UAB MEDICINE
PEDIATRICS

Children's of Alabama

Dear Parent/Guardian:

We are sending you an Intake Form to complete based on a request by one of your child's health care providers to conduct a comprehensive evaluation of your child. The Intake Form must be completed and returned to our office to begin the evaluation process and schedule appointments. Appointments cannot be confirmed until this information is received. Please use the checklist below before returning the Intake Form to ensure that we have all the information we need to schedule the appropriate appointments for your child.

_____ ***Complete all relevant questions on the Intake Form.*** Please ***pay special attention to page 8*** which requests information about other providers that have cared for or evaluated your child. Provide us as much of the information requested about these providers as possible so that, with your permission, we can contact them about your child.

_____ Be sure to complete and sign the ***Insurance information/authorization*** of the Intake Questionnaire.

_____ Be sure to complete and sign the ***Non-Covered Services Waiver***.

_____ If you have ***copies of any recent evaluations*** (psychological, development testing, speech/language, hearing, vision) please include them when you mail us your Intake Form.

_____ If your child is between the ages of 2 and 10 years old and is receiving special services at school, please include any copies of their ***IEP or the results of any testing the school*** conducted if you have that information available to you.

_____ If you are the ***child's guardian and not the birth or adoptive parent*** please include copies of the ***Guardianship papers*** (court order or Power of Attorney) with your Intake Form.

If you need assistance in completing the Intake Form, please call (205) 638-5277 and we will assist you with your questions.

We look forward to working with you and your family. Upon receipt of the above information, you can expect to hear from our office within a few weeks. If you do not hear from us, please call to make sure we have received this information.

Please mail or fax packet to the mailing address or fax number listed below.

Physical Address:
1600 7th Avenue South, Clinic 7
Birmingham, AL 35233
Phone: 205-638-5277
Fax: 205-212-2997

Mailing Address:
Medical Autism Clinic
McWane Bldg Dearth Tower Ste 5602
1600 7th Ave South
Birmingham, AL 35233

MEDICAL AUTISM CLINIC AT THE CHILDREN'S HOSPITAL OF ALABAMA rev 9-15
PARENT QUESTIONNAIRE

Chart #________________
(For office use only)

DEMOGRAPHIC INFORMATION:

Date Completed: ________________

Child's Name: ____
Last First Middle Nickname

Birth Date: ________________ Age: _________ Gender: ☐ Male ☐ Female Race: __________

Address: ____ Home Phone: ______________________

____ Second Phone: ______________________
City State Zip County

Name of person completing form: ______________________ Relationship to child: _______Email______________________

____
Relative or friend for emergency contact Relationship Primary phone Additional Phone

Referred to this clinic by: ____

____
Address City State Phone

Reason(s) for requesting evaluation:
____
____
____

What concerns would you like us to address during your visit?

☐ Feeding Problems ☐Sleep Problems ☐ Motor Problems ☐ Possible genetic problem
☐Sensory Problems ☐Hearing ☐Vision ☐ Severe behavioral problems
☐ Speech/language/social

Has your child ever been given a diagnosis of Autism, PDD NOS or Asperger's Disorder? If so, what was the diagnosis and who made the diagnosis and when?
____
____

MEDICAL HISTORY

PRENATAL HISTORY:

Were fertility medications or treatments used for this pregnancy? ☐ Yes ☐ No
If yes, what type? ____

☐ Singleton pregnancy ☐ Twin pregnancy ☐ Other: ________________

Mother's age (at time of child's birth) ________ yrs. Father's age (at time of child's birth) ________ yrs.

Number of pregnancies: _______ Number of miscarriages: _______ Stillbirths? _______

Were any substances used during pregnancy? (e.g., alcohol, tobacco, drugs) ☐ Yes ☐No
If so, please specify: ____

Did mother take Pre-natal Vitamins during her pregnancy? ☐Yes ☐ No any medications? ☐Yes ☐ No
Please describe: ____
____

Were there any problems experienced during pregnancy with this child? ☐ Yes ☐ No
If yes, please explain: ____
____

BIRTH HISTORY

Hospital where child was born:____

If baby was transferred to another hospital please name hospital: _______________________________________

Birth weight: Pounds _________ Ounces _________ Length _________ Head circumference _________

What was the baby's gestational age? (if known)_______

Was the baby ☐ average for gestational age (AGA) ☐ small for gestational age (SGA) ☐ large for gestational age (LGA)

Was the baby born at:

☐ term (37-42 weeks); ☐ preterm (36 weeks or less gestation); ☐ post-term (greater than 42 weeks gestation)

Was this a Vaginal Delivery or Cesarean Section? ☐ VD ☐ C-section

Was delivery induced (medication given to start labor)? ☐ Yes ☐ No

If no, were meds given to help delivery progress (augmentation)? ☐ No ☐ Yes

Length of Labor (time in active labor): _____________ hours ☐ N/A

Presentation: ☐ Vertex or head first ☐ Breech ☐ Other

Did baby require resuscitation (CPR, intubation and ventilation, medications) at birth? ☐ No ☐ Yes

Apgar scores: _______ at 1 min, _______ at 5 min, ☐ do not know ☐ normal ☐ abnormal/low

If your baby experienced difficulties during labor or delivery, please describe:

____

____

Did baby go to the intensive care nursery? ☐Yes ☐No

If baby was in the intensive care nursery, for how long? ____

And why? ____

____

INFANCY

Did the baby have colic or significant irritability? ☐ No ☐ Yes

How old was the baby when he/she first started sleeping more at night than during the day? _________________

Were there any feeding problems during infancy? ☐ No ☐ Yes

Was the child noted to be either floppy or stiff as infant? ☐ Floppy ☐ Stiff ☐ Normal

Please describe any problems: ____

____

MEDICAL/SURGICAL HISTORY

Has the child had any serious Illnesses or other Health problems (Other Than Colds): ☐ No ☐ Yes (if yes list below)

<u>Type</u> <u>How Often</u> <u>Approximate Date</u>

____

____

____

If the child is currently taking medications, please list below:

<u>Type of Medication</u> <u>Dose</u> <u>Reason</u>

____

____

____

____

Has the child had any hospitalizations: ☐No ☐Yes (if yes list below)

<u>Date</u> <u>Hospital name and location</u> <u>Reason</u>

____

____

____

Has the child had any serious Accidents or Injuries: ☐No ☐Yes (if yes list below)

<u>Date</u> <u>Type</u>

____

____

Has the child had any Surgeries: ☐No ☐Yes (if yes list below)

<u>Date</u> <u>Type</u> <u>Hospital name and location</u> <u>Reason</u>

____

____

____

Does the child have any Drug or medication Allergies? ☐ No ☐ Yes (explain): ____________________________

Food Allergies? ☐ No ☐ Yes (explain): ____

Environmental Allergies? ☐ No ☐ Yes (explain): ____

Are the child's <u>immunizations</u> up to date? ☐ Yes ☐No (explain) ___________________________________

Current Pediatrician (PCP) Address Phone

Names of other Medical Providers/Specialists:

Has your child ever had genetic testing? ☐No ☐Yes (if which tests?) ______

Has your child ever had an MRI? ☐No ☐Yes (explain) ______

Has your child ever had a CT Scan? ☐No ☐Yes (explain) ______

Has your child had other procedures or medical tests? ☐No ☐Yes (explain) ______

REVIEW OF SYMPTOMS: **Circle or check mark any past or current problems (if yes, please explain)**

- ☐ Eyes/Vision problems
- ☐ Ear, Nose, or Throat problems (recurrent ear infections)
- ☐ Stomach or intestinal problems
- ☐ Stomach or intestinal problems
- ☐ Growth/weight problems
- ☐ Kidney problems
- ☐ Heart or blood pressure problems
- ☐ Blood Abnormalities (anemia, leukemia, etc)
- ☐ Respiratory problems (asthma, sleep issues, snoring)
- ☐ Other not listed:
- ☐ Seizures
- ☐ Other neurological problems (Shunts, bleed, stroke, meningitis)
- ☐ Skin problems (rashes, acne, eczema, etc)
- ☐ Liver, pancreas, or digestive
- ☐ Thyroid problems, Diabetes
- ☐ Other Endocrine Problems
- ☐ Musculoskeletal (joints or bone) problems
- ☐ Psychiatric problems (depression, bipolar, etc)

Hearing: (*If your answer is yes, please explain*)
Did your child pass their newborn hearing screening in both ears? ☐ No ☐Yes
Has your child had their hearing tested since birth? ☐ No ☐Yes What were the results? ______

Date and Location of last hearing test ______

Is there any family history of childhood hearing loss? ☐No ☐Yes ______

Sleep:
Does the child have any difficulties around sleeping? ☐ No ☐ Yes (check the following that apply)

- ☐ Sleeps with parents
- ☐ Sleeps in own bed
- ☐ Maladaptive behaviors around going to bed (reluctance or avoidance)
- ☐ Problems with sleep maintenance (staying asleep)
- ☐ Other: ______
- ☐ Nightmares
- ☐ Night Terrors
- ☐ Problems with sleep onset (falling asleep)
- ☐ Problems with early wakening

On an average, how many hours per day does your child sleep? ______

Appetite is ______.
Does he/she have any significant food preferences/dislikes (marked food selectivity)? ☐ No ☐ Yes
If food selective, please describe

☐ Texture selective ☐ Temperature selective ☐ Color selective ☐ Very limited variety of foods: ______

FAMILY INFORMATION:

Child's Legal Guardian:
☐Both Birth Parents ☐Birth Father
☐Birth Mother ☐Adoptive Parents
☐Department of Human Resources
☐Other (Please explain)____________________

Marital Status of Birth Parents:
☐Not Married ☐Divorced
☐Married ☐Father remarried
☐Separated ☐Mother remarried

If Birth parents are not legal guardian (s), please indicate with whom child lives: ______________________________

Birth Mother's Name: ____________________________ Age: ______ Education (highest grade): ______
Place of Employment: ____________________________ Telephone: ______________
Medical Problems: ______________________________
Academic/Learning Problems: ______________________________

Birth Father's Name: ____________________________ Age: ______ Education (highest grade): ______
Place of Employment: ____________________________ Telephone: ______________
Medical Problems: ______________________________
Academic/Learning Problems: ______________________________

Brothers and Sisters: (Please include and indicate half-brothers/sister). For additional siblings add on separate piece of paper.

Name	**Age**	**How related (maternal ½ sib; paternal ½ sib; full brother or sister)**	**Grade**	**Medical Problems**	**Behavior Problems**	**Academic or Developmental Problems**

Is there family history on either side of the child's family (extended family) of any of the following conditions?

Condition	**Father's Side** Yes	**Who (dad's mom, dad, etc)? Describe Problem**	**Mother's Side** Yes	**Who (mom's mom, dad, etc)? Describe Problem**
Autism/ Asperger's Disorder/ PDD NOS				
Developmental delay				
Learning Problems				
Mental Retardation/Cognitive Impairment				
Hyperactivity				
Attention Deficit (ADD or ADHD)				
Speech or language problem(s)				
Tics or other movements				
Epilepsy (seizures)				
Severe emotional problem(s) (e.g., depression, schizophrenia, bipolar disorder, etc)				
Alcohol/drug problem(s)				
Stillbirths				
Birth defect(s)				
Congenital heart problems				
Diabetes				
Thyroid problem(s)				
Hearing loss/problem(s)				
Other: (describe)				

DEVELOPMENTAL HISTORY

Caregiver became concerned about: Social Interaction at age ___________________ Language at age ___________________

Cognitive/Intellectual at age __________________ Behavioral at age __________________

Did your child lose abilities (regress)? ☐No ☐Yes (explain) __________________________________

Please fill age when the child attained the skill, if you do not know the age just use "early", "late", "on time" or "not yet"
Gross Motor Skills:

Roll over ______________ Sit alone (unsupported) ______________ Crawl ______________ Walk ______________ Run ______________

Does your child walk on their toes? ☐No ☐Yes

Does your child have balance problems: ☐No ☐Yes

Does your child: Climb Stairs ☐No ☐Yes Ride a bicycle/tricycle ☐No ☐Yes Play Sports ☐No ☐Yes

Comments: ____

Fine Motor Skills:

Transfers objects between hands ____________ Turns paper pages in a book ____________

Develop Right or Left-handedness? __________ ☐ Right Handed ☐ Left Handed ☐ Can't tell

If your child has difficulty with coloring, fastening or handwriting please explain: ____

____

Speech Language

At what age did your child first smile? ________________________

Your child communicates by which of the following (check all that apply)

☐ Crying ☐ Sentences ☐ Playful Sounds ☐ Sign language
☐ Words ☐ Eye pointing ☐ Electronic talking devices ☐ Picture Communication Boards/Schedules
☐ Phrases ☐ Pointing with index finger

How much of your child's speech is understandable to you? ☐Some ☐Most ☐All
How much of your child's speech is understandable to others? ☐Some ☐Most ☐All

Please give an example of words/phrases/sentences your child typically uses to communicate: ____

____

Does the child have any problems:

Understanding what someone says ☐No ☐Yes (explain)____
Talking ☐No ☐Yes (explain)____

Feeding:

Does the child have any feeding difficulties? ☐ Yes ☐ No
Does he or she feed self? ☐ Yes ☐ No If no, who feeds him/her? _____________________________________
☐ Prefers to use fingers
Uses: ☐ Scoops with spoon ☐ Spreads with knife ☐ Spears with fork ☐ Sippy cup ☐ open-top cup ☐ straw
Current weight_________
What special diets or dietary supplements does the child take? ☐ None ☐ CF/GF diet
☐ He/she takes the following vitamins/supplements: ____

Toileting: ☐ Not Toilet Trained

At what age was child urine / bladder trained? ______________. At what age was child bowel trained? ______________.
Were there/are there any problems? ____

Dressing / Self-Help

Please check all that apply for this child:

☐ Does not assist with dressing ☐ Helps with dressing ☐ Helps with undressing ☐ Undresses completely
☐ Dresses completely ☐ Buttons ☐ Ties Shoes ☐ Brush teeth / rinse mouth
☐ Brush /comb hair ☐ Prepare meal ☐ Use Microwave

BEHAVIOR/EMOTIONAL CONCERNS:

Please check any of the following behaviors that you feel your child has and their frequency. Please make comments to the side:

☐ **Displays Aggressiveness**	☐ **No**	☐ **Sometimes**	☐ **Often**
☐ Temper Tantrums	☐ No	☐ Sometimes	☐ Often
☐ Acts Out	☐ No	☐ Sometimes	☐ Often
☐ Has Poor Organizational Skills	☐ No	☐ Sometimes	☐ Often
☐ Difficulty following direction	☐ No	☐ Sometimes	☐ Often
☐ Mood Swings	☐ No	☐ Sometimes	☐ Often
☐ Day Dreams	☐ No	☐ Sometimes	☐ Often
☐ Cries Easily	☐ No	☐ Sometimes	☐ Often
☐ Difficulty changing routine	☐ No	☐ Sometimes	☐ Often
☐ Repetitive behaviors	☐ No	☐ Sometimes	☐ Often
☐ Acts without thinking	☐ No	☐ Sometimes	☐ Often
☐ Conduct problems	☐ No	☐ Sometimes	☐ Often
☐ Fails to complete tasks	☐ No	☐ Sometimes	☐ Often
☐ Fails to follow instructions	☐ No	☐ Sometimes	☐ Often
☐ Loses things	☐ No	☐ Sometimes	☐ Often
☐ Easily distracted	☐ No	☐ Sometimes	☐ Often
☐ Forgetful	☐ No	☐ Sometimes	☐ Often
☐ Out of seat	☐ No	☐ Sometimes	☐ Often
☐ Fidgety	☐ No	☐ Sometimes	☐ Often
☐ Runs and climbs excessively	☐ No	☐ Sometimes	☐ Often
☐ Very loud	☐ No	☐ Sometimes	☐ Often
☐ Always on the go	☐ No	☐ Sometimes	☐ Often
☐ Talks excessively	☐ No	☐ Sometimes	☐ Often
☐ Excessive crying	☐ No	☐ Sometimes	☐ Often
☐ Self injury	☐ No	☐ Sometimes	☐ Often
☐ Food refusal	☐ No	☐ Sometimes	☐ Often
☐ Head-Banging	☐ No	☐ Sometimes	☐ Often
☐ Poor eye contact	☐ No	☐ Sometimes	☐ Often
☐ Difficult transitions	☐ No	☐ Sometimes	☐ Often
☐ Hand flapping/finger flicking	☐ No	☐ Sometimes	☐ Often
☐ Sound Anxiety	☐ No	☐ Sometimes	☐ Often
☐ Separation Anxiety	☐ No	☐ Sometimes	☐ Often
Other:			

Types of Discipline Used:

☐ Time-out ☐ Spanking / Physical Punishment ☐ Withdraw Privileges ☐ 1, 2, 3 Counting ☐ Reprimand

☐ Other: ____

Discipline is generally ☐ effective ☐ ineffective

Other parental concerns about child's behavior: ____

____

Does your child prefer to play (mark any that applies):

☐ Alone ☐ With all ages ☐ With same children ☐ With younger children ☐ With older children

☐ With other children (specify) ____

Do you have any concerns about your child's social skills or play skills? ☐ Yes ☐ No

If yes, please explain: ____

____

What does child enjoy doing in his/her spare time? ____

In your opinion how old does your child act? ____

Child's best ability: ____

Skill with greatest difficulty: ____

EDUCATIONAL / SCHOOL HISTORY:

*Please attach child's Early Intervention IFSP or IEP or any previous psychological or school evaluations

Name of school & address: ____

______________________City ____________ State________ Zip Code ____________

School district where you live: ____
☐Public School ☐ Private ☐ Home Schooled
Current grade ________ Teacher's name ____
Grades repeated, if any: __________________ Does the child have an Individual Educational Plan (IEP)? ☐ No ☐ Yes
If your child received Early Intervention, when was it started: ______________________

Type of classroom: ☐ Daycare ☐ Early Intervention ☐ Preschool ☐ Kindergarten ☐ Regular classroom ☐ Head Start
☐ Regular and special classes ☐ Special classes (Describe) ______________________________
What is his/her current academic performance like? ____

____

Please describe how your child gets along with other students at school: ____

____

Please describe any behavioral problems in the classroom: ____

____

Please add any additional comments you would like to make: ____

____

Does your child receive the following special services (check all that apply)?

☐ Physical therapy ☐ Occupation therapy ☐ Speech/language therapy ☐ Adaptive P.E.
☐ Hearing impaired ☐ Vision impaired ☐ Resource room/special instruction ☐ Bus/transportation services
☐ Other, specify ____

If your child is not in school, please list any service(s) he/she is receiving

Type	Address	How long

PREVIOUS EVALUATIONS/SERVICES:
***Please attach copies of previous evaluations**
List previous or most recent developmental or psychological evaluations that have been done on the child:

____

____

____

____

____

____

____

BIRTH, TREATMENT, AND SCHOOL HISTORY SERVICES

Please complete any of the following pertaining to your child. It is very important that you furnish the complete address of each Agency/Provider you list.

Name ____

If your child's records are not under his/her current name, what should we request under? ____________________

Type of Service Provider	Agency/Provider Name	Agency/Provider Address	Date(s)Seen
Place of Birth:			
Hospitalizations:			
Hospitalizations:			
Pediatrician:			
Neurologist			
Orthopedist			
Geneticist			
Eye Specialist			
Hearing Specialist			
Otorhinolaryngologist (ENT)			
Psychiatrist			
Psychologist			
Nutritionist/Dietician			
Occupational Therapist			
Physical Therapist			
Speech Language Therapist			
Social Worker			
Children's Rehab. Services			
Public Health Department			
Dept. of Human Resources			
Mental Health Center			
Others, specify			

Schools Attended	Address	Date (year) Attended

Evaluations may be required on separate days. Would you have transportation problems or other difficulties in keeping appointments? ☐ Yes ☐ No

If yes, please explain. ____

PLEASE RETURN TO: CHILDREN'S MEDICAL AUTISM CLINIC

Children's Health-System-Authorization for Release of Information

Patient Name (First, Last, MI):____

Address:____

Phone Number: (_____)____________________________Date of Birth:______________________________

This Authorization applies to the following Information:

X *All* Information. I understand that the information may contain psychiatric/psychological, alcohol/drug abuse, and/or HIV information and I expressly consent to the release of the information.

Only the following records or types of Information: ____

____

Treatment Dates: from (month/day/year) ______/______/______ **to** (month/day/year) ______/______/______

The Information may be released as follows:

by **to** (Please check all that apply)

X X Children's Health System (*Please provide address & phone number*): Children's of Alabama Medical Autism Clinic, 1600 7th Avenue South, Dearth Tower Ste. 5602 Birmingham, AL 35233 (205) 638-5277

External Individual/Agency/Organization (*Please provide address & phone number*):________________

____

Purpose of the release:

X Continuity of Treatment Other (*Please specify*):____

I understand the Information released will be limited to information necessary to fulfill the need or purpose for the disclosure. If I have authorized the disclosure of Information to a recipient who is not subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), then the recipient may re-disclose it and it may no longer be protected under HIPAA, a federal privacy law. This Authorization is valid for ninety (90) days from the date of signature, unless otherwise noted. This Authorization only applies to treatment occurring before the date of signature. I may decline to sign this Authorization. I understand I may revoke this authorization in writing at any time by completing a form available from Medical Information Services. If I revoke this authorization, the revocation will not apply to information that has already been released in response to this authorization. I understand the patient's health care and the payment for the patient's health care will not be affected if I do not sign this form. I understand I may see and copy the Information described on this form if I ask for it, and I may receive a copy of this form after I sign it. Before requesting medical record copies, please about the copy fee by law that may apply. I represent that I have the authority to and voluntarily grant permission for the Information to be released as described above.

Print name here! ! !

____

Patient/Parent/Legal Guardian Printed Name

Sign name here ! ! !

____

Patient/Legal Guardian Signature Date

Witness Signature here! ! !

____

Witness Signature Date

____

Patient Signature (if 14 or older) Date

UAB MEDICINE
PEDIATRICS

Children's of Alabama

MEDICAL AUTISM CLINIC (MAC)

Once you have received your appointment time, please arrive 30 minutes prior to your appointment time to check in.

If you cannot keep this appointment, please call the office to reschedule.

Our office number is
205-638-5277

Appointments can take several hours so please be prepared for this by bringing snacks or other items that can make the wait less stressful for your child.

Please bring any information you have received regarding your child's health, education or progress, a list of all medications, and a list of questions or concerns you may have for the specialist. If you only have one copy of these documents, just notify us once you reach your exam room and we can make copies and return them to you.

We look forward to seeing you!

Clinic Address:
Medical Autism Clinic
1600 7th Avenue South
McWane Building, Clinic 7
Birmingham, AL 35233

UAB Department of Pediatrics, Division of Developmental and Behavioral Pediatrics,
McWane Bldg Dearth Tower Ste. 5602
1600 7th Avenue South, Birmingham, Al 35233 tel. 205-638-5277 fax 205-212-2997 www.peds.uab.edu
Clinic address: 1600 7th Avenue South, Clinic 7