Pediatric/Child Intake Form
Mercy Autism Clinic

Toddler/ Preschool History Form (Under 5-years of age)

A. Identification

1. Child's name: _____ Birth date: _____Age: ____
Home Address: _____
Child's Preschool: _____

Person(s) completing this form: _____Today's date: _____
Relation to child _____
Please describe your current concerns about your child
_____
_____
_____
_____
_____
_____
_____
_____

How long have you had these concerns?
_____

2. Mother's name: _____ Age:_____Home: phone: _____
Address:_____City_____State_____Zip_____Cell:_____
Highest grade completed_____ Learning Problems _____
Occupation: _____

3. Father's name: _____ Age: _____ Home phone:_____
Address:_____City_____State_____Zip_____Cell: _____
Highest grade completed_____ Learning Problems_____
Occupation: _____

4. Parents are currently: ☐Married ☐Divorced ☐Remarried ☐Never married
☐Other
Child's legal custodian/guardian is_____

5. Please list the child's siblings (Age, Medical Problems, Social, & School Problems)
_____
_____
_____
_____

B. Development

Please fill in any information you have on the areas listed below.

Pregnancy and delivery

Any prenatal (before birth) problems?

_____
_____
_____
_____
_____

Was the child premature? _____ Weight and height at birth: _____

Any birth complications or problems?

_____
_____
_____
_____

The first few months of life

Breast-fed? ☐ Yes ☐ No If so, for how long?_____

Any allergies? ☐ Yes ☐ No

_____

Please list any problems during infancy

_____
_____
_____
_____

During this child's first years, were any special problems noted in the following areas?

☐ Irritability	☐ Breathing problems	☐ Colic
☐ Difficulty sleeping	☐ Eating problems	☐ Temper tantrums
☐ Failure to thrive	☐ Excessive crying	☐ Withdrawn behavior
☐ Poor eye contact	☐ Early learning problems	☐ Destructive behavior
☐ Convulsions/Seizures	☐ Twitching	☐ Unable to separate from parent

☐ Other:_____

Milestones: At what age did this child do each of these?

Sit without support: _____ Crawl:_____
Walk without holding on: _____ Help when being dressed: _____
Eat with a fork:_____ Stay dry all day:_____
Didn't soil his/her pants: _____ Stay dry all night:_____
Dress self completely: _____

Can the child be described as clumsy/uncoordinated? ☐ Yes ☐ No

Having fine motor delay? ☐Yes ☐ No

Which hand does your child use for:

Writing/drawing? _____ Eating? _____ Cutting?_____

Current eating behavior: ☐ Normal ☐ Picky ☐ Eats too much ☐ Weight loss/gain

Oral Motor concerns: ☐ None ☐ Difficulty swallowing ☐ Drooling ☐ Gagging

Speech/language development

Age when child said first word understandable to strangers:

_____

Age when child said first sentence understandable to strangers:

_____

Any speech, hearing, or language difficulties?

_____

_____

_____

Has there ever been a regression in the adolescent's speech? ☐ Yes ☐ No

If yes, please explain: _____

_____

Checklist: Please mark any of the following in each area that describe your child currently or in the past:

Speech

Past	Current		Past	Current	
☐	☐	slow speech development	☐	☐	doesn't understand without gestures
☐	☐	unusual tone or pitch	☐	☐	repeats words/phrases over and over
☐	☐	difficult to understand speech	☐	☐	repeats questions, instead of answering them
☐	☐	seldom speaks unless prompted	☐	☐	repeats dialogue from movies/songs verbatim
☐	☐	speaks in a concrete/literal form			
☐	☐	doesn't understand idioms/ figures of speech			
☐	☐	has language of his/her own (may sound like foreign language/jargon)			

Relating with other people

Past	Current		Past	Current	
☐	☐	prefers to be by self	☐	☐	"in a world of his/her own"
☐	☐	aloof, distant	☐	☐	clings to people
☐	☐	fearful of strangers	☐	☐	not cuddly as baby
☐	☐	doesn't like to be held	☐	☐	doesn't recognize parent
☐	☐	doesn't play with other children			
☐	☐	prefers playing with younger or older children			

