CENTRA MEDICAL GROUP
Developmental Pediatrics

693 Leesville Road, Lynchburg, VA 24502
phone: 434.200.3047
fax: 434.200.5209
www.centraautism.com

Child Information

First Name: _____ Preferred Name: _____ Middle Name: _____

Last Name: _____ Suffix: Jr. Sr. III IV Birth Date: _____

Gender: O Male O Female Ethnicity: O Hispanic or Latino O Not Hispanic or Latino

Race of child:

O African American or Black O American Indian/Alaska Native O Asian
O Other Pacific Islander O More than one race O Other (specify):
O White O Native Hawaiian

Currently lives with:

O both biological parents O biological father O biological mother
O biological father and stepmother O biological mother and stepfather O adoptive parents
O joint custody – 2 separate homes O foster parents O non-family care
O relatives, who?_____

If not biological parent, please describe the circumstances that led to child being placed into your care. Please describe the length of time the child has been in your care and the circumstances that led to the biological parent not being the primary caretaker. Please include estimated number of foster placements: (use the back side of this page as necessary):

Parent/Guardian 1

Name: _____ Relationship to child: _____

Address: _____

City: _____ State: _____

Zip code: _____ County: _____

Birth date: _____ Email address: _____

Best Phone Number to reach you: _____ Alternate Phone 1: _____

Ethnicity: O Hispanic or Latino O Not Hispanic or Latino

Race: O African American or Black O American Indian/Alaska Native O Asian
O Other Pacific Islander O More than one race O Other (specify):
O White O Native Hawaiian

Highest Education Completed:

O Graduate/Professional degree O BA, BS or 4-year degree
O Technical school degree O Associates degree
O High School graduate GED diploma O 1-3 years of high school Completed up to ninth grade
O Completed less than ninth grade

Occupation: _____

Place of Employment: _____ Phone: _____

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Parent/Guardian 2

Name: _____ Relationship to child: _____

Address: _____

City: _____ State: _____

Zip code: _____ County: _____

Birth date: _____ Email address: _____

Best Phone Number to reach you: _____ Alternate Phone 1: _____

Ethnicity: O Hispanic or Latino O Not Hispanic or Latino

Race: O African American or Black O American Indian/Alaska Native O Asian
O Other Pacific Islander O More than one race O Other (specify):
O White O Native Hawaiian

Highest Education Completed:

O Graduate/Professional degree O BA, BS or 4-year degree
O Technical school degree O Associates degree
O High School graduate GED diploma O 1-3 years of high school Completed up to ninth grade
O Completed less than ninth grade

Occupation: _____

Place of Employment: _____ Phone: _____

Marital Status

Are parents married to each other? O Yes O No Date of Marriage: _____

Are parents separated or divorced? O Yes O No Date of Separation or Divorce: _____

If divorced or separated, please indicate custody arrangements: Joint / Sole (which parent?) _____

Other (please describe):

Please provide copy of custody agreement

Sibling Information

First Name Only	Birth Date	Gender	Relationship	Does sibling have Autism Spectrum Disorder	Other Developmental or Health Disorder	Does sibling live in the home with client
		O Male O Female	O Full O Step O Half O Foster	O Yes O No		O Yes O No
		O Male O Female	O Full O Step O Half O Foster	O Yes O No		O Yes O No
		O Male O Female	O Full O Step O Half O Foster	O Yes O No		O Yes O No
		O Male O Female	O Full O Step O Half O Foster	O Yes O No		O Yes O No

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Insurance Information

Name of Insurance Company: _____ Group #: _____

Policy Holder Name: _____ Policy Holder Birthdate: _____

Policy Number + suffix: _____ Primary Care Provider Name: _____

Insurance Claims Address: _____

Customer Service Phone Number: _____ Effective Date of Policy: _____

Language and Communication

Primary Language of the Child: O English O Spanish O Other (specify): _____

Other languages spoken in the child's home: _____

Interpreter needed? O Yes O No

Can the client speak in full sentences: O Yes O No

If no, please select the appropriate level of language and/or communication skills

O No verbal language (Gestures) O Single Word O Phrase speech (3-word phrases)

O Sign language O Picture exchange O Augmentative communication device

Please give an estimate of how many words are in your child's vocabulary.

