



Please complete all information below:

**SECTION I
NEW PATIENT INFORMATION**

PATIENT NAME		DATE OF BIRTH
PATIENT ADDRESS		CITY, STATE ZIP
PARENT/GUARDIAN/RELATIONSHIP TO CHILD	HOME/CELL PHONE	WORK PHONE
ADDRESS (IF DIFFERENT FROM CHILD)		CITY, STATE ZIP
PARENT/GUARDIAN EMAIL:	PREFERRED METHOD OF CONTACT:	
PARENT/GUARDIAN/RELATIONSHIP TO CHILD	HOME/CELL PHONE	WORK PHONE
ADDRESS (IF DIFFERENT FROM CHILD)		CITY, STATE ZIP
EMERGENCY CONTACT PERSON/RELATIONSHIP TO CHILD		PHONE
PRIMARY CARE PHYSICIAN	OFFICE PHONE	DATE OF LAST VISIT
ADDRESS		CITY, STATE ZIP
CURRENT MEDICATIONS		ALLERGIES
HOSPITAL PREFERENCE		
PERSON COMPLETING FORM/RELATIONSHIP TO CHILD	PHONE	DATE FORM COMPLETED
WHO REFERRED THIS CHILD?		



SECTION II
PATIENT MEDICAL HISTORY QUESTIONNAIRE

Clinician Notes	Patient to fill out this column ONLY	
Reviewed by (initials/date):	PLEASE DESCRIBE THE TOP 3 BEHAVIORAL CONCERNS YOU HAVE FOR THE YOUTH	
	1.)	
	2.)	
	3.)	
	SPEECH / LANGUAGE CONCERNS?	
	SOCIAL / PEER INTERACTION CONCERNS?	
	<i>MEDICAL HISTORY</i>	
	ARE IMMUNIZATIONS UP TO DATE? YES NO	
	PLEASE CHECK IF THE YOUTH HAS HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS:	
	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Heart Problems
	<input type="checkbox"/> Headaches	<input type="checkbox"/> High Blood Pressure
	<input type="checkbox"/> Vision Problems	<input type="checkbox"/> Asthma
	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Respiratory Problems
	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Constipation
	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Endocrine Disorders
	<input type="checkbox"/> Muscle Disorders	<input type="checkbox"/> Scoliosis
	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Skin Problems
	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Anemia
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Seizures	
Other:		
PREVIOUS TESTING:		
EEG		
CT SCAN		
MRI	WHEN/WHERE:	RESULTS:
GENETICS		
LIST PREVIOUS HOSPITALIZATIONS:		
	DATE (or age):	REASON:
LIST PREVIOUS SURGERIES:		
	DATE (or age):	REASON:



