BURRELL BEHAVIORAL HEALTH
BURRELL AUTISM CENTER
Child and Family History

Child's Name: ______________________ MRN: __________

DOB: __________ Age: ________ ☐ M ☐ F Date Completed: __________

Completed By: ______________________ Relationship to Child: __________

Home Address: ______________________

Pediatrician: ______________________ Address: __________

Referred by: ______________________ Specialty: __________

What is the reason for this appointment? ______________________

____

CURRENT CONCERNS ABOUT YOUR CHILD

Please check all that apply:

☐ Hyperactivity	☐ Fearful	☐ Language abilities	☐ Difficulty calming down
☐ Aggression	☐ Self-injury	☐ Peer relationships	☐ Self-stimulatory behaviors: *rocking, spinning, flapping hands, visual scrutiny*
☐ Biting	☐ Motor skills	☐ Separation problems	
☐ Hitting	☐ Temper tantrums	☐ Medication problems	☐ school environment, describe:
☐ Inattentive	☐ Toilet training	☐ Preoccupations	__________
☐ Anxious	☐ Sleep problems	☐ Appetite/food selections	☐ Other: __________
☐ Depressed	☐ Muscle tone	☐ Problems w/transitions	__________
☐ Irritability	☐ Self-help skills	☐ Sexualized behaviors	__________

HOUSEHOLD INFORMATION

Who lives in the home with the child?

Name	Age	Relationship

Highest level of education of each biological parent:

	11 grade or less	GED	High school graduate	Bachelor's Degree	Graduate/ Professional	Vocation Certificate
Biological Mother	☐	☐	☐	☐	☐	☐
Biological Father	☐	☐	☐	☐	☐	☐

CLIENT NAME: ______________________ MRN: __________

If child does *not* live with BOTH biological parents, who has legal custody of the child? __________

____

Names of biological parents: ______________________

How often does the other biological parent see this child? ______________________

Number of years married/together: __________ Approximate date of divorce/separation: __________

Number of times married: Mother: __________ Father: __________

If child is with ADOPTIVE parent, age child was first in home: __________ Date of legal adoption: __________

What has the child been told about the adoption? ______________________

If your child spends a significant amount of time with a caregiver other than someone described above, (i.e., spends more than 4 hours/day) *excluding* school personnel, please complete the following information for that person:

Name: ______________________ Age: ______ Birth date: __________

Relationship to child: ______________________ Ethnic/Cultural Background: __________

Occupation: ______________________ Highest level of education: __________

What languages does the child use (List PRIMARY language first): ______________________

What other language is your child exposed to? ______________________

PRENATAL/PREGNANCY

Did the biological mother have any of the following immediately before/after or during pregnancy?

- ☐ Maternal injury? Describe: ______________________
- ☐ Hospitalization during pregnancy? Reason: ______________________
- ☐ X-rays during pregnancy? What month of pregnancy? ______________________
- ☐ Chemical/Substance use: ☐ Tobacco ☐ Alcohol ☐ Marijuana ☐ Other: __________

Did the biological mother have any of the following during pregnancy?

☐ Emotional problems	☐ Infections	☐ Premature labor
☐ Rashes	☐ Bed-rest	☐ Toxemia
☐ Difficulty in conception	☐ Anemia	☐ Gained more than 35 pounds
☐ Excessive swelling	☐ Vaginal bleeding	☐ Measles/German measles
☐ Excessive nausea/vomiting	☐ Flu	☐ High blood pressure
☐ Kidney disease	☐ Strep Throat	☐ Threatened miscarriage
☐ Rh incompatibility	☐ Headaches	☐ Severe cold
☐ Urinary problems	☐ Airplane trip during pregnancy	☐ Other virus: __________

- ☐ Special diet, describe: ______________________
- ☐ Meds: ______________________
- ☐ Other: ______________________

CLIENT NAME: ______________________ MRN: __________

Mother's age at conception: __________ Father's age at conception: __________

Did the mother have previous pregnancies? ☐ Yes ☐ No How many, including miscarriages? ______