O No words O 1 to 5 words: first words O 10 to 25 words O 25 to 50 words

O 50 to 75 words O 75 to 100 words O 100+ words

How much of your child's speech do you understand?

O 10% or less O 11-24% O 25-50% O 51-74% O 75-100%

How much of your child's speech do others understand?

O 10% or less O 11-24% O 25-50% O 51-74% O 75-100%

Does your child demonstrate frustration when he/she is not understood? O Yes O No

Please explain: _____

_____

Does your child engage in eye contact during communication? O Yes O No O Sometimes

When given a choice, does your child prefer to play alone or with others? O Alone O Others

How does your child interact with others (shy, aggressive, cooperative, etc.)? _____

_____

Does your child:	**Yes**	**No**	**Sometimes**
Answer questions logically?			
Greet people arriving or leaving?			
Engage in turn taking?			
Initiate conversation?			
Maintain a topic?			
Recall & tell about everyday events?			
Follow one-step directions?			

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Education

Please tell me about your child's school experiences (if applicable)

School: _____ Teacher's Name: _____

County/location of school: _____ Grade_____

Classroom: O Regular O Resource support O Special education O Self-contained special education

O My child is not currently enrolled in school.

Name of School	City	Special Education Services Received	Grades
Preschool:		O Yes O No	
Elementary:		O Yes O No	
Middle:		O Yes O No	
High:		O Yes O No	

Number of school changes since Kindergarten (if applicable) _____

Has your child ever been retained? O Yes O No

Has your child's school ever held a Student Support Team meeting or Child Study meeting to address learning, speech, behavioral challenges, or etc. for your child? O Yes O No

If so, what was the result?

Has your child ever been evaluated for a learning problem, speech problem, behavioral challenges, or etc. through the school or through a private agency/clinic? O Yes O No

If yes, Agency/Clinic Name: _____ Date of assessment: _____

Does your child receive other support services now? (check any that apply):

O IFSP O IEP O 504 plan O Child Study/Student Support Team O Title 1 services O Day Treatment

Does your child receive School Based Related Therapies? O Yes O No

Occupational Therapy Frequency:	Speech Therapy Frequency:	Other Frequency:

Has your son/daughter had past or current difficulties in school? O Yes O No

If yes, please describe: _____

_____

_____

Contact person: _____ Title: _____

Other school personnel routinely working with your child: _____

Indicate special classes or repeated grades your child has had: _____

_____

Ease of transition to school: _____

Age at which applicant entered kindergarten: _____

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Typical academic performance: _____

Recent academic performance: _____

In-school suspensions: _____

Out-of-school suspensions: _____

Other disciplinary interventions:

_____

Please provide a copy of your child's current IEP or 504 Plan and any Psychological, Speech, OT reports completed by the school.

Medical History

Pediatrician: _____

Psychiatrist: _____

Psychologist: _____

Speech Therapist: _____

Occupational Therapist: _____

Neurologist: _____

Ear, Nose & Throat: _____

Eye: _____

Early Intervention Specialist: _____

Has your child ever been hospitalized for psychiatric or medical challenges? O Yes O No

If so, please describe

Does your child have any medical diagnosis? O Yes O No

If so, please describe:

Has your child ever had a vision test/screen? O Yes O No

Results of Vision Test: ___ Normal ___ Impaired

If impaired, does your child wear glasses or contacts?

Does your child receive treatment from a Developmental Ophthalmologist? O Yes O No

Has your child ever had a hearing test/screen? O Yes O No

Results of the Hearing Test: ___ Normal ___ Impaired

Does your child have a history of a head trauma (concussion) or seizures? O Yes O No

If yes, please provide details of injury including approximate dates.

Has your child ever had genetic testing? O Yes O No

If so, what were the results?

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Does your child have any life-threatening food allergies and/or dietary restrictions? O Yes O No

If yes, please describe:

What Medication(s) and/or Vitamin(s) has your child taken or is currently taking?

Medication:	Date(s):
Reason/Effectiveness:	
Medication:	Date(s):
Reason/Effectiveness:	
Medication:	Date(s):
Reason/Effectiveness:	

Has your son/daughter had any of the following? If so, please indicate age.