Clinician Notes	Patient to fill out this column ONLY																																			
<p>Reviewed by (initials/date):</p>	NEURODEVELOPMENTAL HISTORY																																			
	PLEASE DESCRIBE ANY DEVELOPMENTAL CONCERNS:																																			
	AT WHAT AGE DID THE YOUTH ACCOMPLISH THE FOLLOWING SKILLS?																																			
	<table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">_____ Smile</td> <td style="width: 33%;">_____ Roll</td> <td style="width: 33%;">_____ Finger feeds self</td> </tr> <tr> <td>_____ Babble</td> <td>_____ Sit alone</td> <td>_____ Spoon feeds self</td> </tr> <tr> <td>_____ Say first word</td> <td>_____ Crawl</td> <td>_____ Drink from open cup</td> </tr> <tr> <td>_____ Put 2 words together</td> <td>_____ Walk</td> <td>_____ Undress completely</td> </tr> <tr> <td>_____ Know first name</td> <td>_____ Kick a ball</td> <td>_____ Shoes on correct feet</td> </tr> <tr> <td>_____ Print name</td> <td>_____ Pedal Tricycle</td> <td>_____ Ties shoes with bow</td> </tr> </table>	_____ Smile	_____ Roll	_____ Finger feeds self	_____ Babble	_____ Sit alone	_____ Spoon feeds self	_____ Say first word	_____ Crawl	_____ Drink from open cup	_____ Put 2 words together	_____ Walk	_____ Undress completely	_____ Know first name	_____ Kick a ball	_____ Shoes on correct feet	_____ Print name	_____ Pedal Tricycle	_____ Ties shoes with bow																	
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LEARNING STYLE: Visual _____ Oral _____ Reading _____ Other: _____																																				
IS THE YOUTH TOILET TRAINED? Bowel _____ Bladder _____ Daytime _____ Nighttime _____																																				
PLEASE CHECK ANY BEHAVIORAL/MENTAL HEALTH CONCERNS:																																				
<table style="width: 100%; border: none;"> <tr> <td>___ Hyperactivity</td> <td>___ Excessive crying</td> <td>___ Peculiar habits</td> <td>___ Sad/Depressed</td> </tr> <tr> <td>___ Short Attention Span</td> <td>___ Food refusal</td> <td>___ Unusual vocalizations</td> <td>___ Anger</td> </tr> <tr> <td>___ Doesn't play well</td> <td>___ Pica (eating inedible items)</td> <td>___ Unusual motor movements</td> <td>___ Truancy</td> </tr> <tr> <td>___ Sleepwalking</td> <td>___ Inflexible routines</td> <td>___ Noncompliance</td> <td>___ Fire Setting</td> </tr> <tr> <td>___ Nightmares</td> <td>___ Avoids new situations</td> <td>___ Temper tantrums</td> <td>___ Lying</td> </tr> <tr> <td>___ Attention seeking</td> <td>___ Fearless</td> <td>___ Destructiveness</td> <td>___ Stealing</td> </tr> <tr> <td>___ Anxious</td> <td>___ Fearful</td> <td>___ Self-injury</td> <td>___ Cruelty to Animals</td> </tr> <tr> <td>___ Hard to soothe</td> <td>___ Impulsivity</td> <td>___ Aggression</td> <td>___ Suicidal</td> </tr> <tr> <td></td> <td></td> <td></td> <td>___ Homicidal</td> </tr> </table>	___ Hyperactivity	___ Excessive crying	___ Peculiar habits	___ Sad/Depressed	___ Short Attention Span	___ Food refusal	___ Unusual vocalizations	___ Anger	___ Doesn't play well	___ Pica (eating inedible items)	___ Unusual motor movements	___ Truancy	___ Sleepwalking	___ Inflexible routines	___ Noncompliance	___ Fire Setting	___ Nightmares	___ Avoids new situations	___ Temper tantrums	___ Lying	___ Attention seeking	___ Fearless	___ Destructiveness	___ Stealing	___ Anxious	___ Fearful	___ Self-injury	___ Cruelty to Animals	___ Hard to soothe	___ Impulsivity	___ Aggression	___ Suicidal				___ Homicidal
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CHECK ANY ASSISTIVE TECHNOLOGY / SPECIAL EQUIPMENT THE YOUTH REQUIRES:																																				
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Clinician Notes	Patient to fill out this column ONLY
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SCHOOL HISTORY

NAME OF CURRENT SCHOOL/PRESCHOOL:

CURRENT GRADE:

TEACHER'S NAME:

HAS THE YOUTH BEEN RETAINED: NO YES If yes, when:

PREVIOUS SCHOOLS THE YOUTH HAS ATTENDED:

GRADE	SCHOOL	ACADEMIC PERFORMANCE		
K		Below Ave.	Average	Above Ave.
1st		Below Ave.	Average	Above Ave.
2nd		Below Ave.	Average	Above Ave.
3rd		Below Ave.	Average	Above Ave.
4th		Below Ave.	Average	Above Ave.
5th		Below Ave.	Average	Above Ave.
6th		Below Ave.	Average	Above Ave.
7th		Below Ave.	Average	Above Ave.
8th		Below Ave.	Average	Above Ave.
9th		Below Ave.	Average	Above Ave.
10th		Below Ave.	Average	Above Ave.
11th		Below Ave.	Average	Above Ave.
12th		Below Ave.	Average	Above Ave.

CHECK ANY SPECIAL EDUCATION SERVICES THE YOUTH RECEIVES:

Current IEP OT Vision Title I Math Behavior disorders class
 Resource PT Title I Reading Speech/Language Mainstreamed class

HAS THE YOUTH HAD PSYCHOLOGICAL OR EDUCATIONAL TESTING? YES NO

IF SO, WHAT WERE THE RESULTS?

