BACKGROUND & HISTORY

RESPONDENT INFORMATION

MRN:	
Full Name	
Birth Date:	
Date of Evaluation:	
Agree to allow child's KKI clinical information to be made part of the CAARE database to be used for research purposes:	
Agree to be contacted for current & future research opportunities:	

DEMOGRAPHIC INFORMATION

Who is completing this questionnaire right now?		**Are you the primary Caregiver?**	
If answered Other in the above Respondent field, please specify:		**Primary Caregiver Name:**	
Respondent Gender:		**Primary Caregiver Gender:**	
If Other Gender please specify:		**If Other Gender, please specify:**	
Biological Mother Name:		**Primary Caregiver Education:**	
Biological Father Name:		**Primary Caregiver Occupation:**	
Biological Mother Education:		**Primary Caregiver Marital Status:**	
Biological Father Education:		**Primary Caregiver Relation:**	
Mother Birth Date:		**If answered other in the above field, then specify:**	
Father Birth Date:		**Who referred you to CAARD?**	
No of Siblings:		**Referral Name:**	
Marital Status of Biological Parents:		**Referral Other:**	
Respondent Name:		**Are you a Legally Authorized Representative of the child?**	

BACKGROUND & HISTORY

SIBLINGS INFORMATION

	Age	Status	Diagnosis	Date of Birth	Gender	Name
Sibling 1:						
Sibling 2:						
Sibling 3:						
Sibling 4:						
Sibling 5:						
Sibling 6:						
Sibling 7:						
Sibling 8:						

SIBLINGS HEALTH OVERVIEW

	Sibling 1	Sibling 2	Sibling 3	Sibling 4
Autism Spectrum Disorder:				
Intellectual Disability:				
Speech Language Disorder:				
Attention Deficit Hyperactivity Disorder:				
Anxiety:				
Obsessive Compulsion Disorder:				
Depression:				
Bipolar Disorder:				
Schizophrenia:				
Siezure:				
Auto-Immune Disorder:				
Gastro Intestinal Disease:				
Learning Disability:				
Immune System Problems:				

	Sibling 5	Sibling 6	Sibling 7	Sibling 8
Autism Spectrum Disorder:				
Intellectual Disability:				
Speech Language Disorder:				
Attention Deficit Hyperactivity Disorder:				

BACKGROUND & HISTORY

	Sibling 5	Sibling 6	Sibling 7	Sibling 8
Anxiety:				
Obsessive Compulsive Disorder:				
Depression:				
Bipolar Disorder:				
Schizophrenia:				
Siezure:				
Auto-Immune Disorder:				
Gastro Intestinal Disease:				
Learning Disability:				
Immune System Problems:				

FIRST EVALUATION & OBSERVATIONS

Is this Pateient's first evaluation concerning Autism or any Developmental Concerns?		**Any Over or Under-Sensitivity to Objects, Events or Situations with the Patient:**	
Describe your Major Concerns:		**Patient's Strengths:**	
Any difficulties or unusual patterns in speech:		**Patient's Weakness:**	
Any Unusual Behavior that you have observed in the Patient:		**Describe your expectations for your evaluation at CAARD:**	

HEALTHCARE DELAY OVERVIEW

During the past 12 months did the patient required care that was not received?		**Care Delay Vision:**	
Care Delay Medical:		**Care Delay Hearing:**	
Care Delay Dental:		**Care Delay Other:**	
Care Delay Mental:		**Care Delay Other Desc.**	

HEALTHCARE DELAY REASONS

	Not Eligible / Not Available / No Appointment / Transportation Issue / Cost Issue
Delay Reason Medical:	
Delay Reason Dental:	
Delay Reason Mental:	
Delay Reason Vision:	
Delay Reaon Hearing:	
Delay Reason Other:	

BACKGROUND & HISTORY

LANGUAGES

Is any Language besides English spoken in the Child's Home?		**Language 4:**	
Language 1:		**Are you worried about the Child's development?**	
Language 2:		**If yes, then why?**	
Language 3:		**Is there anything else you would like to share about the Patient?**	

CAREGIVER DETAILS

	Name	Age	Relationship
Caregiver 1:			
Caregiver 2:			
Caregiver 3:			
Caregiver 4:			
Caregiver 5:			
Caregiver 6:			
Caregiver 7:			
Caregiver 8:			

Social Connections:	
Culture Values:	

MATERNAL FAMILY HISTORY

	Mom	Grandma	Grandpa	Aunt	Uncle	Cousin
Autism Spectrum Disorder:						
Intellectual Disability:						
Speech Language Disorder:						
Attention Deficit Hyperactivity Disorder:						
Anxiety:						
Obsessive Compulsive Disorder:						
Depression:						
Bipolar Disorder:						
Schizophrenia:						