Did mother receive prenatal care during this pregnancy? ☐ Yes ☐ No Beginning at month: ______

During the pregnancy, was the baby: ☐ Very active ☐ Average ☐ Rather quiet

Were there any unusual changes in the baby's activity level during pregnancy? ☐ Yes ☐ No

DELIVERY

Was infant born full-term? ☐ Yes ☐ No If premature, how early? ______ If overdue, how late? ______

Length of active labor: ______ Birth weight: ______ Apgar at 5 minutes: ______

Type of anesthetic used: ☐ None ☐ Spinal ☐ Local ☐ General

Describe any complications during delivery: ______________________

Check all of the following that applied to the delivery:

☐ Spontaneous ☐ Breech ☐ Forceps

☐ Head First ☐ Multiple births ☐ Cord around neck

☐ Induced; Reason: ______________________

☐ Cesarean; Reason: ______________________

Which of the following applied to the infant? (Check all that apply)

☐ Breathing problems ☐ Required oxygen ☐ Required incubator

☐ Jaundice? ☐ Yes ☐ No Were bilirubin lights used? ☐ Yes ☐ No How long? ______

☐ Feeding problems ☐ Sleeping problems ☐ Infection

☐ Rash ☐ Excessive crying ☐ Seizures/convulsions

☐ Unusual appearance, describe: ______________________

☐ Bleeding into the brain Did the infant require: ☐ X-Rays ☐ CT scans ☐ Blood transfusions

☐ Placement in the NICU If so, for how long? ______________________

Length of stay in hospital: Mother: __________ Infant: __________

DEVELOPMENTAL HISTORY

During this child's **first three years**, were any special problems noted in the following areas?

☐ Irritability ☐ Breathing problems ☐ Colic ☐ Temper tantrums

☐ Difficulty sleeping ☐ Eating problems ☐ Failure to thrive ☐ Excessive crying

☐ Twitching ☐ Convulsions/Seizures ☐ Early learning problems ☐ Withdrawn behavior

☐ Bowel Problems ☐ Poor eye contact ☐ Unable to separate from parent ☐ Destructive behavior

☐ Other: ______________________

____

Milestones Indicate age when the child:

______ Sat unaided	______ Rolled Over	______ Crawled
______ Walked	______ Skipped	______ Rode tricycle
______ Rode bike	______ Gave up bottle	______ Started baby food
______ Fed self with fingers	______ Fed self with spoon	______ Started solid food
______ Bladder trained – day	______ Bladder trained – night	______ Bowel trained

The child's favorite things:

Food/Edibles: ____________________

Toys: ____________________

Themes (Thomas, Dora, etc.): ____________________

Can child be described as clumsy/uncoordinated? ☐ Yes ☐ No Having fine motor delay? ☐ Yes ☐ No

Which hand does your child use for: Writing/drawing? ☐ L ☐ R Cutting? ☐ L ☐ R Eating? ☐ L ☐ R

Current eating behavior: ☐ Normal ☐ Picky ☐ Eats too much ☐ Weight loss/gain

Oral Motor concerns: ☐ None ☐ Difficulty swallowing ☐ Drooling ☐ Gagging

Language development

To communicate does the child use:

Spoken Language: ☐ Y ☐ N ☐ single words only ☐ phrased speech (2-3 word combos) ☐ sentences

Sign Language: ☐ Y ☐ N List signs: ____________________

Gestures (reach, point, non-verbals, etc): ☐ Y ☐ N List Gestures: ____________________

____

Please list the age when the child began to:

______ Coo, babble	______ smile	______ play social games (peek-a-boo, Pat-a-cake)
______ use phrases	______ use single words	______ use sounds/gestures to communicate
______ use sentences		

Does child recognize when people are happy, sad, angry? ☐ Y ☐ N

Does child understand:

Words ☐ Y ☐ N Single step directions ☐ Y ☐ N Multi-step directions ☐ Y ☐ N

Are there any hearing concerns (present or past)? ☐ Y ☐ N

History of ear infections ☐ Y ☐ N Frequency of ear infections: ____________________

