



## 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:

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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:

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

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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?

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**MEDICAL HISTORY**

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

<i>Medical Professional &amp; Name</i>	<i>Address</i>	<i>Phone #</i>	<i>Check the box if you <b>currently</b> see them (in the past 6 months)?</i>
Primary Care Physician Name:			
Neurologist Name:			
Psychologist Name:			
Speech Therapist Name:			
Occupational Therapist Name:			
Physical Therapist Name:			
Audiologist Name:			
Social Worker 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		
<b>Condition</b>	<b>Mother's side of family</b>	<b>Father's side of family</b>
Attention Deficit Hyperactivity Disorder		
Bipolar disorder		
Alcoholism/Substance abuse		
Other, please specify		