BACKGROUND & HISTORY

	Mom	Grandma	Grandpa	Aunt	Uncle	Cousin
Siezures:						
Auto-Immune Disorders:						
Gastro Intestinal Disease:						
Diff with Learning:						
Immune System Problems:						

OTHER MATERNAL FAMILY HISTORY

Condition 1:		**Condition 3:**	
Condition 2:		**Condition 4:**	

	Mom	Grandma	Grandpa	Aunt	Uncle	Cousin
Other 1:						
Other 2:						
Ohter 3:						
Other 4:						

PATERNAL FAMILY HISTORY

	Dad	Grandma	Grandpa	Aunt	Uncle	Cousin
Autism Spectrum Disorder:						
Intellectual Disability:						
Speech Language Disorder:						
Attention Deficit Hyperactivity Disorder:						
Anxiety:						
Obsessive Compulsive Disorder:						
Depression:						
Bipolar Disorder:						
Schizophrenia:						
Siezures:						
Auto-Immune Diorders:						
Gastro Intestinal Disease:						
Diff with Learning:						
Immune System Problems:						

BACKGROUND & HISTORY

OTHER PATERNAL FAMILY HISTORY

Condition 1:		**Condition 3:**	
Condition 2:		**Condition 4:**	

	Dad	Grandma	Grandpa	Aunt	Uncle	Cousin
Other 1:						
Other 2:						
Other 3:						
Other 4:						

PREGNANCY & BIRTH HISTORY

Is Birth History of the Patient Available:		**Live Births of the Biological Mother Number:**	
Pregnancies of the Biological Mother:		**Biological Birth Order of the Patient:**	

	Yes / No / Unsure		Yes / No / Unsure
Did the mother receive assisted Reproductive Technology for patient's conception?		**Occurred during Pregnancy - Other Illness:**	
Was the Patient's Pregnancy Planned?		**During Pregnancy did the mother ever take any prescription Medications?**	
Did the mother experience Pre-Term Labor?		**Depakot (Depakene,Valproic Acid) taken during Pregnancy:**	
Occurred During Pregnancy - Fever:		**Lithium taken during Pregnancy:**	
Occurred During Pregnancy - Infection:		**Anti Epileptics taken during Pregnancy:**	
Occurred During Pregnancy - Spot Bleed:		**Anti Depressants taken during Pregnancy:**	
Occurred During Pregnancy -Threatened Miscarriage:		**Asthma Medication taken during Pregnancy:**	
Occured During Pregnancy - High BP:		**Did the mother consume alcohol during Pregnancy?**	
Occurred During Pregnancy - Diabetes:		**Did the mother consume tobacco during Pregnancy?**	

BACKGROUND & HISTORY

	Yes / No / Unsure		Yes / No / Unsure
Occurred During Pregnancy Rh Incompatibilty:		Did the mother consume Marijuana. THC or CBD oil during Pregnancy?	
Occurred During Pregnancy - Severe Stress:		Did the mother consume other substance during Pregnancy?	
Occurred During Pregnancy - Accidents:		What type of assisted Reproductive Technology was used?	
Other Illnesses during Pregnancy:		Other Medcations taken during Pregnancy:	

CHILD BIRTH DETAILS

Pregnancy Length:		Was Pitcoin used to augment Labor:	
Labor Length (In Hours):		Any drugs used to slow or augment Labor:	
APGAR 1 min Test:		List the drugs use to slow or augment Labor:	
APGAR 5 min Test:		Labor or Delivery complications - Breech:	
Birth Weight (Lb):		Labor or Delivery complications - Forcep:	
Birth Weight (Oz):		Labor or Delivery complications - Coord Neck:	
Delivery Type:		Labor or Delivery complications - Other:	

POSTPARTUM CONDITIONS

	Breast / Bottle / Both / Unsure
How was the patient initially Fed?	

	Yes / No / Unsure		Yes / No / Unsure
Any feeding difficulties during the first month?		Have problems with sleeping during Pregnancy:	
Any injections during the first month of life?		Experience any Sensory Motor Isuues during Pregnancy:	

BACKGROUND & HISTORY

	Yes / No / Unsure		Yes / No / Unsure
Experience Jaundice during the first month of life:		Ever show any Self Injurious behaviour during Infancy?	
Experience Seizures or Spasms during the first month of life:		Enjoy cuddling during Infancy:	
Cry excessively during Infacny:			

