UWMC ADULT AUTISM CLINIC – NEW PATIENT HISTORY AND INFORMATION

PLEASE NOTE: We encourage you to review these areas with other family members, such as parents, siblings or other individuals familiar with your early history.

Patient's Name: ______________________________ M / F Age:_______ Birthdate: _________________

____
Address City State Phone

Person completing this form: _____________________________ Relationship to patient: _______________

Who is legally responsible for the patient: ____

____
Address City State Phone

Referred to this clinic by: ____

____
Name Address City State Phone

Why are you seeking this evaluation? ____

____

PATIENT'S CURRENT LIVING SITUATION

Marital Status: ____________

With whom does the patient currently reside? (check all that apply) ☐ Lives Independently

☐ Spouse ☐ Life Partner ☐ Sibling

☐ Biological Mother ☐ Biological Father ☐ Step-mother ☐ Step-father

☐ Adoptive Mother ☐ Adoptive Father ☐ Group Home

☐ Other (describe): ____)

FAMILY CHANGES AND STRESSORS

What major family stresses is the family and/or patient currently experiencing or has experienced within the last year? (check all that apply)

☐ Marital discord/fighting ☐ Separation/divorce ☐ Birth/adoption of a child

☐ Parent-patient conflict ☐ Parent/sibling death ☐ Patient-child conflict

☐ Family deployed extensively ☐ Family emotionally/mentally ill ☐ Involved in court

☐ Family substance abuse ☐ Physical abuse ☐ Sexual abuse ☐ Financial problems

☐ Loss of job ☐ Residential move ☐ Involved with Social Services/Protective Services

☐ Other: ____

MEDICAL/SURGICAL HISTORY

Birth History

Any problems during pregnancy? ☐ None or explain:____

Any problems immediately following birth? ☐ None or explain:____________________________________

List any serious Illnesses or other health problems (other than colds): ☐ None

Type How Often Approximate Date

____

____

____

PLACE PATIENT LABEL HERE

MEDICAL/SURGICAL HISTORY (continued)

Current medications - please list below:

Type of Medication | Dose and Frequency | Reason

____
____
____

Past Medications list date and reason discontinued:

____
____
____
____

Hospitalizations/Surgeries: ☐ No ☐ Yes (if yes, list below)

Date | Hospital name and location | Reason

____
____
____
____

Serious Accidents or Injuries: ☐ No ☐ Yes (if yes, list below)

Date | Type

____
____

Drug or medication allergies? ____________________

Food allergies? ____________________

Environmental allergies? ____________________

Immunizations up to date? ____________________

DOCTORS SEEN NOW OR IN THE PAST

General Physician - name:____________________ Date last seen:__________

Developmental Pediatrician - name:____________________ Date last seen:__________

Neurologist - name:____________________ Date last seen:__________

Geneticist - name:____________________ Date last seen:__________

Psychiatrist - name:____________________ Date last seen:__________

Gastroenterologist - name:____________________ Date last seen:__________

Endocrinologist - name:____________________ Date last seen:__________

DIAGNOSTIC TESTING

EEG (brain wave test) – Date: __________ Results: ____________________

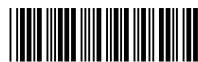
MRI – Date: __________ Results: ____________________

CT scan – Date: __________ Results: ____________________

Ophthalmology evaluation – Date: __________ Results: ____________________

Chromosomal/DNA testing (Genetic) – Date: __________ Results: ____________________

Other (describe): ____________________



FAMILY INFORMATION:

Birth Mother's Name: ______________________________ Age: ________
Education (highest grade): ______________________________
Place of Employment: ______________________________ Telephone: ____________________
Medical/academic/learning problems: ______________________________

Birth Father's Name: ______________________________ Age: ________
Education (highest grade): ______________________________
Place of Employment: ______________________________ Telephone: ____________________
Medical/academic/learning problems: ______________________________

Brothers/Sisters: List age and any medical/academic/learning problems: ______________________________

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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 and relationship to patient):

☐ 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 ☐ Mental Retardation ☐ Speech/language delay
☐ Autism/PDD ☐ Reading problem ☐ Other learning disability
☐ Emotional disturbance/mental illness ☐ 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? ☐ No ☐ Yes, for what reason? ____

____

SCHOOL HISTORY

Patient's Highest Level of Education: ☐ 11th grade or less ☐ High school graduate ☐ GED
☐ Vocational Certificate ☐ Associates Degree
☐ Bachelor's Degree
☐ Graduate/Professional

Did the patient have an IEP (Individualized education plan)? For what reason? ______________________

Psychological/cognitive testing-Date: ___________ Academic testing-Date: ____________

WORK HISTORY

Current Employer: ________________________________ Occupation: ______________________________

Employed since: _____________ # of hours: ______________

Require vocational assistance? ☐ Yes ☐ No

Currently working with Department of Vocational Rehabilitation (DVR): ☐ Yes ☐ No

Past employer and date employed:____

PAST/CURRENT SERVICES

Physical Therapy provide by:_____________________________________ Dates seen:_______________

Occupational Therapy provided by:________________________________ Dates seen:_______________

Speech Therapy provided by:_____________________________________ Dates seen:_______________

Vocational Therapy provided by:__________________________________ Dates seen:_______________

Social Skills provided by:_______________________________________ Dates seen:_______________

Psychotherapy provided by:______________________________________ Dates seen:_______________

Other: (describe)____ Dates seen:_______________

REVIEW OF SYSTEMS: Circle or check any past or current problems (if yes, please explain)

Eyes/vision problems ☐ No ☐ Yes ____

Ear, nose, or throat problems (recurrent ear infections) ☐ No ☐ Yes _____________________________

Gastrointestinal problems (stomach, digestive, constipation) ☐ No ☐ Yes _________________________

Growth/weight problems ☐ No ☐ Yes ____

Kidney problems ☐ No ☐ Yes ____

Heart or blood pressure problems ☐ No ☐ Yes ____

Blood Abnormalities (anemia, leukemia, etc.) ☐ No ☐ Yes ____________________________________

Respiratory problems (asthma, sleep issues, snoring) ☐ No ☐ Yes ______________________________

Neurological problems (seizures, shunts, bleed, stroke, meningitis) ☐ No ☐ Yes __________________

Skin problems (rashes, acne, eczema, etc.) ☐ No ☐ Yes _____________________________________

Endocrine problems (thyroid, diabetes) ☐ No ☐ Yes ____

Musculoskeletal (joints or bone) problems ☐ No ☐ Yes ______________________________________

Psychiatric problems (depression, bipolar, etc.) ☐ No ☐ Yes __________________________________

Smoker: ☐ No ☐ Yes, if yes how many packs per day ____ Year last quit _________

Alcohol: ☐ No ☐ Yes, if yes number of drinks per week ____________

Other drug use (describe): ____

What questions would you like answered at your appointment?

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