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ACES FOR AUTISM

Client Information – Emergency Contact/Medical History/Treatment Release

Client Information			
Name (First, M.I., Last):			
Date of birth:	Sex/Gender:	Preferred Name:	
Race/Ethnicity:	Child lives with:	Primary Language:	
Street Address:			
City:	State:	ZIP Code:	County:

Parent/Guardian (A) Information:			
Name (First, M.I., Last):			
Date of birth:	Sex/Gender:	Preferred Name:	
Race/Ethnicity:	Relationship to Client:	If Legal guardian, indicate relationship to client:	
Street Address:			
City:	State:	ZIP Code:	County:
Email:		Primary Language:	
Home Phone:	Cell Phone:	Work Phone:	

Parent/Guardian (B) Information:			
Name (First, M.I., Last):			
Date of birth:	Sex/Gender:	Preferred Name:	
Race/Ethnicity:	Relationship to Client:	If Legal guardian, indicate relationship to client:	
Street Address:			
City:	State:	ZIP Code:	County:
Email:		Primary Language:	
Home Phone:	Cell Phone:	Work Phone:	

Person Financially Responsible (Guarantor)			
If person financially responsible is Guardian A or Guardian B circle which on and skip to next section: Guardian A / Guardian B			
Name (First, M.I., Last):			
Date of birth:	Sex/Gender:	Preferred Name:	
Relationship to Client:	Power of Attorney:		
Street Address:			
City:	State:	ZIP Code:	County:
Email:	Employer:		
Home Phone:	Cell Phone:	Work Phone:	

Insurance Information			
Is the client covered by Medicaid? Yes ☐ No ☐	If yes, please provide Medicaid program's phone number: _____ Medicaid Member ID #: _____		
Insurance Provider:			
Effective Date:	ID#:		
Name of Insurance Company:		Group #:	
Name of Insured (subscriber):	Relationship to Client:		
Insured Street Address:			
City:	State:	ZIP Code:	County:
Date of Birth:	Social Security #:		
Home Phone:	Cell Phone:	Work Phone:	
Email:	Employer:		

Authorization for the Release of Medical Information and Assignment of Benefits

I authorize the release of my medical record from Aces for Autism Developmental Day Center in order to process any claims. I hereby authorize payment directly to Aces for Autism Developmental Day Center for mental health benefits entitled under my insurance plans. I understand that as the client (or the client's parent/guardian) I am responsible for full payment. U understand fees for visits or evaluation serves are payable at the time of service unless covered by insurance or arrangements have been made in advance.

_____ _____

Client Date

_____ _____

Signature of Client Legally Responsible Person Relationship to Client

_____ _____

Witness Date

Significant Life Events: Have any of the following stressful events happened within the past 12 months? Please check all those that apply			
☐	Parents divorced or separated	☐	Family accident or illness
☐	Death in the family	☐	Death of family pet
☐	Change or loss in employment	☐	Change in child care arrangements
☐	Change in school	☐	Family Moved
☐	Family financial difficulties	☐	Other:
☐	Other:	☐	Other:
Comments/Description:			

Family History:
Please note if any family member has had any of the following disorders on the left side by checking the box

	Client	Mother	Father	Brother	Sister	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa
Problems with aggression, defiance, and oppositional behavior as a child	☐	☐	☐	☐	☐	☐	☐	☐	☐
Problems with attention, activity, and impulse control as a child	☐	☐	☐	☐	☐	☐	☐	☐	☐
Learning Disabilities	☐	☐	☐	☐	☐	☐	☐	☐	☐
Speech Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐
Failed to graduate high school	☐	☐	☐	☐	☐	☐	☐	☐	☐
Intellectual Disability	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychosis or Schizophrenia	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression for more than 2 weeks	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tics or Tourette's Syndrome	☐	☐	☐	☐	☐	☐	☐	☐	☐
Alcohol Abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arrests	☐	☐	☐	☐	☐	☐	☐	☐	☐
Physical Abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sexual Abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Mental Illness:	☐	☐	☐	☐	☐	☐	☐	☐	☐

Client's Developmental and Medical Information

Pregnancy and Delivery:	
Length of pregnancy (e.g., full term, 40 weeks, 32 weeks, etch:	Length of delivery (number of hours from initial labor pains to birth):
Mother's age when child was born:	Child's birth weight:

