Great Lakes Center for Autism Treatment and Research
an roi program

Please complete all information below:

SECTION I NEW PATIENT INFORMATION

SUPERVISING BCBA		ACCOUNT #
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/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

1.)

2.)

3.)

MEDICAL HISTORY

ARE IMMUNIZATIONS UP TO DATE? YES NO

PLEASE CHECK IF THE YOUTH HAS HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS:

___ Ear Infections	___ Heart Problems	___ Kidney Problems	___ Muscle Disorders
___ Headaches	___ High Blood Pressure	___ Endocrine Disorders	___ Scoliosis
___ Vision Problems	___ Asthma	___ Diabetes	___ Skin Problems
___ Hearing Problems	___ Respiratory Problems	___ Thyroid Problems	___ Anemia
___ Meningitis	___ Constipation	___ Arthritis	___ 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:**

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
	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: **___ Alcohol If yes, amount:** **___ Tobacco If yes, amount:** **___ Prescription medications If yes, name/reason:** **___ Over-the-counter medications If yes, name/reason:** **___ Drugs: ___ Marijuana ___ Cocaine ___ Heroine ___ LSD ___ PCP ___ Amphetamines ___ Methadone ___ Other:**
	PLEASE CHECK ANY COMPLICATIONS DURING PREGNANCY OR LABOR: **___ Infections/Rash ___ Maternal fever ___ Seizures ___ Induced labor** **___ Vaginal bleeding ___ Rh incompatibility ___ Gestational diabetes ___ Other:** **___ Blood pressure problems ___ Trauma ___ Premature labor**
Reviewed by (initials/date):	**WERE ANY TESTS DONE DURING PREGNANCY (Ultrasound, Amnio)?**
	PLEASE CHECK ANY OF THE FOLLOWING THAT WERE PRESENT AT BIRTH: **___ Breathing problems ___ Heart problems ___ Jaundice (yellow color) ___ Seizures** **___ Oxygen therapy ___ Infection ___ Cyanosis (blue color) ___ Apnea** **___ 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

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:

Reviewed by (initials/date):

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	

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

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:

Reviewed by (initials/date):

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:

- ☐ Verbal reprimand
- ☐ Removal of preferred item/activity
- ☐ Physical attention
- ☐ Redirection
- ☐ Time-out
- ☐ Ignore
- ☐ Other:
- ☐ Escape from demands
- ☐ Access to Preferred item/activity
- ☐ Restraint

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:** **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** _____. **Other:** _____ ***Yes*** ***No*** **Name:** **Location:** **Reason for visit:** **Dates:** **from** _____ **to** _____.
Reviewed by (initials/date):	

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?
	The last time the patient had sexual intercourse, what method was used to prevent pregnancy? **___ None** **___ Condoms** **___ Birth control pills** **___ IUD (such as Mirena) or implant (such as Implanon)** **___ Shot (such as Depo-Provera), patch (such as Ortho Evra), or birth control ring (such as NuvaRing)** **___ Withdrawal** **___ Not sure**
Reviewed by (initials/date):	**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					
	FAMILY HISTORY					
	PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS THAT ARE OR HAVE BEEN PRESENT IN THE CHILD'S IMMEDIATE OR EXTENDED <u>BIOLOGICAL</u> 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					
Reviewed by (initials/date):	**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
an roi program

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.