MULTIPLE BIRTH DETAILS

Was the patient a product of Multiple Births?		How many days in the NICU?	
Multi Birth Type:		Twin Birth Weight A1 (lbs):	
Twin Type:		Twin Birth Weight A2 (oz):	
Twin APGAR:		Twin Birth Weight B1 (lbs):	
For this delivery what was the birth order of the Patient?		Twin Birth Weight B2 (oz):	
Was the patient admitted to NICU?		Twin Birth Weight C1 (lbs):	
Why was the patient admitted to NICU?		Twin Birth Weight C2 (oz):	

MEDICAL HISTORY & HEALTH CONDITIONS

	Previously a Problem / Currently a Problem / Never a Problem		Previously a Problem / Currently a Problem / Never a Problem
Sleep:		Skin:	
Headache:		Endocrine:	
Vision:		Seizure:	
Hearing:		Tics:	
Dental:		Head Injury:	
Heart:		Allergies:	
Asthma:		History of NICU:	
Fine Motor:		Failure to thrive:	
Eat/Feeding:		Tuberous Sclerosis:	
Please describe the eating and feeding conditions:		Downs Syndrome:	

BACKGROUND & HISTORY

Kidney:		**Retts Syndrome:**	
Bone or Joints:		**Fragile X:**	
Gross Motor:		**Other Genetic Conditions:**	
Blood or Anaemia Conditions:		**Please describe allergies:**	

Genetic 1:		**Genetic 4:**	
Genetic 2:		**Genetic 5:**	
Genetic 3:		**Did the patient lose consciousness when the Head Injury Happened?**	

HOSPITALIZATIONS

Hospital:	

	Hospital 1	Hospital 2
Stay:		
Date:		
Days:		
Reason for Stay:		

MENTAL HEALTH CONDITIONS

	Suspected of Having / Diagnosed / Never Diagnosed
Depress:	
Bipolar:	
Anxiety:	
Obsessive Compulsive Disorder:	
Attention Deficity Hyperactivity Disorder:	
Other Psych:	
Other Psychiatric Disorder, please specify:	

OTHER INFORMATION:

About how tall is the patient (ft)?			
About how tall is the patient (in)?		**About how much does the patient weigh (lbs)?**	
Was the patient born with any Birth Defects?		**Describe Birth Defects:**	

BACKGROUND & HISTORY

HEARING TEST INFO

	Hear Test 1	Hear Test 2	Hear Test 3
Provider:			
Location:			
Date:			
Results:			
Description:			

Hear Test Newborn:		**Hear Test Since:**	

DEVELOPMENTAL HISTORY

	Years	Months	Age
Sit:			
Crawl:			
Walk:			
Ride a tricycle:			
Fully toilet trained:			
Button-up clothing:			
Tie shoelaces:			
Use a fork/spoon without spilling:			
Spoke first word other than mama/dada:			
Speak phrases with at least 2-3 words:			
Can have a conversation:			
Tell you about their day:			
Read:			

How does the patient usually communicate:		**Does the patient use sign language or any other communication device:**	

Picture based supports:		**Please describe Patient's toileting habits:**	[strToiletDesc]
Speech generating device:		**Did the Patient ever lose skills that he/she previously had?**	
Does the patient use any other communication method?		**At what age did you first notice the loss (months)?**	
What other method does the patient use?		**At what age did you first notice the loss (years)?**	
Describe loss of skills:			

BACKGROUND & HISTORY

Does the patient have problem talking?		**Does the patient have Problem Understanding?**	
Does the patient have problem hearing?		**Any Concerns about Patient's play with toys?**	
Does the patient have problem being understood?		**Describe patient's play with toys at a young age and anything Unusual about his/her Play:**	

BEHAVIORAL & EDUCATIONAL PROGRAMS (1= Yes, 0= No):

Has patient participating / participated in the Infant / Toddler program?		**Services Patient is Receiving - Physical Therapy:**	
Infant/Toddler Type patient is part of:		**Services Patient is Receiving - Individual Counseling:**	
Do you have any Concerns about the patient's performance in specific academic areas?		**Services Patient is Receiving - Family Therapy:**	
Describe the academic Concerns you have:		**Services Patient is Receiving - AcademicTutoring:**	
Services Patient is Receiving - Speech Therapy:		**Services Patient is Receiving - Social Skills Training:**	
Services Patient is Receiving - Early Intervention:		**Services Patient is Receiving - Special Instructions:**	
Services Patient is Receiving - Behavioral Management:		**Services Patient is Receiving - Other:**	
Services Patient is Receiving - Applied Behavioral Analysis:		**Services Patient is Receiving - Other:**	
Services Patient is Receiving - Occupational Therapy:			

SERVICE PROVIDER & FREQUENCY SUMMARY

	How Often	How many sessions per week/month?	Name of Service Provider	Currently receiving/Previously received
Speech Therapy:				
Early Intervention:				
Behavior Management:				
Applied Behavior Analysis:				