Check	Condition	Age		Check	Condition	Age
	Meningitis and/or encephalitis				Bladder or kidney infection	
	Accidents				Headaches and/or migraines	
	Heart disease				Poisoning	
	Convulsions and/or seizure disorders				Diabetes	
	Measles				Head injuries	
	Whooping cough (pertussis)				Mumps	
	Recurrent ear infections				German measles	
	Chicken pox				Recurrent tonsillitis	
	Fainting spells				Pneumonia with hospitalization	
	Eye or visual problems				EEG	
	Severe diarrhea with dehydration				Chromosome studies	
	Allergies				Other genetic studies	
	Severe reaction to immunizations				Hospitalization	
	CNS (brain) studies (e.g. MRI, CT)				Chronic infections (e.g. TB, cytomegalovirus, herpes, HIV)	
	Surgery (please specify):					
	Other (please specify):					

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Traumatic Life Events

Has your child ever been exposed to a life situation that may have been traumatic for him or her (for example: death of family member or close friend, violent divorce, observing domestic violence/disputes, house fire, victim or observer of a violent crime, physical abuse, sexual abuse, neglect etc.)? O Yes O No

How old was the child when this event occurred? _____

Please describe possible traumatic exposure:

Did your child's behavior change after the event? O Yes O No

Please describe:

Has a report ever been made to Child Protective Services regarding this child or his/her immediate family?

O Yes O No

Pregnancy Information

Please check any of the following which occurred during the pregnancy with this child:

	Excessive nausea & vomiting		Spotting or bleeding		German measles (rubella)
	Other infectious disease, flu		Kidney or bladder infection		High blood pressure
	Toxemia		Anemia (low iron)		Smoking
	Alcohol use		Drugs (prescription, non-prescription)		RH incompatibility
	Accidents		Medical problems unrelated to pregnancy		Hospitalization during pregnancy
	Premature birth		Emotional strain		Physical strain
	Difficulty conceiving	Regularly saw doctor, first visit in month #:			
	Ultrasound	Other (please specify):			
	Amniocentesis				
	Other prenatal diagnostic studies				

Were there any problems during other pregnancies (include items listed above as well as difficulty conceiving, miscarriages, stillbirths, premature births)? O Yes O No

If yes, please specify:

_____

_____

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Applicant's Birth History

Hospital where child was born: _____

Birth weight: _____ lbs. _____oz. City/State _____

APGAR Scores: range 1-10			Delivery:	No complications	Multiple births	Breech
#1	#2			Cesarean section	Forceps	Cord around neck
				Other birth complications:		

Neonatal History

Please check any of the following which applied during the first month.

	Breathing problem		Convulsions		Cyanosis (skin blue)
	Excessive crying		Infections		Jaundice (skin yellow)
	Sleeping problems		Received care in an intensive care nursery		Very inactive
	Feeding problems	Any other neonatal problems? Please specify:			

Developmental History

Milestones: As closely as you can recall, please indicate age when your child did the following things

Milestone	Age		Milestone	Age
Eating			Motor	
Gave up bottle			Rolled over	
Drank from cup without help			Reached for objects	
Started eating solids			Sat without support	
Fed self with spoon			Crawled	
Toilet Training			Pulled to standing	
Bladder trained – daytime			Stood without support	
Bladder trained – nighttime			Walked using furniture as support	
Bowel trained – daytime			Walked alone	
Bowel trained – nighttime			Rode tricycle	
Went to bathroom alone			Social Communication	
Dressing Skills			Smiled	
Undressed self			Followed with eyes	
Dressed self			Made single sounds (babbling)	
Buttoned clothes			Said first word	
Tied shoelaces			Used words every day	
			Combined words in short sentences	

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Family Tree

If any of your child's biological relatives have had any of the following conditions, please write the person's relationship to your child next to the condition. By relatives we mean your son's or daughter's grandparents, aunts, uncles, first cousins, siblings and/or parents.

