:** ___ /___ /___ (Mo Day Yr) **Age**: _____ **Sex:** M / F

Address: _____ (Street City State Zip)

Phone: Home: (____)_____ Work: (____)_____Cell: (____)_____ **E-mail**: _____

Referred by (name): _____

☐ Self ☐ Physician ☐ School ☐ Agency ☐ Friend ☐ the Media ☐ Other _____

Primary Medical Care Provider: _____ **Phone:** (____)_____

Address: _____ (Street City State Zip)

Specialty: ☐ Pediatrics ☐ Family Practice ☐ Internal Med. ☐ Nurse Practitioner

Primary Contact Person:

Name: _____ Relationship _____

Address: _____ (Street City State Zip)

Phone: Home: (____)_____ Work: (____)_____Cell: (____)_____ **E-mail**: _____

Information is same as patient: ☐ Address ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email

Additional Contact Person (e.g. social worker, family members):

Name: _____ Relationship _____

Address: _____ (Street City State Zip)

Phone: Home: (____)_____ Work: (____)_____Cell: (____)_____ **E-mail**: _____

Information is same as patient: ☐ Address ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email

**Please indicate how you would prefer to be contacted (e.g. email/phone/mail)? _____

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CURRENT DIAGNOSES

What are your child's current diagnoses? ☐ N/A

_____

_____

CURRENT CONCERNS AND/OR REASONS FOR REFERRAL

1. _____

   _____

2. _____

   _____

3. _____

   _____

Is anyone concerned your child has **autism**? **Yes / No** **ADHD**? **Yes / No** **OTHER** ? _____ **Yes / No**

PRENATAL/BIRTH HISTORY ***(uk=unknown)***

Age when patient was born: Mom _____ Dad _____

Birth place: City _____ State _____ Hospital/Clinic _____

Was child product of a multiple birth? **Y / N / UK** **Twin / Triplet / Quadruplet** Were babies identical? **Y / N / UK**

Totals: # of pregnancies _____ # of live births_____ # of miscarriages _____

Mother's health during pregnancy:

- ☐ Unknown
- ☐ Dehydration
- ☐ Fevers
- ☐ Toxemia (High Blood Pressure/Tremors, etc)
- ☐ Diabetes
- ☐ Hospitalization Reason: _____
- ☐ High Blood Pressure
- ☐ Bleeding/Spotting
- ☐ Serious Infections (Example: Flu, measles, CMV)
- ☐ Seizures
- ☐ Depression/mental health issues

Exposures during pregnancy:		***please circle the appropriate trimester***	
Smoking	**Y / N / UK**	Trimester 1,2,3	Amount/day:
Alcohol	**Y / N / UK**	Trimester 1,2,3	Amount/day:
Caffeine	**Y / N / UK**	Trimester 1,2,3	Amount/ day:
Street drugs/other	**Y / N / UK**	Trimester 1,2,3	
Prenatal Vitamins	**Y / N / UK**	Trimester 1,2,3	
Folic Acid (supplement separate from vitamin)	**Y / N / UK**	Trimester 1,2,3, Prior to Pregnancy	
Antidepressant Medications	**Y / N / UK**	Trimester 1,2,3	
Other Medication(s) (_____)	**Y / N / UK**	Trimester 1,2,3	

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PRENATAL/BIRTH HISTORY CONT.

Prenatal Tests:

Ultrasound	**Y / N / UK**
Maternal Serum Alpha-Fetoprotein (MSAFP) /Triple Screen blood test	**Y / N / UK**
Amniocentesis	**Y / N / UK**

If abnormal, please explain:

_____

Did you experience significant stress during pregnancy? *(i.e. separation from spouse, divorce, loss of job, etc)* **Y / N / UK**

If yes, please explain: _____

_____

BIRTH HISTORY

Problems with the labor and/or delivery: **Y / N / UK**

If yes, please explain:

_____

Number of weeks pregnant when baby was born _____ weeks

Baby was born: ☐ head first ☐ breech (Feet first) ☐ vaginal delivery ☐ C-section

If C-Section, please explain why: _____

Birth weight _____ lbs _____ oz length _____ in. head circumference _____ in.

