UNLV School of MEDICINE

Grant a Gift AUTISM FOUNDATION

UNLV Ackerman Center for Autism and Neurodevelopment Solutions

630 S Rancho Drive, Suite A, Las Vegas, NV 89106
Phone: (702) 998-9505 • Fax: (702) 527-5353

Clinical Diagnostic Intake Form

Please fill out this questionnaire as completely as possible. All information will be kept strictly confidential. If you have questions or need help with this form, please contact: UNLV Ackerman Center (702) 998-9505.

Child's Name	Date of Birth	Age	Male _____ Female____
School		Grade	Form Completion Date
Form Completed By	Relationship to Patient		
Referred By:			

Please describe your concerns about your child:
1. _____
2. _____
3. _____
4. _____

Please describe your child's strengths:

_____

_____

MEDICAL HISTORY

PREGNANCY	Yes	No	Comment
Complications	____	____	_____
Excessive stress	____	____	_____
Diabetes	____	____	_____
Exposure to: Alcohol	____	____	_____
Tobacco/Smoking	____	____	_____
Drugs	____	____	_____
Medications	____	____	_____
BIRTH	**Yes**	**No**	**Comment**
Born term (37-40 weeks)	____	____	If not when?_____
Delivery was a C-section	____	____	If yes, why?_____
Problems during delivery	____	____	_____
What was the birth weight	_____lbs	_____oz	
Breathing problems	____	____	_____
Feeding problems	____	____	_____
Birth defects	____	____	_____
Extended hospital stay/ NICU?	____	____	Why?_____ _____
Jaundice	____	____	Treatment?_____
CHILDHOOD	**Yes**	**No**	**Comment**
Reflux	____	____	_____
Poor/slow growth	____	____	_____
Serious infection	____	____	_____
Seizures	____	____	_____
Ear infections	____	____	_____
Heart problems	____	____	_____
Serious accidents/injuries	____	____	_____
Hospitalizations	____	____	_____
Surgeries	____	____	_____
Previous/current diagnoses	____	____	What?_____ Who diagnosed?_____

DEVELOPMENTAL HISTORY

Was the child's early developmental typical/normal? Yes___ No___ Comment_____

Please list approximate age when the child (or circle Not Yet):

Rolled Over	_____ months old	Not Yet	Dressed independently	_____ years	Not Yet
Sat up	_____ months old	Not Yet	Ate with a spoon	_____ years	Not Yet
Walked alone	_____ months old	Not Yet	Could speak 4-5 single words	_____ years	Not Yet
First combined words	_____ months old	Not Yet	Spoke so others could understand	_____years	Not Yet
Toilet Training- Urine	_____ Years	Not Yet	Toilet Training- Bowel	_____ Years	Not Yet
Dry at Night	_____ Years	Not Yet			

Has the child had an evaluation? No____ Yes_____ When?_____ Result?_____
Reason for evaluation?_____
Do you expect your child to have any difficulty with the physical and neuropsychological examinations? No_____ Yes_____
If yes, please check the reason: Fear of doctors/dentists/medical procedures_____ Fear of new situations_____
Oppositional/defiant behavior _____ Difficulty understanding/following directions_____
Other:_____
Do you feel that your child needs special assistance for examinations for one of the above reasons? No_____ Yes_____

FAMILY HISTORY

Has anyone in your family ever been diagnosed with:

	Yes	No	Who
ADD/ADHD			
Autism/Asperger's/PDD NOS			
Developmental Delay			
Genetic syndrome			
Birth defect			
Intellectual Disability			
Speech/language problems			
Learning disability/dyslexia			
Hearing problems			
Vision problems			
Depression			
Anxiety			
Bipolar			
Heart problems			
Substance Use			
Suicide			
Schizophrenia/Schizoaffective Disorders			

PARENT/GUARDIAN HISTORY

Parent/Guardian #1	Occupation	Age
Health Problems	School Level Completed: K-8th Grade _____ 9th____ 10th____ 11th____ 12th ____ Technical School____ Some College___ Graduated College____ Post College_____	
Parent/Guardian #2	Occupation	Age
Health Problems	School Level Completed: K-8th Grade _____ 9th____ 10th____ 11th____ 12th ____ Technical School____ Some College___ Graduated College____ Post College_____	

Child's Brother(s) Age(s) _____ _____ _____ _____ General Health_____
Child's Sister(s) Age(s) _____ _____ _____ _____ General Health_____

REVIEW OF SYSTEMS

	Yes	No	Comment
Problems playing with peers			
Headaches			
Vision problems			
Hearing problems			
Allergies			
Asthma			
Chest pain			
Stomachache			
Constipation			
Diarrhea			
	Yes	No	Comment
Joint pain			
Problems falling asleep			
Snoring			
Muscle Pain			
Tired during the day			
Seems sad, unhappy, depressed			
Cries or whines easily			
Seems nervous or irritable			
Tics or twitches			

What time does the child go to sleep at night? _____PM What time does the child wake up? _____AM
What kind of eater is the child? Good ____ Picky_____ Overeats_____ Poor_____ Comment:_____
Special Diet? Yes_____ No_____ If yes, describe: _____
Media hours per day: TV_____ Computer_____ Video Games_____

Please list any:
-**Current Medications**:_

Current Medications	**Dosage**	**Prescribing Provider**

-**Other doctors seen**:
Pediatrician_____ Neurologist_____ Psychiatrist_____ Other: _____

SCHOOL PERFORMANCE **(Grade 1 & above)**

Is your child receiving special services in school? No_____ Yes_____ If Yes, please describe/list below:
_____
_____
_____

****Please provide a copy of all evaluations and IEP****

Has your child ever repeated a grade? No_____ Yes_____ If yes, please list the grades repeated _____
How long does homework take to complete? _____

School Skills: Please check the correct level				
	Don't Know	Below Grade	At Grade	Above Grade
Reading				
Spelling				
Written				
Oral				
Math				
Calculation (can they +/-)				
Application (when to +/-)				
Writing				
Speed				
Neatness (how to form letters)				
Content (what they write about)				
Study Skills				
Completing homework				
Remembering homework				
Knowing what & how to study				
Handing it in the next day				
Organizational Skills				
Loses school materials				
Forgets notes, papers & projects				
Waits until the last minute to do things				

What time is homework usually done? Never____ Before dinner____ After dinner____ After school program_____
As soon as he/she gets home from school_____
How long does homework usually take? 15 minutes ____ 30 minutes____ 1 hour____ 1-2 hours_____ 2-3 hours_____ More than 3 hours ____

BEHAVIOR INVENTORY

Inattention	Never	Just a Little	Often	Almost always
Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities				
Often has difficulty sustaining attention in tasks or play activities				
Often does not seem to listen when spoken to directly				
Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)				
Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort such as schoolwork or homework				
Often distracted by extraneous stimuli				
Often forgetful in daily activities				
Hyperactivity	Never	Just a Little	Often	Almost Always
Often fidgets with hands or feet or squirms in seat				
Often leaves seat in classroom or in situations in which remaining seated is expected				
Often runs about or climbs excessively during situations in which it is inappropriate (in adolescents, it may be feelings of restlessness)				
Often has difficulty playing or engaging in leisure activities quietly				
Is often "on the go" or often acts as if "driven by a motor"				
Often talks excessively				
Impulsivity	Never	Just a Little	Often	Almost Always
Often blurts out answers before questions have been completed				
Often has difficulty awaiting turn				
Often interrupts or intrudes on others (i.e. butts into conversations or games, or talks out of turn)				
Oppositional	Never	Just a Little	Often	Almost Always
Loses temper				
Argues with adults				
Refuses to obey rules or commands				
Deliberately annoys people				
Blames others for personal mistakes or misbehaviors				
Is touchy or easily annoyed by others				
Seems angry/spiteful or warns revenge				

Peer Interactions/ Social Skills	Never	Just a Little	Often	Almost Always
Has a friend				
Makes friends easily				
Keeps friends				
Is bossy- needs to be in control				
Shows good sportsmanship				
Is physically aggressive				
Prefers to play alone				
Gets teased				
Teases others				
Prefers peers who are (circle which apply): younger, older or same aged				

Additional comments or concerns:

_____

_____

_____

_____

Signature:_____ Date:_____
Parent/Guardian