BACKGROUND & HISTORY

	How Often	How many sessions per week/month?	Name of Service Provider	Currently receiving/Previously received
Occupationa Therapy:				
Physical Therapy:				
Individual Counseling:				
Family Therapy:				
Academic Tutoring:				
Social Skills Tutoring:				
Special Instruction:				
Other:				

THERAPY LOCATIONS

	In which setting		In which setting
Speech Therapy:		Individual Counseling:	
Early Intervention:		Family Therapy:	
Behavior Management:		Academic Tutoring:	
Applied Behavior Analysis:		Social Skills Tutoring:	
Occupational Therapy:		Special Instructions:	
Physical Therapy:		Other:	

DAYCARE INFORMATION

Is the Patient in any Childcare program?		What type of classroom environment is Patient in?	
Name of the Daycare /ChildCare program:		School Name:	
Are you waiting for or receiving- Developmental Disabilities Administration?		School State:	
Are you waiting for or receiving - Autism Waiver?		School Country:	
Are you waiting for or receiving - Social Security Income?		School Type:	
Are you waiting for or receiving- Division of Rehabilitation Services?		Patient is in what Grade?	
Is the Patient in School?		If other, please specify the grade:	

BACKGROUND & HISTORY

BEHAVIORAL & PSYCHIATRIC FUNCTIONING

	How often?	Home	School	Community	Doctor Office
Aggression:					
Verbal Aggression:					
Explosive Outbursts:					
Property Destruction:					
Non Compliance:					
Elopement:					
Self Injururios Behavior:					
Talking about wanting to be dead/Suicide:					
Talking about wanting to kill others:					
Pica:					
Fecal Smearing:					
Disrobing:					
Unsafe Sexual Behavior:					
Starting Fires:					
Unsafe in Car:					

BEHAVIORAL PATTERNS

Has any of the above behavior resulted in Injury to self or others?		
Has your child received Treatment for any of the above behaviors?		
Has any of the behaviors above prompted a Emergency Behavior?		
Hospital Behavior:		
Is your child waiting for placement in a Residential Treatment center?		
What works to help your child calm down?		
Manage Behavior:		

BACKGROUND & HISTORY

DIET & CAM

Is Patient on a Special Diet?		**Chiropractic:**	
Gluten Free Diet:		**Sulfation:**	
Casien Free Diet:		**High dosing Vitamin B6 or Magnesium:**	
No Processed Sugar:		**Amino Acid:**	
No Sugar Salicylates:		**Other Vitamins:**	
Fein Gold Diet:		**Essential Fatty Acids:**	
Diet Other (int):		**Probiotics:**	
Describe Other Diet:		**Hyperbaric Oxygen:**	
Does the Patient receive any other treatment - Alternative Thereapy?		**Anti Fungal:**	
Acupuncture:		**Digestive Enzymes:**	
Chelation:		**Cooling:**	
Rolfing:		**Any Other (int):**	
Glutathione:		**Describe the Other Alternative Therapy:**	

VITAMIN INTAKE DETAILS

Is the Patient currently taking any vitamins or supplements?	
Number of Vitamins the patient is taking:	

	Name	Reason
Vitamin 1/Supplement 1:		
Vitamin 2/Supplement 2:		
Vitamin 3/Supplement 3:		
Vitamin 4/Supplement 4:		
Vitamin 5/Supplement 5:		
Vitamin 6/Supplement 6:		
Vitamin 7/Supplement 7:		

BACKGROUND & HISTORY

MEDICATIONS INTAKE DETAILS

Does the patient take any Medications?	
How many prescribed medications does the patient currently take?	

	Name	Reason	Prescriber	Prescriber Type
Medication 1:				
Medication 2:				
Medication 3:				
Medication 4:				
Medication 5:				
Medication 6:				
Medication 7:				

GASTROINTESTINAL SYMPTOMS

Abdominal/Belly pain:		**Spit up to 2 or more times a day:**	
Nausea:		**Retching:**	
Bloatong:		**Tilted head to the side and arched back:**	
Constipation:		**Regurgitated food and chewed it again:**	
Diarrhea:		**Refuse many foods that the patient would eat in the past:**	
Other:		**Other Gastro Intestinal and tummy symptoms:**	

AUTISM PARENTING STRESS INDEX (APSI)

Social Development:		**Diet:**	
Communication Ability:		**Bowel Problem:**	
Tantrums:		**Potty Training:**	
Aggressive:		**Feel Close:**	
Self Injury:		**Concern Accepted:**	
Diff Transition:		**Concern Living:**	
Sleep Problem:			

Autism Score:		**Physical Score:**	
Behaviors Score:		**Total Score**	