Imitation

Past	Current	
☐	☐	doesn't imitate waving "bye-bye" or "patty cake" etc. (physical imitation)
☐	☐	doesn't repeat words/things said to him
☐	☐	doesn't repeat words generally**,** but usually did what he was asked to do

Response to Sounds, Speech

Past	Current		Past	Current	
☐	☐	often ignores sounds	☐	☐	often ignores what is said to him/her
☐	☐	afraid of certain sounds	☐	☐	really likes certain sounds (music,
☐	☐	doesn't respond/orient to name			motors, etc.)
☐	☐	seems to hear distant or soft sounds that most other people don't hear or notice			
☐	☐	unpredictable response to sounds (sometimes reacts, sometimes doesn't)			
☐	☐	responds to speech and sounds like other children of the same age			

Visual Response

Past	Current		Past	Current	
☐	☐	stares vacantly around room	☐	☐	plays with turning lights on and off
☐	☐	often doesn't look at things	☐	☐	distracted by lights – stares at certain lights
☐	☐	likes to look at self in mirror	☐	☐	very interested in small parts of an object
☐	☐	likes to look at shiny objects	☐	☐	looks at things out of the corners of eyes
☐	☐	stares at parts of his/her body (e.g. hands)			
☐	☐	often avoids looking at people when they are talking to him			

Other Senses

Past	Current		Past	Current	
☐	☐	puts many objects in mouth	☐	☐	likes vibrations
☐	☐	licks objects	☐	☐	doesn't notice pain as much as most people
☐	☐	overreacts to pain	☐	☐	smells objects unusual or unfamiliar objects
☐	☐	chews or eats objects that are not supposed to be eaten			

Emotional Responses

Past	Current	
☐	☐	temper tantrums
☐	☐	laughs/smiles for no obvious reason
☐	☐	overly responds to situations
☐	☐	moods change quickly/for no apparent reason
☐	☐	cries/seems sad for no obvious reason
☐	☐	often has blank expression on face
☐	☐	little response to what is happening around him/her

Adaptive Skills:

Feeds self	☐ No	☐ Yes, beginning at age _____
Dresses self	☐ No	☐ Yes, beginning at age _____
Bathes self	☐ No	☐ Yes, beginning at age _____
Helps with household chores	☐ No	☐ Yes, beginning at age _____
Knows first and last name	☐ No	☐ Yes, beginning at age _____
Says "please" and "thank you"	☐ No	☐ Yes, beginning at age _____
Able to walk up/down stairs	☐ No	☐ Yes, beginning at age _____

Has the child ever lost skills, which at one time he/she was able to perform? ☐ Yes ☐ No

If yes, please explain: _____

C. Health

List all past illnesses, hospitalizations, medications, allergies, head trauma, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition: Age: Treatment? Consequences?

_____
_____
_____
_____
_____

Please list all **current** medications the child is taking.

Name of medication: Dosage prescribed: How many times per day:

_____
_____
_____
_____
_____
_____

Please list **past** medications child has taken previously.

_____
_____
_____
_____

D. Behavior

Please list any concerns you have about your child's behavior.

_____
_____
_____
_____
_____
_____

How does your child get along with peers?

_____
_____
_____
_____

How does your child get along with siblings?

_____
_____

_____

Are there any stressful events occurring in the family that may be affecting your child?

_____

_____

Does your child exhibit aggression, self-injury, destruction of items, elopement or other problem behaviors?

_____

_____

To your knowledge, has your child ever been abused or neglected?

_____

_____

Is there anyone in the child's family that has ever had: Family member(s):
Learning Difficulties _____
Attentional Problems _____
Emotional Difficulties _____
Diagnosed Disorder(s) _____
Alcohol or Drug problems, _____
Their own history of abuse_____

Please list any **current** intervention your child is receiving (Speech, OT, PT, psychotherapy).
From/To Description of treatment Provider Diagnosis

_____

_____

_____

_____

_____

_____

Please list any **past** treatment for your child (Speech, OT, PT, psychotherapy).
From/To Description of treatment Provider Diagnosis

_____

_____

_____

_____

_____

_____

Please list any past **evaluations** for your child (Speech, OT, PT, Psychological), and the provider's name

_____

_____

_____

_____

E. Schools/Learning

Please list all daycare centers/preschools your child has attended beginning with the school they are enrolled in at present:

_____
_____
_____
_____
_____

Has your child ever had difficulty adjusting to preschool (i.e. staying on task, understanding and following instructions, interacting well with other children)?

_____
_____

Does your child currently receive any early childhood special education services?

☐ Yes ☐ No

_____

If so, what is your child's classification

_____

How often does your child receive services?

_____

Has your child ever received any special services in the past?

_____

Does (did) your child have any problems learning letters/numbers?

_____

Does he/she confuse the sounds in words when speaking?_____

Can your child rhyme words?

_____

Can your child follow one step directions? Two step directions?

_____
_____

Does your child appear to use vocabulary that is age-appropriate?

_____

Describe his/her oral expression (uses 1-2 words, full sentences) :

_____

Behavior questions:
Does your child…

1. Cuddle like other children:	☐ Yes	☐ No
2. Look at you when you are talking or playing?	☐ Yes	☐ No
3. Smile in response to a smile from others?	☐ Yes	☐ No
4. Engage in reciprocal, back-and-forth play?	☐ Yes	☐ No
5. Play simple imitation games, such as pat-a-cake or peek-a boo?	☐ Yes	☐ No
6. Show interest in others?	☐ Yes	☐ No
7. Point with his or her finger?	☐ Yes	☐ No
8. Gesture (e.g., nod yes and no)?	☐ Yes	☐ No
9. Direct your attention by holding up objects for you to see?	☐ Yes	☐ No
10. Show things to people?	☐ Yes	☐ No
11. Give inconsistent response to his or her name (or to commands)?	☐ Yes	☐ No
12. Use rote, repetitive, or echolalic speech?	☐ Yes	☐ No
13. Memorize strings of words or scripts?	☐ Yes	☐ No
14. Have repetitive, stereotyped, or odd motor behavior?	☐ Yes	☐ No
15. Have preoccupations or a narrow range of interests?	☐ Yes	☐ No
16. Attend more to parts of an object (e.g., the wheels of a toy car)?	☐ Yes	☐ No
17. Have limited or absent pretend play?	☐ Yes	☐ No
18. Imitate other people's actions (e.g. wave bye-bye, play patty cake?)	☐ Yes	☐ No
19. Play with toys in the same exact way every time?	☐ Yes	☐ No
20. Appear strongly attached to a specific unusual object(s)?	☐ Yes	☐ No
Does your child seem sensitive to….		
1. Touch (tags, clothing, touch by others)?	☐ Yes	☐ No
2. Noise (puts hands over hears, becomes very distracted)?	☐ Yes	☐ No
3. Foods (textures, tastes, temperatures)?	☐ Yes	☐ No
4. Smells (highly sensitive to faint smells or smells objects)?	☐ Yes	☐ No
5. Movement (does not like swings, somersaults, etc.)?	☐ Yes	☐ No
6. Changes in routine (cannot transition, becomes upset)?	☐ Yes	☐ No
7. Activity (tires easily, props self when playing/sitting)?	☐ Yes	☐ No

Please list your child's play interests, toy preferences, and any special talents.

_____

_____

_____

What things do you and your child enjoy doing together?

_____

_____

_____

What reports/information have you gotten from caregiver/teacher about your child?

_____
_____
_____

What methods do you use for discipline?

_____
_____

G. Other

Please list any other information that you think is important with regard to your child (write notes on back if needed).

_____
_____
_____
_____
_____
_____
_____
_____

Name of child's pediatrician/primary care doctor_____

Would you like a copy of any assessment results sent to the doctor? ☐ Yes ☐ No

Confidential patient medical record.