Complications: Please note if any of the following happened during pregnancy/birth by checking the box		
Abnormal Bleeding	☐	
Excessive Weight Gain (more than 30 lbs.)	☐	
Toxemia/ preeclampsia	☐	
RH factor incompatibility	☐	
Frequent nausea or vomiting	☐	
Serious injury	☐	
Took prescription medications	☐	If yes, name of medication:
Took illegal drugs	☐	
Consumed alcoholic beverage	☐	If yes, approx. number of drinks per week:
Used tobacco products	☐	If yes, approx. times per day:
Was given medication to ease labor pains	☐	If yes, name of medication:
Forceps were used during delivery	☐	
Had a breech delivery	☐	
Had a cesarean section delivery	☐	
Other Problems:	☐	Please Describe:

Infancy: Please note if any of the following pertain to your child during the first 12 mths. by checking the box if appropriate				
Difficult to feed	☐	Affectionate	☐	Comments:
Difficult to get to sleep	☐	Sociable	☐	Comments:
Colicky	☐	Easy to comfort	☐	Comments:
Difficult to put on a schedule	☐	Difficult to keep busy	☐	Comments:
Alert	☐	Overactive	☐	Comments:
Cheerful	☐	Very stubborn, challenging	☐	Comments:
Other comments/concerns:				

Cultural Information:
Are there any ethnic, cultural, and/or religious traditions, beliefs, or values of which you would like us to be aware of? Yes ☐ No ☐ If Yes, please explain:

Client's Health History

At any time has your child had any of the following:				
	Never	Past	Present	Comments/Description
Asthma	☐	☐	☐	
Allergies	☐	☐	☐	
Diabetes, Arthritis, other chronic illness	☐	☐	☐	
Epilepsy or Seizure disorder	☐	☐	☐	
Febrile Seizures	☐	☐	☐	
Chicken Pox	☐	☐	☐	
Heart or Blood Pressure Problems	☐	☐	☐	
High Fevers (over 103)	☐	☐	☐	
Broken Bones	☐	☐	☐	
Severe cuts requiring stitches	☐	☐	☐	
Lead poisoning	☐	☐	☐	
Head injury with loss of consciousness	☐	☐	☐	
Surgery	☐	☐	☐	
Lengthy Hospitalization	☐	☐	☐	
Speech or language problems	☐	☐	☐	
Chronic ear infections	☐	☐	☐	
Hearing difficulties	☐	☐	☐	
Eye or vision problems	☐	☐	☐	
Other comments/concerns:				

Client's allergies including food, medication, environmental, etc. and/or dietary restrictions		
Allergen/Restricted Item(s)	Effect(s)/Reaction(s)	Medication (if necessary)

Client's Diagnoses		
Diagnoses	Date of Diagnoses	Who Diagnosed?

Client's hospitalizations or serious/recurring illness(es) or injury(ies)			
Dates	Age	Hospital	Describe

Client's past or current health/medical services:			
Treatment Type	Date(s) stated/discontinued	Effective?	Physician

Client's past or current biomedical autism treatment(s)/Medication(s):			
Treatment Type	Date(s) stated/discontinued	Effective?	Physician

Client's past or current supplemental specialized services (e.g., speech language therapy, occupational therapy):			
Treatment Type	Date(s) stated/discontinued	Effective?	Physician

Client's current daycare/school placement:			
Name of placement:	Dates of enrollment:	Grade(s):	Placement (e.g., typical, autism, gifted):
Have you ever been contacted by this placement concerning any behavioral or developmental concerns? Yes ☐ No☐		If yes, please explain:	
Teacher's Name:		Teacher's email:	
Principal's name:		Contact Phone #:	

Current Behaviors

Communication/Language (Within the last 6mth, has the client been observed to):			
Attempts to communicate wants/needs by:	Yes	No	Comments/Description
Babbling	☐	☐	
Crying	☐	☐	
Engaging in Self-injurious behavior (e.g., head banging, head hitting, self-biting)	☐	☐	
Engaging in aggressive behavior (e.g., hitting, pinching, biting, kicking)	☐	☐	
Engaging in destructive behavior (e.g., banging on surfaces, throwing objects)	☐	☐	
Pulling on others	☐	☐	
Looking at others	☐	☐	
Pointing	☐	☐	
Gesturing	☐	☐	
Using sign language	☐	☐	
Using an augmentative communication device	☐	☐	
Making 1 word requests	☐	☐	
Making 2-3 work requests	☐	☐	
Making full-sentenced requests	☐	☐	
Asking questions (e.g., who, where)	☐	☐	
Answering questions	☐	☐	
Conversing with adults	☐	☐	
Conversing with peers	☐	☐	
Repeating words over and over	☐	☐	
Speaking well but slow to develop language	☐	☐	
Speaking difficult to interpret words	☐	☐	
Used to speak, but no longer does	☐	☐	
Follows simple instructions (e.g., come here)	☐	☐	
Follows complex instructions (e.g., multiple steps)	☐	☐	
Academic Skills (Within the last 6mth, has the client been observed to):			
Academically perform at grade level in math	☐	☐	
Academically perform at grade level in reading	☐	☐	
Academically perform at grade level in writing	☐	☐	

