



Southlake Autism and Behavior Services, PA
355 Citrus Tower Blvd, Suite 116
Clermont, FL 34711
Phone: 352.223.1999 0 Fax: 352.600.3119
www.southlakeautism.com

Case History & Background Information

Today's Date: _____

Part I: Child and Family History

Child's Name: _____

Date of Birth: _____ Age: _____ Gender: M or F

Delivery: Vaginal C-section Weeks of gestation when the child was born _____

Were there any complications with pregnancy or delivery? Yes No. If yes, please explain

Current diagnosis (all)

age at time of diagnosis

What school does your child attend _____

Grade _____ Is there an IEP in place: yes no

If yes, what was the date of last IEP meeting _____

*please provide us with a copy of the IEP for the last 2 years.

What type of classroom is your child in at school:

mainstream, self-contained, combination

Describe (if any) the special support your child gets at school:

Child's home address: _____

Language(s) spoken in the home: _____

Child presently lives with: _____

Child's primary caregiver(s): _____

Parent's Full Name: _____

Date of Birth: _____

Occupation: _____

E-mail address: _____

Business Phone: _____

Cell phone: _____

Significant Medical history: _____

Parent's Full Name: _____

Date of Birth: _____

Occupation: _____

E-mail address: _____

Business phone: _____

Cell phone: _____

Significant Medical history: _____

Developmental History

At approximately what age did your child do the following?

	Early	Average	Late
Sit	_____	_____	_____
Crawl	_____	_____	_____
Walk	_____	_____	_____
Babble	_____	_____	_____
Use single words	_____	_____	_____
Combine 2 words	_____	_____	_____
Use phrases	_____	_____	_____
Use sentences	_____	_____	_____
Ask questions	_____	_____	_____
Engage in conversation	_____	_____	_____

Siblings:	Name	Date of Birth	School and grade
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Is there any family history of difficulties similar to those your child is experiencing? Is there any family history of language, learning or developmental delays, mental illness, autism or other pervasive developmental problems? If so, please describe. _____

Medications, list all separately:

<u>Name of medication</u>	<u>Dosage</u> <u>Frequency taken</u>	<u>For what</u> <u>diagnosis</u>	<u>Age when</u> <u>medication</u> <u>started</u>	<u>Prescribing doctor</u>
EXAMPLE: Vyvance	10 mg once a day	ADHD	4 years	Dr. Who

Current Treatment or Intervention:

☐Speech Therapy
 ☐Occupational Therapy
 ☐Physical Therapy
 ☐Behavior Intervention
 ☐psychotherapy

List special things your child likes: sugar cookies, Disney movies, toys, etc

<u>Edible</u>	<u>tangible</u>	<u>activity</u>	<u>social</u>	<u>Other</u>

List Food Allergies _____

List Insect Allergies _____

List Drug Allergies _____

If your child's medical history includes any of the following, please report the child's age at occurrence, number of occurrences and any other pertinent information.

Accidents: _____

Allergies: _____

Asthma: _____

Childhood diseases: _____

Colds (persistent): _____

Colic: _____

Ear infections: _____

Eye infections: _____

High fever (persistent): _____

Hospitalizations: _____

Operations: _____

Seizures: _____

Sinusitis: _____

Throat infections: _____

Tonsillitis: _____

Other: _____

Present medical conditions your child is being treated for:

History and Synopsis of concerns:

Describe **what your child spends most of his/her time doing** during the day when with you _____

Describe **what you spend most of your time doing** during the day when with your child _____

Does your child play alone? _____

Has your child had a recent hearing test?_____ Results?_____

Academics: Does your child:

Skill	Yes or No	Only w/ help	independently	Is ability consistent with age? Y N	Refuses
Read					
Identify letters					
Identify numbers					
Cut					
Sit for a story					
Color					
Write Color					
Hold a crayon					
Hold a pencil					
Sit in a chair					
Look when name is called					

Activities of Daily Living:

Skill	Yes or No	Only w/ help	independently	Is ability consistent with age? Y N	Refuses
Brush teeth					
Wipe after toileting					
Wash in the bath					
Pick out clothes					
Use a fork					
Use a spoon					
Drink from open cup					
Drink from sippy cup					
Dress					
Undress					
Tie shoes					

Additional concerns related to daily living skills

Sensory issues your child currently

Describe any Sensory seeking
behaviors_____

Describe any sensory defensiveness
behaviors_____

Self Injurious Behaviors: Does your child self-injure? Yes no

Ex. Head bang, cut, self-bite, skin pick

Describe_____

Safety skill deficits your child

has_____

Does your child feel pain? yes no How do you know?