Were there newborn problems?

☐ In NICU **Y / N / UK** (# ____days)

☐ Jaundice
☐ ABO blood type incompatibility
☐ Low blood sugar
☐ Seizures
☐ Unknown
☐ RH blood type incompatibility
☐ Infection
☐ Breathing Issues / On oxygen
☐ Birth defects
☐ Other_____

Was the child discharged home with mom? **Y / N** If not, why not _____

DEVELOPMENTAL HISTORY

It may be helpful to review infant/toddler milestone books or past reports when completing the following questions. If you are uncertain, estimate as best as you can. Please record the ages in months.

Smiled in response to others	**Y / N**	____ months	First words (other than mama and dada)	**Y / N**	____ months
Rolled over	**Y / N**	____ months	Spoke in 2-word phrases	**Y / N**	____ months
Sat without support	**Y / N**	____ months	Spoke in full sentences (at least 4 words)	**Y / N**	____ months
Crawled	**Y / N**	____ months	Bladder control (daytime)	**Y / N**	____ months
Stood alone	**Y / N**	____ months	Bladder control (nighttime)	**Y / N**	____ months
Walked independently	**Y / N**	____ months	Bowel control	**Y / N**	____ months

At what age did you first notice problems (developmental delays or differences) or have concerns about your child in:

Motor skills (fine, gross motor)	_____	months
Speech and language	_____	months
Social development	_____	months
Problem solving	_____	months
Behavior	_____	months
Play	_____	months
Other	_____	months

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DEVELOPMENTAL HISTORY CONT.

Did your child experience a significant loss of an acquired skill or skills (not just a delay in acquiring the skill)? If so, please indicate:

☐ Motor coordination explain: _____
☐ Speech / language explain: _____
☐ Social functioning explain: _____
☐ Problem solving explain: _____
☐ Bladder/bowel control explain: _____

BEHAVIOR ISSUES (for your child)

☐ Anxious or worries
☐ Aloof / Doesn't notice things/people
☐ Short attention span
☐ Hyperactivity
☐ Less active than you'd expect
☐ Obsessive-compulsive
☐ Aggressive
☐ Hurting animals or other people
☐ Sensory problems
☐ Unusual or excessive fears
☐ Shy / Slow to warm up
☐ Depressed/sad
☐ Impulsive
☐ Picky eater / Restricted diet
☐ Defiant
☐ Self injury (head banging, biting, scratching, cutting, etc.)
☐ Toileting issues, accidents

Please describe:

_____
_____
_____
_____
_____

Please describe your discipline strategies:

_____
_____
_____

CHILD'S EDUCATIONAL HISTORY *Please bring copies of all educational testing to your appointment*

School name: _____ Phone: _____

Grade in school: _____ (ever repeat a grade? Yes / No) Teacher (or best contact):_____

☐ IEP ☐ 504 Plan ☐ Special Ed ☐ Therapy: OT/PT/SLT

Grades: Math _____ Reading_____ Language_____ Science _____ Social Studies _____

Are there any concerns with friends or bullying? **Y / N / UK**
If yes, please explain:

_____
_____
_____

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What best describes your child's current educational program?

- ☐ Not Applicable
- ☐ Full time in a regular class
- ☐ Regular class supplemented by resource specialist room/learning lab time
- ☐ Time split between regular and special education classes
- ☐ Special education class in a school district
- ☐ Aide/Paraprofessional or extra help
- ☐ Specialized school outside of district
- ☐ Home schooled
- ☐ Participation in Birth – 3 Early Intervention Program (First Steps)

Intelligence Testing

If I.Q. has been tested, what is the functional assessment?