Age range of ear infections: __________ Ear Tubes ☐ Y ☐ N Date/age: __________

Adaptive Skills

Dresses self	☐ Y	☐ N	Beginning at age:	______
Bathes self	☐ Y	☐ N	Beginning at age:	______
Helps with household chores	☐ Y	☐ N	Beginning at age:	______
Knows phone number and address	☐ Y	☐ N	Beginning at age:	______
Says "please" and "thank you"	☐ Y	☐ N	Beginning at age:	______
Tells time accurately	☐ Y	☐ N	Beginning at age:	______

Has the child ever lost skills, which at one time he/she was able to perform? ☐ Y ☐ N

If yes, please explain: ______________________

When your child is disruptive or misbehaves, what steps are you likely to take to deal with the problem?

☐ Time out ☐ Loss of allowance/privileges ☐ Physical punishment ☐ Yelling ☐ Ignoring

☐ Grounding ☐ Other, describe: ______________________

Who is mainly in charge of discipline? ______________________

What do you find most difficult about raising your child? ______________________

Family Changes and Stressors

Please indicate any major family stresses the family and/or child is currently experiencing or has experienced within the last year.

☐ Marital discord/fighting ☐ Separation ☐ Divorce

☐ Birth/Adoption of another child ☐ Sibling conflict ☐ Parent-Child conflict

☐ Custody disagreement ☐ Single-parent family ☐ Parent/sibling death

☐ Parent deployed extensively ☐ Parent emotionally/mentally ill ☐ Involved in juvenile court

☐ Abandonment by parent ☐ Financial problems ☐ Parent substance abuse

☐ Child neglect ☐ Physical abuse ☐ Sexual abuse

☐ Parental disagreement about child-rearing ☐ Involved with Social Services/Child Protective Services

☐ Other, if not listed: ______________________

Checklist: Please mark any of the following in each area that describe your child currently or in the past:

Speech Concerns

Past	Current		Past	Current	
☐	☐	No speech or slow speech development	☐	☐	Unusual tone or pitch
☐	☐	Doesn't understand without gestures	☐	☐	Difficult to understand speech
☐	☐	Repeats words/phrases over and over again	☐	☐	Seldom speaks unless prompted
☐	☐	Repeats questions, instead of answering them			
☐	☐	Repeat dialogue from movies or songs verbatim			
☐	☐	Has language of his/her own (may sound like foreign language/jargon)			
☐	☐	Loss of speech skills If so, what age? ________ Describe: ______________			

Relating with other people

Past	Current		Past	Current	
☐	☐	Prefer to be by self	☐	☐	"In a world of his/her own"
☐	☐	Aloof, distant	☐	☐	Clings to people
☐	☐	Fearful of strangers	☐	☐	Not cuddly as a baby
☐	☐	Doesn't like to be held	☐	☐	Doesn't recognize parent
☐	☐	Doesn't play w/ other children	☐	☐	Prefers playing w/ younger or older children

Imitation

Past	Current	
☐	☐	Doesn't imitate waving "bye-bye" or "patty cake" etc. (physical imitation)
☐	☐	Doesn't repeat words/things said to him
☐	☐	Doesn't repeat words generally, but usually did what he was asked to do

Response to Sounds, Speech

Past	Current	
☐	☐	Often ignores sounds
☐	☐	Afraid of certain sounds
☐	☐	Often ignores what is said to him/her (speech)
☐	☐	Really likes certain sounds (music, motors, etc.)
☐	☐	Seems to hear distant or soft sounds that most other people don't hear or notice
☐	☐	Unpredictable response to sounds (sometimes reacts, sometimes doesn't)
☐	☐	Responds to speech and sounds like other children of the same age

Visual Response

Past	Current		Past	Current	
☐	☐	Stares vacantly around room	☐	☐	Plays with turning lights on and off
☐	☐	Often doesn't look at things	☐	☐	Distracted by lights
☐	☐	Stress at certain lights	☐	☐	Likes to look at self in mirror
☐	☐	Very interested in small parts of an object	☐	☐	Likes to look at shiny objects
☐	☐	Looks at things out of the corners of eyes			
☐	☐	Stares at parts of his/her body (e.g. hands)			
☐	☐	Often avoids looking at people when they are talking to him/her			

Other Senses

Past	Current		Past	Current	
☐	☐	Puts many objects in mouth	☐	☐	Likes vibrations
☐	☐	Licks objects	☐	☐	Doesn't notice pain as much as most people
☐	☐	Overreacts to pain	☐	☐	Smell objects unusual or unfamiliar objects
☐	☐	Chew or eat objects that are not supposed to be eaten			

Emotional Responses

Past	Current		Past	Current	
☐	☐	Temper tantrums	☐	☐	Laughs/smiles for no obvious reason
☐	☐	Moods change quickly,for no apparent reason	☐	☐	Overly responds to situations
☐	☐	Cries/seems sad for no obvious reason	☐	☐	Often has blank expression on face
☐	☐	Little response to what is happening around him/her			

MEDICAL HISTORY

Has your child ever had?

☐ Head injury Age:______ Describe: ______________________

☐ Loss of consciousness Age:______ How long? __________ Describe: ______________

☐ Allergies to food/medication List: ______________________

☐ Surgery Age:______ Reason: ______________ Describe: ______________

☐ Ear Infections Age:______ Describe: ______________________

Is the child up to date on immunizations? ☐ Yes ☐ No Why not? ______________

Doctors seen (check all that apply)

☐ Family Doctor Date of last visit: __________ Diagnosis: ______________

☐ Pediatrician Date of last visit: __________ Diagnosis: ______________

☐ Developmental Pediatrician Date: __________ Diagnosis: ______________

☐ Neurologist Date: __________ Diagnosis: ______________

☐ Suspected seizures Describe: ______________________

☐ Seizure type diagnosed: ______________________

☐ Genetics: Date: __________ Diagnosis: ______________

☐ Psychiatry: Date: __________ Diagnosis: ______________

☐ Endocrinology: Date: __________ Diagnosis: ______________

☐ Gastroenterology: Date: __________ Diagnosis: ______________

☐ Stomach/intestinal problems: Describe: ______________________

Diagnostic Testing (check all that apply)

☐ EEG (brain wave test) Date: __________ Results: ______________

☐ MRI Date: __________ Results: ______________

☐ CT Scan Date: __________ Results: ______________

☐ Ophthalmology Evaluation Date: __________ Results: ______________

☐ Chromosomal/DNA testing (Genetic) Date: __________ Results: ______________

☐ Other - Describe: ______________________

CLIENT NAME: ______________________ MRN: ____________

MEDICATION HISTORY

PLEASE NOTE: DO ADMINISTER child's regularly scheduled medications, if any, on the day of your appointment.

CHILD'S CURRENT MEDICATIONS:

Type: ____________ Dosage: ____________ How does it work? ____________

Type: ____________ Dosage: ____________ How does it work? ____________

Type: ____________ Dosage: ____________ How does it work? ____________

Type: ____________ Dosage: ____________ How does it work? ____________

Type: ____________ Dosage: ____________ How does it work? ____________

Who prescribes these medications? ____________ Date of last visit: ____________

Please also list any medications your child has been on in the PAST:

Name of medication	Dose & Frequency	Date Started	Date Ended/ Reason	Effectiveness

Who prescribed past medications? ____________

Family History

Have any members of the biological mother's or biological father's families had any of the following problems or disorders (check all that apply):