Play/ Social Skills (Within the last 6mth, has the client been observed to):			
Skill	Yes	No	Comments/Description
Interacts with toys in a repetitive or unusual manner	☐	☐	
Plays with electronic toys as designed	☐	☐	
Plays with non-electronic cause/effect toys toys as designed (e.g., making a ball roll down a slide)	☐	☐	
Plays with manipulative toys as designed (e.g., puzzles, blocks)	☐	☐	
Engages in simple pretend play (e.g., feeding doll)	☐	☐	
Engages in complex pretend play (classroom/teacher schemes)	☐	☐	
Plays with board games as designed	☐	☐	
Plays computer games as designed	☐	☐	
Can entertain self for up to 5 min	☐	☐	
Readily explores new toys and activities	☐	☐	
Usually plays alone	☐	☐	
Joins others in play	☐	☐	
Appropriately interacts with parent(s)/guardian(s)	☐	☐	
Appropriately interacts with teacher(s)	☐	☐	
Appropriately interacts with other adults	☐	☐	
Appropriately interacts with sibling(s)	☐	☐	
Appropriately interacts with peers	☐	☐	
Difficulty sharing toys/waiting for turn	☐	☐	
Avoids eye contact	☐	☐	
Avoids social interactions	☐	☐	
Encounters peer rejection	☐	☐	
Makes negative comments about others	☐	☐	
Teases others	☐	☐	
Does not like losing	☐	☐	

Physical/Adaptive skills (Within the last 6mth, has the client been observed to):			
Skill	Yes	No	Comments/Description
Display stereotypic behavior (e.g., hand flapping, rocking, humming)	☐	☐	
Poor motor coordination	☐	☐	
Lethargic/low energy	☐	☐	
Hyper/over energetic	☐	☐	
Excessively noisy	☐	☐	
Short attention span	☐	☐	
Requires constant attention	☐	☐	
Often complains about physical state (e.g., headaches, stomachaches)	☐	☐	
Difficulty staying awake	☐	☐	
Difficulty falling asleep	☐	☐	
Difficulty staying asleep	☐	☐	
Naps frequently	☐	☐	
Has frequent nightmares	☐	☐	
Has self-limited diet/food refusal	☐	☐	
Self-feeder with finger foods	☐	☐	
Self-feeder with utensils	☐	☐	
Disruptive during meal times	☐	☐	
Toilet trained on schedule	☐	☐	
Initiates toilet	☐	☐	
Diapered	☐	☐	
Cries, whines frequently	☐	☐	
Frequently irritable	☐	☐	
Tantrums frequently	☐	☐	
Engaging in Self-injurious behavior (e.g., head banging, head hitting, self-biting)	☐	☐	
Engaging in aggressive behavior (e.g., hitting, pinching, biting, kicking)	☐	☐	
Engaging in destructive behavior (e.g., banging on surfaces, throwing objects)	☐	☐	
Difficulty responding to changes in routine	☐	☐	
Difficulty separating from parent(s)/caregiver(s)	☐	☐	
Unreasonable/excessive fears	☐	☐	
Can recognize a dangerous situation	☐	☐	
Runs away from caregiver in the community	☐	☐	
Runs away from the home	☐	☐	
Talks back to figures of authority	☐	☐	

Additional Information

Name three strengths of the client (e.g., very affectionate, loves astronomy, athletic)	
1	
2	
3	
Others	

List client's current favorite items (e.g., toys, foods, activities, characters)		

What behavior or skill deficit is of highest concern (list in order of priority)	
1	
2	
3	
Others	

Please provide any other information that would help Aces for Autism staff serve your family

_____ _____

Signature of Parent/Guardian Relationship to Client

_____

Date