☐ Superior >130+	☐ Mild MR 55-70	☐ Unspecified MR
☐ High Average 116 -130	☐ Moderate MR 40-54	☐ Unknown
☐ Average 85-115	☐ Severe MR 20-39	
☐ Borderline 71-84	☐ Profound MR <20	

Describe what tests were done and the dates and results:

_____
_____
_____
_____
_____
_____
_____
_____

Please indicate the educational program in which your child participated during his/her school* years:

School Year	**Type of School**		**Type of Class**		*Any Special Services*		
	Regular*	Special	Regular*	Special*	Yes	No	Type
3-5 preschool							
Kindergarten							
1st							
2nd							
3rd							
4th							
5th							
6th							
7th							
8th							
9th							
10th							
11th							
12th							

*** REGULAR school applies to public or private schools for children without disabilities.**
SPECIAL school applies to any schools intended for children with disabilities

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MEDICAL/PSYCHIATRIC HISTORY*: *Please list all diagnoses or illnesses for your child (use an additional page if needed)

Diagnosis/Illness	Age	Date - year	Professional who made diagnosis

MEDICAL/PSYCHIATRIC HISTORY CONT.

List all hospitalizations for your child, include overnight stays (medical or psychiatric)

Reason for hospitalization	Age	Length of stay
1)		
2)		
3)		
4)		

List all surgeries for your child:

Reason for surgery	Age	Date - year
1)		
2)		
3)		

Therapy History	Age	Date - year

IMMUNIZATIONS

Up to date **Y / N / UK**
Given on time **Y / N / UK**

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ALLERGIC HISTORY

if yes, please describe type and the symptoms (rash, vomiting, etc)

Medications	**Y / N / UK**	**Type: _____** **Symptom(s):_____**
Food	**Y / N / UK**	**Type: _____** **Symptom(s):_____**
Environmental (eg. Pollen, dust, etc.)	**Y / N / UK**	**Type: _____** **Symptom(s):_____**

CURRENT MEDICATIONS/SUPPLEMENTS

Medication	Dosage	Age when started	Reason for medication	Making an improvement?	
				Yes	**No**
				Yes	**No**
				Yes	**No**
				Yes	**No**
				Yes	**No**
				Yes	**No**

Details:

_____

_____

_____

_____

_____

_____

_____

REVIEW OF HEALTH SYSTEMS

Circle Yes or No for concerns NOW or in the PAST

Dental Problems	YES	NO	Kidney/Urinary/Genital Problems	YES NO
Does your child see a dentist	YES	NO	Chronic Ear infections	YES NO
Birth defects	YES	NO	Long term use of antibiotics	YES NO
Heart Problems	YES	NO	Easy bruising/bleeding/anemia	YES NO
Lung problems	YES	NO	Endocrine Problems (eg. thyroid)	YES NO
Constipation	YES	NO	Skeletal/Bone problems (eg. scoliosis)	YES NO
Diarrhea	YES	NO	Accidents	YES NO
Nausea/vomiting	YES	NO	Skin problems (rash, eczema)	YES NO
Stomach ache/pain/reflux	YES	NO		

If yes, please explain:

_____

_____

_____

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NEUROLOGICAL SYSTEMS*: *Does your child have any of the following?

Tic Disorder/Tourette	YES	NO	Attention Deficit Hyperactivity Disorder (ADHD)	YES	NO
Tremors	YES	NO	Migraines/headaches	YES	NO
Hypotonia (low muscle tone/ floppy)	YES	NO	Toe Walking (After age 2 or persistent > 6 months)	YES	NO
Hypertonia (tight muscle tone)	YES	NO	Staring Spells	YES	NO

What hand does your child use? **Left / Right / Ambidextrous (both) / UK** Mother: **L / R,** Father: **L / R**