DESCRIBE CURRENT ACADEMIC CONCERNS REPORTED BY CHILD'S TEACHERS:

DESCRIBE CURRENT BEHAVIORAL CONCERNS REPORTED BY CHILD'S TEACHERS:

Reviewed by (initials/date):

Clinician Notes

Patient to fill out this column ONLY

SOCIAL HISTORY



THIS CHILD CURRENTLY LIVES WITH:

PRIMARY CARETAKER:

THIS IS THE CHILD'S: Biological Family Adoptive Family
 Foster Family Group Home Institution (how long? _____)

WHO LIVES IN CHILD'S CURRENT HOME:

Name	Age	Relationship to Child

<u>BIOLOGICAL MOTHER:</u>	MARITAL STATUS:
AGE:	BIRTHDATE:
OCCUPATION:	HIGHEST GRADE LEVEL:

<u>BIOLOGICAL FATHER:</u>	MARITAL STATUS:
AGE:	BIRTHDATE:
OCCUPATION:	HIGHEST GRADE LEVEL:

<u>FOSTER/ADOPTIVE MOTHER:</u>	MARITAL STATUS:
AGE:	BIRTHDATE:
OCCUPATION:	HIGHEST GRADE LEVEL:

<u>FOSTER/ADOPTIVE FATHER:</u>	MARITAL STATUS:
AGE:	BIRTHDATE:
OCCUPATION:	HIGHEST GRADE LEVEL:

SIBLINGS/AGES:

RACE / ETHNICITY: Hispanic / Latino White Black / African American Asian
 Native Hawaiian / Other Pacific Islander American Indian / Alaska Native Other

PREFERRED LANGUAGE: _____

RELIGION: _____ **OR:** N/A

PLEASE CHECK ANY STRESSFUL SITUATIONS THE YOUTH HAS EXPERIENCED WITHIN THE LAST YEAR:

Death of family member Parents' separation Change in parent(s) employment
 Major health change in family member Parents' divorce Parent's marriage
 New family member (birth, adoption, etc.) Domestic violence Moving to a new location

PLEASE CHECK ANY OF THE FOLLOWING SITUATIONS THE YOUTH HAS EXPERIENCED:

Physical abuse Alcohol use Tobacco use CPS/Foster placement
 Sexual abuse Drug use Legal problems/arrest Residential placement

Reviewed by (initials/date):



Clinician Notes	Patient to fill out this column ONLY		
Reviewed by (initials/date):	Behavior (please specify behavior)	Onset (age)	Frequency (please circle)
	Self-Injurious Behavior:		Once per week or less 1-3 per week Once Daily Multiple per day Hourly
	Aggression:		Once per week or less 1-3 per week Once Daily Multiple per day Hourly
	Property Destruction:		Once per week or less 1-3 per week Once Daily Multiple per day Hourly
	Tantrums:		Once per week or less 1-3 per week Once Daily Multiple per day Hourly
	Inappropriate Vocalizations:		Once per week or less 1-3 per week Once Daily Multiple per day Hourly
	Pica (eating inappropriate objects):		Once per week or less 1-3 per week Once Daily Multiple per day Hourly
	Elopement:		Once per week or less 1-3 per week Once Daily Multiple per day Hourly
	Other:		Once per week or less 1-3 per week Once Daily Multiple per day Hourly
	Other:		Once per week or less 1-3 per week Once Daily Multiple per day Hourly
	Please describe any related injuries, consequences, or damage caused by above behaviors:		
Please check any typical consequences implemented after problem behavior:			
<input type="checkbox"/> Verbal reprimand <input type="checkbox"/> Time-out <input type="checkbox"/> Escape from demands <input type="checkbox"/> Removal of preferred item/activity <input type="checkbox"/> Access to Preferred item/activity <input type="checkbox"/> Physical attention <input type="checkbox"/> Ignore <input type="checkbox"/> Restraint <input type="checkbox"/> Redirection <input type="checkbox"/> Other:			

Clinician Notes	Patient to fill out this column ONLY
	<i>PRIOR PROFESSIONAL CONTACT</i>



HAS THE CHILD EVER BEEN SEEN BY ANY OF THE FOLLOWING PROFESSIONALS?

Psychiatrist / Child Psychiatrist: *Yes* *No*

Name:

Location:

Reason for visit:

Dates: from _____ to _____.

Developmental/Behavioral Pediatrician: *Yes* *No*

Name:

Location:

Reason for visit:

Dates: from _____ to _____.

Psychologist / Child Psychologist: *Yes* *No*

Name:

Location:

Reason for visit:

Dates: from _____ to _____.

Speech Therapy: *Yes* *No*

Name:

Location:

Reason for visit:

Dates: from _____ to _____.

Occupational Therapy: *Yes* *No*

Name:

Location:

Reason for visit:

Dates: from _____ to _____.

Physical Therapy: *Yes* *No*

Name:

Location:

Reason for visit:

Reviewed by (initials/date):



	<p>Dates: <u>from</u> _____ <u>to</u> _____.</p> <p>Other: _____ Yes No</p> <p>Name: _____</p> <p>Location: _____</p> <p>Reason for visit: _____</p> <p>Dates: <u>from</u> _____ <u>to</u> _____.</p>
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Clinician Notes	Patient to fill out this column ONLY
Reviewed by (initials/date):	<i>FOR PATIENTS 12 YEARS AND OLDER: SEXUAL BEHAVIOR HISTORY</i>
	Please describe any concerns regarding the patient's sexual behavior:
	Has the patient ever had sexual intercourse? (If no, skip the rest of this section)
	How old was the patient when he/she had sexual intercourse for the first time?
	In total, how many sexual partners has the patient had?
	During the past 3 months, how many sexual partners has the patient had?
	Does the patient drink alcohol or use drugs before having sexual intercourse?
	The last time the patient had sexual intercourse, what method was used to prevent pregnancy?
	<input type="checkbox"/> None <input type="checkbox"/> Condoms <input type="checkbox"/> Birth control pills <input type="checkbox"/> IUD (such as Mirena) or implant (such as Implanon) <input type="checkbox"/> Shot (such as Depo-Provera), patch (such as Ortho Evra), or birth control ring (such as NuvaRing) <input type="checkbox"/> Withdrawal <input type="checkbox"/> Not sure
	Has the patient ever been pregnant or impregnated a sexual partner? If so, how many times?



Clinician Notes	Patient to fill out this column ONLY					
Reviewed by (initials/date):	<i>FAMILY HISTORY</i>					
	PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS THAT ARE OR HAVE BEEN PRESENT IN THE CHILD'S IMMEDIATE OR EXTENDED BIOLOGICAL FAMILY:					
		SIBLINGS	MOTHER	FATHER	MOTHER'S RELATIVES	FATHER'S RELATIVES
	Developmental Delay					
	ADHD					
	Mental Retardation					
	Learning Disability					
	Special Education					
	Cerebral Palsy					
	Blindness					
	Deafness					
	Seizures					
	Autism					
	Tics/Tourette's					
	Enuresis (bedwetting)					
	Depression					
	Anxiety					
	Suicide					
	OCD					
	Schizophrenia					
	Sleep disorder					
	Alcoholism					
	Drug abuse					
	Migraine headaches					
	High blood pressure					
	Heart disease					
	Diabetes					
	Obesity					
HIV or AIDS						
Cancer						
Dementia/Alzheimer's						
Genetic disorder						

WHAT MY CHILD LIKES

	ITEM/ACTIVITY	FAVORITE	LIKES	DOES NOT LIKE
TOYS	Toys with lights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Toys that spin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Toys with music	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Toys that beep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Toys with sirens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



	Toys with car sounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Dolls/action figures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Playing or trading cards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Puzzles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Legos/blocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Board games	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Educational games	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Toy vehicles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Arts & crafts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Stuffed animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Dress up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ACTIVITY WITH CHILD	Being spun	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Swinging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Wrestling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Being tickled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Pretend play	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Being read to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Being sung to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Being told a story	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Attention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OTHER	Mirror	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Shiny objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Fuzzy objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Playing in water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Bubbles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Lighted objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Objects that spin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Cold things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Hot things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Electronic	Video/computer games	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Music	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Television/videos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Reviewing Clinician
Great Lakes Center for Autism Treatment and Research

Date



Date: _____

Patient Name: _____

Date of Birth: _____

Please complete this form to assist in us in processing insurance claims for services with your insurance company.

Name of Primary Insurance Company: _____

Claims Mailing Address: _____

Insurance Phone Number: _____

Policy #: _____ Group #: _____ Effective Date of Policy: _____

Name of Insured: _____

DOB: _____ SSN: _____ Relationship: _____

Employer Name & Address: _____

Name of Secondary Insurance Company: _____

Claims Mailing Address: _____

Insurance Phone Number: _____

Policy #: _____ Group #: _____ Effective Date of Policy: _____

Name of Insured: _____

DOB: _____ SSN: _____ Relationship: _____

Employer Name & Address: _____

Medicare #: _____ Medicaid #: _____

Physicians Assignment: I hereby assign my medical benefits to which I may be entitled to be paid directly to my physician.

Signature: _____ Date: _____

[] Please check this box if you do not have any insurance coverage.