- ☐ Birth defect
- ☐ Chromosomal/genetic disorder
- ☐ Obsessive Compulsive Disorder
- ☐ Cerebral Palsy
- ☐ Severe head injury
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Migraine headaches
- ☐ Multiple sclerosis
- ☐ Physical handicap
- ☐ Nervousness/Anxiety
- ☐ Stroke
- ☐ Tuberous Sclerosis
- ☐ Alzheimer's disease
- ☐ Hemophilia
- ☐ Huntington's chorea
- ☐ Muscular dystrophy
- ☐ Parkinson's disease
- ☐ Sickle-cell anemia
- ☐ Cancer
- ☐ Seizures/epilepsy
- ☐ Diabetes
- ☐ Heart disease
- ☐ Food allergies
- ☐ Alcohol/drug abuse
- ☐ Depression
- ☐ Physical/sexual abuse
- ☐ Schizophrenia
- ☐ Reading problem
- ☐ Speech/language delay
- ☐ Autism/PDD
- ☐ Emotional disturbance/mental illness
- ☐ Other learning disability
- ☐ Mental Retardation
- ☐ Bipolar/manic-depressive disorder
- ☐ Tics/Tourette's syndrome
- ☐ Antisocial Behavior (assaults, thefts, arrests, etc.)
- ☐ Childhood behavior disorder (aggressive/defiant/ADHD)
- ☐ Other: ____________

Has anyone in the family ever received special education services? ☐ Yes ☐ No For what reason?

SCHOOL HISTORY

(If more space is necessary, please attach additional sheets or write on the back of this page.)

Current school: ______________________ School district: ______________

Grade level: ____________ Type of class: ☐ Regular Ed ☐ Special Ed ☐ SDC ☐ ED ☐ RSP

Current # of: Students: __________ Teachers: __________ Aides: __________

Does your child have a 1:1 Aide? ☐ Yes ☐ No

Has your child had special education testing in school? ☐ Yes ☐ No

☐ Psychological/Cognitive Date: __________ ☐ Speech/Language Date: __________

☐ Academic Date: __________ ☐ Other: Date: __________

Is your child receiving any special education services at school? ☐ Yes ☐ No

Is your child on an IEP (Individual Education Plan)? ☐ Yes ☐ No For what reason? __________

Please list all of the schools, including preschools, your child has attended:

Name of school	Age/grade attended	Hours per day	Days per week

SERVICES

School District (Please bring copies of your most recent Individual Education Plan (IEP)

Child's age when school services began: ______________________

Individual Education Plan (IEP) eligibility:

Which services is your child CURRENTLY receiving through the SCHOOL DISTRICT?

☐ Speech therapy ☐ Occupational therapy ☐ Physical therapy

☐ Adaptive Physical Education ☐ Discrete Trial Training (DTT/ABA) ☐ Social Skills

☐ Other – describe: ______________________

Regional Center: (Please bring copies of your most recent Regional Center assessment and Service Plan and relevant reports to your appointment.)

Is your child currently a client of the Regional Center? ☐ Yes ☐ No If No, skip to Private Services)

Which Regional Center: ______________________

Eligibility category: ______________________

Child's age when Regional Center services began: ______________________

Which services is your child CURRENTLY receiving through the REGIONAL CENTER?

- ☐ Speech therapy
- ☐ Occupational therapy
- ☐ Physical therapy
- ☐ Adaptive Physical Education
- ☐ Discrete Trial Training (DTT/ABA)
- ☐ Social Skills
- ☐ Other – describe: ____________________

Private Services (Please bring copies of relevant reports to your first appointment.)

Are you or your insurance companies currently paying for services to address your child's needs? ☐Yes ☐No

- ☐ Speech therapy Provided by: ____________________ Age when began: ________
- ☐ Occupational therapy Provided by: ____________________ Age when began: ________
- ☐ Physical therapy Provided by: ____________________ Age when began: ________
- ☐ Adaptive Physical Education Provided by: ____________________ Age when began: ________
- ☐ Social Skills Provided by: ____________________ Age when began: ________
- ☐ Other: ____________________ Describe: ____________________

Extracurricular activities

- ☐ Sports: ____________________
- ☐ Clubs: ____________________
- ☐ Hobbies: ____________________
- ☐ Church: ____________________

Strengths

What do you like best about the child? ____________________

What are the child's greatest assets? ____________________

What are the family's strengths? ____________________