Hearing problems **Y / N / UK**

If Yes, sensorineural or conductive?_____

Uses hearing aid? **Y / N / UK**

Sound over sensitivity? **Y / N / UK** **Explain: _____**

Sound under sensitivity? **Y / N / UK** **Explain: _____**

Vision/eye problems **Y / N / UK**

If Yes, what? _____

Correctable? **Y / N / UK**

Glasses? **Y / N / UK**

Contact Lenses? **Y / N / UK**

Does your child have seizures? **Y / N / UK**

If Yes, please check the type of seizures

☐ Febrile (Fever) ☐ Grand mal (rhythmic jerking) ☐ Petit mal/Absence

☐ Myoclonic ☐ Complex partial ☐ Unknown

Please explain: _____

_____

_____

_____

_____

Has your child had any of the following laboratory tests? **Results:**

		Normal	**Abnormal**	**Unknown**
To check for anemia	**Y / N / UK**	☐	☐	☐
Lead Blood Level	**Y / N / UK**	☐	☐	☐
Chromosomal Microarray	**Y / N / UK**	☐	☐	☐
Karyotype (chromosome study)	**Y / N / UK**	☐	☐	☐
Fragile X DNA	**Y / N / UK**	☐	☐	☐
Rett syndrome DNA (MECP2)	**Y / N / UK**	☐	☐	☐
Plasma Amino Acids	**Y / N / UK**	☐	☐	☐
Urine for Organic Acids	**Y / N / UK**	☐	☐	☐
MRI of the brain	**Y / N / UK**	☐	☐	☐
EEG/Video Telemetry	**Y / N / UK**	☐	☐	☐
Sleep Study	**Y / N / UK**	☐	☐	☐
Audiologic (hearing) testing	**Y / N / UK**	☐	☐	☐
Brain stem audio evoked response (BAER/ABR)	**Y / N / UK**	☐	☐	☐

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		Normal	Abnormal	Unknown
Vision Testing	**Y / N / UK**	☐	☐	☐
Metabolic Tests	**Y / N / UK**	☐	☐	☐
Other: _____	**Y / N / UK**	☐	☐	☐

DIETARY/NUTRITION/METABOLIC

Feeding Issues in infancy **Y / N / UK**

Current feeding issues **Y / N / UK**

Is child's nutrition intake adequate? **Y / N / UK**

Picky eater *	YES	NO	Difficulty with solids	YES	NO
Does child drink milk?	YES	NO	Difficulty with liquids	YES	NO
Eating/craving non-food items	YES	NO	Spacey, lethargy, coma with illness	YES	NO
Avoids specific food groups	YES	NO	Dehydration needing hospitalization	YES	NO
Reactions to specific foods	YES	NO	Anorexia	YES	NO
Special diet *	YES	NO	Bulimia	YES	NO

***If picky eater or on special diet, please describe**

_____
_____
_____
_____
_____

DENTAL
Does your child receive dental care? **Y / N**
If yes, where does your child receive dental care? _____

SLEEP HISTORY **Answer about behaviors when he/she is not on any sleep medicines.**

RARELY = never or 1 time /week, **SOMETIMES** = 2-4 times/week, **USUALLY**= 5 or more times/week

Does your child…..?	**How often?**			**Is it a problem?**	
	Rarely (0-1)	**Sometimes (2-4)**	**Usually (5-7)**	**No**	**Yes**
Fall asleep within 20 minutes?	☐	☐	☐	☐	☐
Fall asleep in parent's or sibling's bed?	☐	☐	☐	☐	☐
Fall asleep alone in own bed?	☐	☐	☐	☐	☐
Sleep too little**?**	☐	☐	☐	☐	☐
Awaken more than once during the night?	☐	☐	☐	☐	☐
Snore loudly?	☐	☐	☐	☐	☐
Seem tired during the day?	☐	☐	☐	☐	☐

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ABUSE HISTORY **Y / N - if no please skip to next section**

Was your child "traumatized" in any way? Please explain.

_____

_____

_____

RESOURCES

Are you or your child receiving services from the following agencies? Check all that are appropriate.

