Great Lakes Center for
Autism Treatment and Research
an roi program

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: | Would you like to receive our newsletter? ____Yes ____No |
| 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 |
|---|---|
| | **PLEASE DESCRIBE THE TOP 3 BEHAVIORAL CONCERNS YOU HAVE FOR THE YOUTH**<br>1.)<br>2.)<br>3.) |
| | **SPEECH / LANGUAGE CONCERNS?** |
| | **SOCIAL / PEER INTERACTION CONCERNS?** |
| | ***MEDICAL HISTORY*** |
| | **ARE IMMUNIZATIONS UP TO DATE? YES NO** |
| | **PLEASE CHECK IF THE YOUTH HAS HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS:**<br>__ Ear Infections __ Heart Problems __ Kidney Problems __ Muscle Disorders<br>__ Headaches __ High Blood Pressure __ Endocrine Disorders __ Scoliosis<br>__ Vision Problems __ Asthma __ Diabetes __ Skin Problems<br>__ Hearing Problems __ Respiratory Problems __ Thyroid Problems __ Anemia<br>__ Meningitis __ Constipation __ Arthritis __ Seizures<br>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:** |
| Reviewed by (initials/date): | |

| Clinical Notes | Patient to fill out this column ONLY |
|---|---|
| | HAS THE YOUTH HAD A SEVERE HEAD OR BODILY INJURY? YES NO<br>IF YES, PLEASE DESCRIBE: |
| | LIST ANY OTHER PHYSICIANS THE YOUTH HAS SEEN: |
| | PLEASE DESCRIBE THE YOUTH'S SLEEP: |
| | PLEASE DESCRIBE THE YOUTH'S APPETITE AND EATING HABITS: |
| | ***PREGNANCY AND BIRTH HISTORY*** |
| | MOTHER'S AGE AT DELIVERY: / LENGTH OF PREGNANCY: / WEIGHT GAIN: |
| | FATHER'S AGE AT DELIVERY: / DELIVERY: __ Spontaneous Vaginal __ Induced Vaginal __ Elective C-Section __ Emergency C-Section |
| | BIRTH WEIGHT: / BIRTH LENGTH: / BIRTH HEAD SIZE: |
| | APGAR SCORE (if known) |
| | NUMBER OF PREVIOUS PREGNANCIES: Term: _____ Premature: Abortions: _____ Living: |
| | PLEASE CHECK ANY PRENATAL EXPOSURES:<br>__ Alcohol If yes, amount:<br>__ Tobacco If yes, amount:<br>__ Prescription medications If yes, name/reason:<br>__ Over-the-counter medications If yes, name/reason:<br>__ Drugs: __ Marijuana __ Cocaine __ Heroin __ LSD __ PCP __ Amphetamines __ Methadone __ Other: |
| | PLEASE CHECK ANY COMPLICATIONS DURING PREGNANCY OR LABOR:<br>__ Infections/Rash __ Maternal fever __ Seizures __ Induced labor<br>__ Vaginal bleeding __ Rh incompatibility __ Gestational diabetes __ Other:<br>__ Blood pressure problems __ Trauma __ Premature labor |
| | WERE ANY TESTS DONE DURING PREGNANCY (Ultrasound, Amnio)? |
| Reviewed by (initials/date): | PLEASE CHECK ANY OF THE FOLLOWING THAT WERE PRESENT AT BIRTH:<br>__ Breathing problems __ Heart problems __ Jaundice (yellow color) __ Seizures<br>__ Oxygen therapy __ Infection __ Cyanosis (blue color) __ Apnea<br>__ Congenital abnormalities __ Needed antibiotics __ Feeding problems Other: |

| Clinician Notes | Patient to fill out this column ONLY |
|---|---|

## *NEURODEVELOPMENTAL HISTORY*

**PLEASE DESCRIBE ANY DEVELOPMENTAL CONCERNS:**

**AT WHAT AGE DID THE YOUTH ACCOMPLISH THE FOLLOWING SKILLS?**

| | | |
|---|---|---|
| _____ 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 |

**LEARNING STYLE:** Visual_____ Oral _____ Reading _____ Other: _____

**IS THE YOUTH TOILET TRAINED?** Bowel _____ Bladder_____ Daytime _____ Nighttime _____

**PLEASE CHECK ANY BEHAVIORAL/MENTAL HEALTH CONCERNS:**

| | | | |
|---|---|---|---|
| ___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 |

**PLEASE DESCRIBE ANY OTHER BEHAVIORAL/MENTAL HEALTH CONCERNS:**

**PLEASE CHECK ANY DISORDERS THE YOUTH HAS BEEN DIAGNOSED WITH:**

| | | | |
|---|---|---|---|
| __ ADHD | __ Tics | __ Pervasive Developmental Disorder | __ Learning Disability |
| __ Anxiety | __ Tourette's | __ Communication Disorder | __ Mental Retardation |
| __ Depression | __ Eating Disorder | __ Oppositional Defiant Disorder | __ Bipolar Disorder |
| __ OCD | __ Autism | __ Separation Anxiety | __ Substance/alcohol Abuse |

Other:

**CHECK ANY ASSISTIVE TECHNOLOGY / SPECIAL EQUIPMENT THE YOUTH REQUIRES:**

| | | | |
|---|---|---|---|
| __ Crutches | __ Cane | __ Nebulizer | __ Communication Device |
| __ Wheelchair | __ Walker | __ Oxygen | (e.g., PECS book, ipad, Dinovox, etc… |
| __ Leg brace | __ Glasses | __ Feeding tube | |
| __ Arm/hand splints | __ Hearing aid | __ Epi-pen | |

Reviewed by (initials/date):

| Clinician Notes | Patient to fill out this column ONLY |
|---|---|

## *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:**

**Reviewed by (initials/date):**

**DESCRIBE CURRENT BEHAVIORAL CONCERNS REPORTED BY CHILD'S TEACHERS:**

| **Clinician Notes** | **Patient to fill out this column ONLY** |
|---|---|
| | ***SOCIAL HISTORY*** |

Reviewed by (initials/date):

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 |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

BIOLOGICAL MOTHER: MARITAL STATUS:

AGE: BIRTHDATE:

OCCUPATION: HIGHEST GRADE LEVEL:

BIOLOGICAL FATHER: MARITAL STATUS:

AGE: BIRTHDATE:

OCCUPATION: HIGHEST GRADE LEVEL:

FOSTER/ADOPTIVE MOTHER: MARITAL STATUS:

AGE: BIRTHDATE:

OCCUPATION: HIGHEST GRADE LEVEL:

FOSTER/ADOPTIVE FATHER: MARITAL STATUS:

AGE: BIRTHDATE:

OCCUPATION: HIGHEST GRADE LEVEL:

SIBLINGS/AGES:

RACE / ETHNICITY: __Hipanic / 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

| Clinician Notes | Patient to fill out this column ONLY | | |
|---|---|---|---|
| | **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:** | | |
| **Reviewed by (initials/date):** | **Please check any typical consequences implemented after problem behavior:**<br>☐ **Verbal reprimand** ☐ **Time-out** ☐ **Escape from demands**<br>☐ **Removal of preferred item/activity** ☐ **Access to Preferred item/activity**<br>☐ **Physical attention** ☐ **Ignore** ☐ **Restraint**<br>☐ **Redirection** ☐ **Other:** | | |

| Clinician Notes | Patient to fill out this column ONLY |
|---|---|
| | ***PRIOR PROFESSIONAL CONTACT*** |

**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:**

**Reviewed by (initials/date):**

**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:**

| | |
|---|---|
| | **Dates:** from _____ to _____.<br>**Other:** _____ *Yes* *No*<br>**Name:**<br>**Location:**<br>**Reason for visit:**<br>**Dates:** from _____ to _____. |

| Clinician Notes | Patient to fill out this column ONLY |
|---|---|
| | ***FOR PATIENTS 12 YEARS AND OLDER: SEXUAL BEHAVIOR HISTORY*** |
| | **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?** |
| **Reviewed by (initials/date):** | **The last time the patient had sexual intercourse, what method was used to prevent pregnancy?**<br>**___ None**<br>**___ Condoms**<br>**___ Birth control pills**<br>**___ IUD (such as Mirena) or implant (such as Implanon)**<br>**___ Shot (such as Depo-Provera), patch (such as Ortho Evra), or birth control ring (such as NuvaRing)**<br>**___ Withdrawal**<br>**___ 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):

## *FAMILY HISTORY*

**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 | ☐ | ☐ | ☐ |
| | Toys that spin | ☐ | ☐ | ☐ |
| | Toys with music | ☐ | ☐ | ☐ |
| | Toys that beep | ☐ | ☐ | ☐ |
| | Toys with sirens | ☐ | ☐ | ☐ |

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

Reviewing Clinician
Great Lakes Center for Autism Treatment and Research

Date

Great Lakes Center for Autism Treatment and Research

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.