INTEGRATED AUTISM CONSULTING

# History Form for Adult Client

Referral Date: ____________________________________________________

Who referred you to our office (please circle one)?

Self Other, please specify: __________________________________________

**Reason for Referral:**

Require a Diagnostic Evaluation for Autism Spectrum Disorder

Have an ASD diagnosis and need Treatment Services

Other: _____________________________________________________________

## CLIENT INFORMATION

Date Form Completed: _________________________________

First Name: ________________________________

Last Name: _________________________________________

Birth Date: ______________________

Sex: Male Female Transgender

**Mailing Address:**

___________________________________________________________________Suite or Apt #:__________________ City: __________________________________________Province: ____________________Postal Code:________________ County:______________________

Email: ____________________________________________________________

Primary Phone: ______________________________________

Alternate Phone #: ______________________________________

**Current Living Situation**:

- Independently alone with spouse or life partner
- Independently with friends
- With both biological parents
- With biological father
- With biological mother
- With biological father and stepmother
- With biological mother and stepfather
- With adoptive parents
- With foster parents
- In a group home
- In a supervised apartment with other, who? ___________
- Other:_____________________________________________

Client's marital status: Single /Married /Separated /Divorced /Remarried /Living with Life Partner

Will anyone be accompanying you to appointments/sessions? Yes No

If yes, Name: ________________________________________________________________

Relationship ________________________________________________

Language Spoken at home: __________________________________________________

Will an interpreter be needed? Yes No

## EDUCATIONAL/VOCATIONAL INFORMATION

Client Education (check highest level completed):

_____ PhD or Masters university degree

_____ 3/4-year university degree

_____ College degree

_____ Some college or university

_____ Ontario Secondary School Diploma

_____ Ontario Secondary School Certificate

_____ 1-3 years of secondary school

_____ Completed up to ninth grade

_____ Completed less than ninth grade

Did you receive special assistance in school? Yes No

If yes, please describe the type of extra academic assistance or special class placement:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

History of Behavioural Issues: [verbal/physical aggression, threats/bullying, inappropriate sexualized behaviour, violence towards self or others?]

(Please circle one): YES / NO If you circled YES, describe:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Involvement in conflict with the Law/Criminal Justice System? Yes/No. If yes, please indicate involvement and date(s):

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

During the day, do you currently:

Have a job? Yes No

Occupation: ____________________________________________________

Place of employment:_____________________________________________

Go to school? Yes No

Name of School: _________________________________________________

Attend a day program? Yes No

Name of day program: _____________________________________________

Unemployed? Yes No

If yes, for how long? ___________________

Other, please specify:

Do you have access to Group Benefits? If so, who is your provider?

_______________________________________________________________________________

## MEDICAL HISTORY

Please check any of the following professionals with whom you have had contact over the years, even as a younger child.

| *Medical Professional & Name* | *Address* | *Phone #* | *Check the box if you* ***currently*** *see them (in the past 6 months)?* |
|---|---|---|---|
| Primary Care Physician<br><br>Name: | | | |
| Neurologist<br><br>Name: | | | |
| Psychologist<br><br>Name: | | | |
| Speech Therapist<br><br>Name: | | | |
| Occupational Therapist<br><br>Name: | | | |
| Physical Therapist<br><br>Name: | | | |
| Audiologist<br><br>Name: | | | |
| Social Worker<br><br>Name: | | | |

**Have you had any of the following? Please indicate age.**

| Check if yes | Condition | Age diagnosed | Check if yes | Condition | Age diagnosed |
|---|---|---|---|---|---|
| | Meningitis | | | Recurrent ear infections | |
| | Accident (be specific): | | | Chicken pox | |
| | Heart disease | | | Recurrent tonsillitis | |
| | Poisoning | | | Fainting spells | |
| | Convulsions/Seizures | | | Measles | |
| | Measles | | | Mumps | |
| | Whooping cough | | | Eye/vision problems | |
| | Recurrent ear infections | | | Allergies | |
| | Digestive difficulties | | | Severe reaction to immunizations | |
| | CNS (brain) studies (e.g., MRI/CT scan) | | | Attempts to self harm | |
| | Threats and/or attempts to harm others | | | Surgery (please specify): | |
| | Chromosomal studies (please specify): | | | Genetic studies (please specify): | |
| | Abuse/Neglect | | | Head injuries | |
| | Other: | | | Other: | |

**Please check any of the following behavioral or psychiatric diagnoses that you have been given over the years regardless of whether you believe it currently applies.**

| Check if yes | Diagnosis | If yes, by whom? | Check if yes | Diagnosis | If yes, by whom? |
|---|---|---|---|---|---|
| | Alcoholism | | | Post-Traumatic Stress Disorder (PTSD) | |
| | Anxiety disorder | | | Bipolar Disorder | |
| | Autism | | | Manic Depression | |
| | Asperger's Syndrome | | | Depression | |
| | Hyperactivity Disorder | | | Intellectual disability | |
| | Pervasive Developmental Disorder (PDD-NOS) | | | Sensory Integration Disorder | |
| | Seizure Disorder | | | Obsessive Compulsive Disorder (OCD) | |

| | Substance Abuse (drugs) | | | Personality Disorder | |
|---|---|---|---|---|---|
| | Other (please specify) | | | Other (please specify) | |

**What medication(s) and/or vitamins have you taken or are currently taking (If needed attach another page with other medication you have or are taking)?**

Medication: Date(s):

Reason/Effectiveness:

Medication: Date(s):

Reason/Effectiveness:

Medication: Date(s):

Reason/Effectiveness:

Medication: Date(s):

Reason/Effectiveness:

## FAMILY TREE

**If any of your biological relatives have had any of the following conditions, please write the person's relationship to you next to the condition. (By relatives, we mean grandparents, aunts, uncles, first cousins on both sides and your brothers, sisters and parents).**

| **Condition** | **Biological Mother's side of the family** | **Biological Father's side of the family** |
|---|---|---|
| Autism spectrum Disorder | | |
| Communication Disorder | | |
| Convulsions, seizures, epilepsy | | |
| Cerebral Palsy, muscular weakness | | |

| Hearing Loss | | |
|---|---|---|
| Intellectual disability | | |
| School difficulties | | |
| Developmental Delay | | |
| Speech Delay | | |
| Schizophrenia | | |
| Depression | | |
| Dyslexia | | |
| Autoimmune Disorder (e.g., lupus, MS, thyroid) | | |
| Mood Disorder | | |
| Sensory Integration Disorder | | |
| Anxiety Disorder | | |
| Reading Difficulty | | |
| **Condition** | **Mother's side of family** | **Father's side of family** |
| Attention Deficit Hyperactivity Disorder | | |
| Bipolar disorder | | |
| Alcoholism/Substance abuse | | |
| Other, please specify | | |