☐ Regional Center	☐ Counseling	☐ Behavior Therapy/ABA
☐ Department of Mental Health	☐ Cal Works	☐ Speech Language Therapy (SLT)
☐ Division of Family Services (DFS)	☐ Cal Fresh	☐ Physical Therapy (PT)
☐ Child Protective Services (CPS)	☐ WIC	☐ Occupational Therapy (OT)
☐ SSI	☐ Food Access	☐ Psychiatric Services

☐ Other_____

☐ Do you have medical insurance? Type: _____

Please bring reports!

***SOCIAL HISTORY*:**

Child lives with:

☐ both biological parents	☐ biological mother	☐ biological father
☐ adoptive parent(s)	☐ foster parent(s)	☐ live independently
☐ grandparent(s)	☐ group home	☐ residential school/treatment facility

If adopted, at what age was adoption? _____

If foster care, provide name and address of social worker and agency supervising placement: _____

_____

Please list all the people who live with child

Name	Age	Relationship to child

Are biological parents (*circle one*) – Married / Divorced / Separated / Never Married

If not living with both biological parents, please specify visitation arrangement:

Biological Mother: ☐ N/A ☐ No contact ☐ Every other weekend ☐Other: _____

Biological Father: ☐ N/A ☐ No contact ☐ Every other weekend ☐Other: _____

If parents are separated or divorced: What are the custody arrangements?

Biological Mother: ☐ N/A ☐ Joint Custody ☐ Sole Custody ☐ Other: _____

Biological Father: ☐ N/A ☐ Joint Custody ☐ Sole Custody ☐ Other: _____

Any significant losses? _____

Patient Sticker Here

Household Annual Income:

☐ $0-24,999 ☐ $25-49,999 ☐ $50-74,999 ☐ $75-99,999 ☐ $100,000+ ☐ Unknown ☐ Decline to State

Number of people dependent on income: _____ ☐ Unknown

Is housing a problem? _____

PRIMARY CAREGIVER: ☐ Mother ☐ Father ☐ Other _____

Place of employment:_____ Job title: _____

Major Job duties/responsibilities: _____

Level of school completed: # years of school completed _____

☐ Less than 7-8th grade
☐ 7-8th grade school
☐ Partial high school
☐ High school graduate or GED
☐ Partial college or specialized training (Associate's Degree)
☐ Standard college or university graduation (Bachelor's Degree)
☐ Graduate professional training (Graduate degree)

ADDITIONAL CAREGIVER: ☐ Mother ☐ Father ☐ Other _____

☐ N/A – No Additional Caregiver

Place of employment:_____ Job title:_____

Major job duties/responsibilities: _____

Level of school completed: # years of school completed _____

☐ Less than 7-8th grade
☐ 7-8th grade school
☐ Partial high school
☐ High school graduate or GED
☐ Partial college or specialized training (Associate's Degree)
☐ Standard college or university graduation (Bachelor's Degree)
☐ Graduate professional training (Graduate degree)

FAMILY HISTORY

Ethnicity of child: Hispanic or Latino Origin? **Y / N**

Ethnicity of child: *(please select one)*

☐ American Indian or Alaskan Native
☐ Asian _____
☐ Pacific Islander
☐ Black/African American
☐ Hispanic or Latino
☐ White/Caucasian
☐ Other _____
☐ More than one of the ethnicities listed
☐ Do not know
☐ Decline to answer

Primary Language Spoken in the Home: _____ Second Language: _____

MOTHER'S name (biological) _____ Height _____

Address: _____

Street City State Zip

Hispanic or Latino Origin? **Y / N**, Age _____ Birthdate ____/____/_____ Birthplace _____

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Ethnicity: *(please select one)*

☐ American Indian or Alaskan Native
☐ Asian _____
☐ Pacific Islander
☐ Black/African American
☐ Hispanic or Latino
☐ White/Caucasian
☐ Other _____
☐ More than one of the ethnicities listed
☐ Do not know
☐ Decline to answer

