THE CENTER FOR AUTISM
a PHMC affiliate

DATE:

Patient Intake Information		
Name:	Date of Birth:	Social Security Number:
Race: Choose an item.	Ethnicity: Choose an item.	Gender: _____ Gender identity: _____ Pronouns:_____
Preferred language: _____ Is interpreter needed Choose an item.		
Insurance Company Name: Philadelphia Resident: Choose an item. Member ID: Policy ID: Group #: Member Services Phone Number: Specialty Co-Pay:	**Insurance Company Name:** Philadelphia Resident: Choose an item. Member ID: Policy ID: Group #: Member Services Phone Number: Specialty Co-Pay:	
Reason for visit / diagnosis: Choose an item.		
Primary Care Physician:	**Referral Source:**	
PCP Phone Number:	**Referral Source Phone Number:**	
Guardian Information		
Name of Person Filling out Form: Marital Status:	Relationship to Client:	
Legal Guardian: Biological Parent: Involved:	Legal Guardian 2: Biological Parent: Involved:	
DHS Involvement: If yes, Reason: Court Order Who has Legal Custody: Shared Custody with DHS: Who has Legal Signing Rights:	Custody Arrangements: (If Applicable) Legal Custody Documents: (if yes must obtain copy and attach to credible: ☐ Joint Custody between _____&_____ ☐ Sole Custody: _____ ☐ Partial Custody (w/ Visiting Rights) - _____	
	Case Manager (if applicable): Phone Number: Email: Foster Care Agency: (If applicable)	

Guardian #1		
Name:	Home Phone Number:	
Home Address:	Cell Phone:	Email:

Guardian # 2		
Name:	Home Phone Number:	
Home Address:	Cell Phone:	Email:
Contact preference: Choose an item.	Would you like to receive appt reminders?	

Current Concerns:

_____
_____
_____
_____

Immunizations up to date: Choose an item.

Questionnaire for Clients

Developmental History:

It may be helpful to review infant/toddler milestone books or past reports when completing the following questions. If you are uncertain, estimate as best as you can. Leave blank if the skill is not yet developed. Please record the ages in months when your child first:

1. Smiled in response to others
2. Walked independently w/o support
3. Bladder control (days)
4. Bladder control (nights)
5. Bowel control
6. Sat without support
7. First words (more than mama, dada)
8. Spoke in 3-word phrases
9. Spoke in full sentences (at least 4 words)

At what age did you **first** notice problems (developmental delays or differences)?

Has there been any significant LOSS of a previously acquired skill or skills (not just a delay)? For example, the child was engaging in pretend play with other children for at least 4 to 6 months and then stopped or the child was speaking in full sentences for many months and then stopped speaking altogether or began using only single words occasionally (leave blank if not applicable**:**

Social functioning ☐ Age of loss: ; Explain:

_____

Speech / language ☐ Age of loss: Explain:

_____

Adaptive Skills ☐ Age of loss: ; Explain:

_____

Communication/Listening:

1. Is the client verbal or non-Verbal?
2. Does the client point independently with one finger
3. Does the client communicate using gestures?
4. Does the client use picture-based communication?
5. Can the client use one-word phrases?
6. Can the client communicate using 3–5-word phrases?
7. Can the client communicate using full sentences?
8. Can the client hold a conversation with others?
9. Can the client follow 1-step directions?
10. Does the client respond when their name is called?
11. Does the client make eye contact?

Social Skills

1. Does the client have an interest in peers/other children?
2. Does the client have an interest in adults other than immediate family?
3. Does the client allow others to join their play?
4. Does the client initiate play with others?

5. Is the client particular about routines?
6. Does the client play appropriately with toys?
7. Does the client play with toys in ways they are not meant to be played with? (Ex: spinning wheels on a car, throwing toys)
8. Can the client engage in imaginative play? (Ex: pretending to cook)
9. Does the client engage in representational pretend play? (Ex: feeding a doll with a fork or bottle)

Behaviors:

1. Does the client display "Stranger Danger" (ex: cautious around strangers)?
2. Does the client elope/attempt to run away?
3. Does the client have tantrums for longer than 5 minutes?
4. Does the client have tantrums more than 5 times per day?
5. Does the client display signs of hyperactivity?
6. Does the client display signs of inattention?
7. Does the client display signs of impulsivity?
8. Does the client show aggression towards others?
9. Does the client display self-injurious behaviors?

Patient Medical/Behavioral Health History	
ADHD	History of Trauma
Aggression	Gastrointestinal symptoms
Asthma	Gender Dysphoria
Autism Spectrum Disorder	Sensory Concerns:
Developmental Coordination Disorder	Sleep Challenges:
Generalized Anxiety Disorder:	Other:

**** If yes to any of the above, please explain where the diagnosis was given and who gave diagnosis. Please see attached RTOI form to obtain copy of diagnosis/treatment history**

Allergies: If yes, please list allergy and reaction:	

Current Medications (leave blank if none):

Medication	**Dosage**	**Age started**	**Reason for Medication**	**Improved Symptoms?**

Educational History:

School Name: _____ Phone Number: _____

Current Grade: _____

What best describes client's current educational program?

Home School

Full time regular classroom

Specialized School

Aide/Paraprofessional (extra help)

Special Education Classroom

IEP

504 Plan

Resources/Services:

Early Intervention: Agency _____	**Past Current N/A**	**Psychiatry/Medication Management**	
Speech/Language Therapy	**Past Current N/A**	**Group Therapy**	
Occupational Therapy	**Past Current N/A**	**Case Management**	
Behavioral Therapy	**Past Current N/A**	**IBHS services (formerly known as Wrap Around Services (WRAP)**	
Physical Therapy	**Past Current N/A**		

For clients who are 18 years or older

1. Do you understand emotions in others?
2. Do you understand social cues?
3. Do you initiate conversation with others?
4. Are you currently employed?
5. Are you currently involved in a romantic relationship?
6. Do you have a college education?