Condition	Biological mother's family	Biological father's family
Autism, Autism Spectrum Disorder, Asperger's Syndrome, PDD		
Communication disorder		
Convulsions, seizures, epilepsy		
Cerebral Palsy, muscular weakness		
Hearing loss		
Intellectual Disability (formerly known as Mental Retardation)		
School difficulties		
Severe visual impairment		
Slow development, slow talker		
Reading difficulty		
Emotional disorder (specify):		
Attention Deficit Disorder		
Depression		
Manic depression, bipolar disorder, mood disorder		
Alcoholism, substance abuse or dependency		
Autoimmune disorders (specify):		
Special education services		
Suicidal ideations, suicidal attempts		
Other (specify):		

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Previous Diagnoses and Reports

To serve you as effectively and as quickly as possible, we require that you send us copies of previous evaluations. We need all previous evaluation reports 2 weeks prior to your appointment.

1. Has your child ever received an evaluation for ASD, Autism, Asperger's Syndrome, or PDD-NOS made by a school system, psychologist or medical doctor? O Yes O No

   If yes, who? _____ City/State: _____ Date: _____
   Please check one: O Report(s) attached O Report(s) will be sent in a separate mailing.

2. Has your child ever received any developmental or IQ testing? O Yes O No

   If yes, who? _____ City/State: _____ Date: _____
   Please check one: O Report(s) attached O Report(s) will be sent in a separate mailing.

3. Has your child ever received any behavioral or mental health evaluations *(for concerns such as ADHD, depression, anxiety, psychosis, conduct, etc.)***?** O Yes O No

   If yes, who? _____ City/State: _____ Date: _____
   Please check one: O Report(s) attached O Report(s) will be sent in a separate mailing.

4. Has your child ever received any other type of evaluation for other disabilities or concerns (*e.g. OT, medical evaluations)*? O Yes O No

   If yes, who? _____ City/State: _____ Date: _____
   Please check one: O Report(s) attached O Report(s) will be sent in a separate mailing.

Functional Assessment of Possible Functions of Problem Behavior

Does your child engage in any self-injurious behavior(s)? O Yes O No

If Yes, please list: _____

Does your child engage in any aggressive behavior(s)? O Yes O No

If Yes, please list: _____

Does your child elope from buildings and/or outdoor areas? O Yes O No

If Yes, please explain: _____

_____

_____

_____

_____

Please list any other problem behaviors your child exhibits:

1. _____
2. _____
3. _____
4. _____
5. _____

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Please explain how these behaviors interfere with daily activities throughout the day: _____

_____

_____

_____

_____

_____

The following questions address each individual problem behavior addressed above.

1. Does the problem behavior occur during specific times? O Yes O No
2. Does the problem behavior occur in specific settings, activities or events? O Yes O No
3. Does the problem behavior occur around specific people? O Yes O No
4. How often does the problem behavior occur? _____

_____

_____

5. Please identify what appears to cause the behavior:
    1. Demands are being placed
    2. Preferred items or activities are removed
    3. Attention is removed
    4. Sensory Stimulation
    5. Medical condition
    6. Other: _____
6. What typically happens immediately following the behavior? _____

_____

_____

_____

7. What steps have been taken to address the problem? Please describe: _____

_____

_____

_____

8. Have you noticed any results from the above steps? O Yes O No

If yes, please describe: _____

_____

_____

_____

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Child Reinforcer Preferences

Please list your child's favorite items, activities, and foods:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Goals and Expectations

Please describe goals or expectations you hold for your child in his/her environment:

School	Home	Community

Please describe any other concerns or expectations regarding your child's current behavior, communication, and social skills: _____

_____

_____

_____

_____

Who will be involved in your child's treatment? Please list all family members and caregivers:

_____

_____

Are family members or additional caregivers available for training to ensure appropriate support and generalization of skills to the home environment? O Yes O No

Behavioral Health/ABA Therapy

Is your child currently receiving ABA therapy or has your child received ABA therapy in the past? O Yes O No

If so, please describe the past or current program goals and objectives and how specific goals are taught:

_____

_____

_____

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For Current ABA Therapy:

Day:	Time:	Therapist:	Facility:
Please describe if any progress has been made:			

Please describe additional information about your child and things you would like us to know about them (strengths, personality, etc.)?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Other Community Resources / Agency Involvement

Children and Youth: _____
Case worker: _____
MH/MR: _____
Juvenile probation: _____
Probation officer: _____
Other agencies: _____
Please list any other community resources you currently use for your child? _____
_____
_____

Person completing this questionnaire: _____
Relationship to child: _____ Date: _____