General health (major illnesses, hospitalizations, surgeries, medications, mental health concerns, educational problems)

_____

_____

_____

_____

FATHER'S name (biological) _____ Height _____

Address: _____
Street City State Zip

Hispanic or Latino Origin? **Y / N**, Age _____ Birthdate ____/____/_____ Birthplace _____

Ethnicity: *(please select one)*

☐ American Indian or Alaskan Native
☐ Asian _____
☐ Pacific Islander
☐ Black/African American
☐ Hispanic or Latino
☐ White/Caucasian
☐ Other _____
☐ More than one of the ethnicities listed
☐ Do not know
☐ Decline to answer

General health (major illnesses, hospitalizations, surgeries, medications, mental health concerns)

_____

_____

_____

SIBLINGS/OTHER PREGNANCIES *Include any miscarriages, stillbirths, or babies that died*

Name of sibling	Sex (M/F)	Age	Date of Birth	Different Father?	Different Mother?	List any health/behavior/ learning problems	Lives with your child?
				Yes / No	Yes / No		Yes / No
				Yes / No	Yes / No		Yes / No
				Yes / No	Yes / No		Yes / No
				Yes / No	Yes / No		Yes / No
				Yes / No	Yes / No		Yes / No
				Yes / No	Yes / No		Yes / No
				Yes / No	Yes / No		Yes / No

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Are there plans for future pregnancies? **Y / N / UK**

Has anyone in the family died at an early age (younger than 45) from sudden death? **Y / N / UK**

Does anyone in the family have a heart defect, murmur or unusual heart beat? **Y / N / UK** Age: _____

Does anyone in the family have chest pain on exertion? **Y / N / UK**

Comments:

_____
_____
_____
_____

EXTENDED FAMILY HISTORY

*Please list any family member with a history of any of the conditions listed below. Indicate how the family member is **related to the patient** (see guide below):*

Relative/Family Member List:
Mother/Father/Sister/Brother/Twin/Half Sister/Half Brother
Maternal: *Mom's Mom/ Mom's Dad/ Mom's Brother/ Mom's Sister/ Mom's Grandmother/ Mom's Grandfather/ Mom's Uncle/ Mom's Aunt/ Mom's Cousin*
Paternal: *Dad's Mom/ Dad's Dad/ Dad's Brother/ Dad's Sister/ Dad's Grandmother /Dad's Grandfather/ Dad's Uncle/ Dad's Aunt/ Dad's Cousin*

CONDITION/DISORDER **RELATIVE *(Relation To Patient)***

1. Autism Spectrum Disorder: _____
2. Fragile X syndrome: _____
3. Tuberous sclerosis: _____
4. Other genetic disorders: _____
5. Intellectual disability/Mental Retardation: _____
6. Learning disability: _____
7. Language disorder *(ex Speech Therapy/late talker/stutter)*:_____
8. Attention deficit hyperactivity disorder (ADHD): _____
9. Tourette's syndrome (tics): _____
10. Seizure disorder (epilepsy): _____
11. Obsessive compulsive disorder: _____
12. Anxiety disorders: _____
13. Depression: _____
14. Bipolar disorder: _____
15. Schizophrenia: _____
16. Alcoholism: _____
17. Drug addiction: _____
18. Miscarriages or still births *(in the family)*: _____
19. Childhood deaths: _____
20. Birth defects *(ex. cleft lip, club foot, heart defect)*: _____
21. Chromosome disorders: _____
22. Abnormal physical features *(ex big head, abnormal fingers, face)*: _____
23. Gland/endocrine*(ex thyroid, diabetes, delayed puberty)*: _____
24. Immune disorders *(ex arthritis, lupus, fibromyalgia)*: _____
25. Anything that runs in family?: _____

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Additional Comments:

Additional Information or Comments: