

School Medical Autism Review Team Intake Form

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| Child’s Name: Click here | Date of Birth: Click here | Gender: Select |
| Present during Intake: Click here to enter text. | | |
| Primary language: Click here to enter text. | | |

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| Chief Concerns & Family Demographics |
| Chief concerns (brief statement in family’s words as to the reason for this evaluation:  Click here to enter text. |
| History of main concerns (quality, severity, duration, timing, content, modifying factors, precipitating events, and associated signs/symptoms):  Click here to enter text. |
| Family Demographics (who lives in the home? have there been any major stressful events in your family in recent years?):  Click here to enter text. |

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| Pregnancy & Delivery History |
| Pregnancy complications (such as toxemia, measles, vomiting, swelling, stress, accidents, flu, anemia, high blood pressure); Exposure to medications/alcohol/substances; Delivery complications; Special care after delivery: |

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| Medical History |
| Child’s medical history (major illnesses, surgeries, hospitalizations, accidents/injuries, frequent ear infections, chronic illness, allergies, etc):  Click here to enter text. |
| Hearing and/or Vision concerns? Does your child wear glasses? Hearing test date(s)?  Click here to enter text. |
| Is your child prescribed medications? Do they take supplements or OTC medications?  Click here to enter text. |

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| Toileting |
| Is child toilet trained? When were they fully trained? Current toileting issues and/or accidents? Do they ask to use the toilet?  Click here to enter text. |

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| Sleeping |
| How does your child sleep (too much, too little, nightmares, frequent waking, inability to sleep alone, difficulties settling, snoring, teeth grinding, restlessness, hours per night):  Click here to enter text. |

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| Eating |
| Do you have appetite, feeding, or weight concerns? How does your child eat? Drink? GI functioning?  Click here to enter text. |

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| Personal Independence |
| How does your child get dressed (take off clothes, put on clothes, zippers, shoes); bathing, understand common dangers; help with simple chores:  Click here to enter text. |

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| Motor Milestones & Current Skills |
| Milestones & Current skills:  Click here to enter text. |

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| Communication Milestones & Current Skills |
| Milestones: first word? Regression? Understanding meaning of yes/no? Follow instructions?  Click here to enter text. |

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| Assessment History |
| Assessment (age, agency, diagnosis, results)  Click here to enter text. |
| Assessment (age, agency, diagnosis, results)  Click here to enter text. |
| Assessment (age, agency, diagnosis, results)  Click here to enter text. |

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| Intervention History |
| Psychologist/therapist:  Click here to enter text. |
| Speech and Language therapy:  Click here to enter text. |
| Occupational or Physical therapy:  Click here to enter text. |
| Applied Behavior Analysis (ABA):  Click here to enter text. |
| School based services:  Click here to enter text. |
| Other:  Click here to enter text. |