Transitions: Does your child transition cooperatively from preferred activities to non-preferred activities?

Feeding and Nutrition:

Was your child breastfed or bottle fed? _____

When was your child weaned? _____

Was your child weaned to bottles, cups, or both? _____

Does your child currently drink from bottles, sippy cups, straws, or open cups?

Does your child use utensils independently? _____

Was feeding your child ever difficult? If so, please explain. _____

Does your child have any difficulty sucking, chewing, or swallowing? Please describe.

Is your child a picky or fussy eater? _____

Does your child eat a variety of foods? Please check all that apply.

soft _____ chewy _____ crunchy _____

sticky _____ pureed _____ hot _____

cold _____ meats _____ breads _____

fruits _____ vegetables _____ sour _____

sweet _____ spicy _____ dairy _____

If your child does not eat a variety of foods, please describe current diet. _____

Fruit	Vegetables	Lean meats	Dairy	Processed meats	Complex carbohydrates	Snack foods	Fast foods	Home cooked Fried foods	drinks	other

Narrow or Limited Interests: Does your child have limited interest in things (only plays with one toy, watches same movie, eats only certain food)_____

Stereotypical Behaviors: Does your child engage in repetitive behaviors such as spinning, hand flapping, echoing things heard, staring at lights, flicking fingers in front of eyes_____

Attending Skills: how long will your child sit and work on one activity_____. What does your child do if requested to complete a nonpreferred activity_____

Play Skills:

Describe your child's play skills

_____.

What is played with_____. Are toys played with as their intended purpose yes no. Who does your child play with: adults children alone. What does your child's interaction look like when playing with other children_____

Communication Development

When you talk to your child, how much do you feel is understood:

a few words_____ many words and phrases_____

simple directions and questions only_____

almost everything I say_____

How does your child communicate wants and needs? Check all that apply.

cries_____ points_____ signs_____

pulls toward object_____ gestures_____ vocalizes sounds_____

uses single words_____ uses many words, but only one at a time_____

uses phrases_____ uses long sentences_____

Does your child answer when you call?_____

Does your child answer yes/no and wh- questions?_____

Does your child ask for help?_____

Does your child talk about what he/she is doing?_____

What does your child like to talk about?_____

Does your child get stuck on a favorite topic or insist on only talking about what he or she wants to talk about: ie. Disney, dogs, sharks,

What percentage of your child's speech do you understand?_____

Can people outside the family understand your child's speech?_____

Does your child stutter or stammer?_____

Did you ever notice a change in your child's behavior, language, or social skills? If so,
please describe the change and when it occurred._____

What are your child's favorite toys and/or play activities?_____

Describe how he/she plays with them?_____

Does your child have any sensory difficulties (tactile, visual, auditory etc.)? If yes,
please describe._____

How does your child respond to changes in the environment or routine?_____

How does your child transition from one activity to the next?_____

Does your child prefer to be alone: yes no

Does your child show a preference to be with: adults children animals

Does your child insist on routines: yes no

How does your child gain attention?_____

Who does your child enjoy playing with?_____

Describe how your child interacts with adults and peers._____

Does your child engage in behaviors when things change, are out of order or otherwise different: yes no

Please describe such behaviors:

Present Concerns

Please describe your concerns regarding your child's speech, behaviors, feeding, play, following directions and/or social development._____

When did you first notice the difficulty?_____

Has the problem changed since you first noticed?_____

Is your child aware of the problem?_____

Does your child's communication difficulty cause frustration?_____

What have you done to help your child with these difficulties?_____

Has your child ever been evaluated for therapeutic services? If yes, when and what were the recommended services? _____

Does your child currently attend school or group activities? _____

How do his/her peers and teachers react to the communication difficulty? _____

What do you think will be helpful for your child? _____

What do you hope to gain from this evaluation? _____

Any additional comments or questions? _____

Completed by: _____

Print first and last name

signature

date

Relationship to child: _____