UNLV MEDICINE
ACKERMAN AUTISM CENTER
In Partnership with Grant a Gift Autism Foundation

UNLV Ackerman Center for Autism and Neurodevelopmental Solutions
630 S. Rancho Dr., Suite A, Las Vegas, NV 89106
Phone: 702-998-9505
Fax: 702-527-5353

Clinical Diagnostic Intake Form

Please fill out this questionnaire as completely as possible. All information will be kept strictly confidential. If you have questions or need assistance with this form, please contact the UNLV Ackerman Center at (702) 998-9505.

Child's Name:	Date of Birth:	Age:	Male ______ Female ______
School:		Grade:	Form Completion Date:
Form Completed By:		Relationship to Patient:	
Referred By:			

Please describe your concerns about your child:

1.____
2.____
3.____
4.____

Please describe your child's strengths:

____
____
____

MEDICAL HISTORY

PREGNANCY:	**Yes**	**No**	**Comments**
Complications	___	___	____
Excessive Stress	___	___	____
Diabetes	___	___	____
Exposure to:			
Alcohol	___	___	____
Tobacco/Smoking	___	___	____
Drugs	___	___	____
Medications	___	___	____
BIRTH:			
Born term (37-40 weeks)	___	___	If not, when?______________________________
Delivery was a C-section	___	___	If yes, why?______________________________
Problems during delivery	___	___	____
What was the birth weight	_______lbs	_________oz	
Breathing problems	___	___	____
Feeding Problems	___	___	____
Birth Defects	___	___	____
Extended hospital stay/ NICU?	___	___	Why?____________________________________
Jaundice	___	___	Treatment?______________________________

CHILDHOOD:

Reflux	___	___	____
Poor/slow growth	___	___	____
Serious infection	___	___	____
Seizures	___	___	____
Ear Infections	___	___	____
Heart Problems	___	___	____
Serious accidents/ injuries	___	___	____
Hospitalizations	___	___	____
Surgeries	___	___	____
Previous/current diagnosis	___	___	____

DEVELOPMENTAL HISTORY

Was the child's early developmental typical/normal? Yes___ No___ Comment____

Please list the approximate age when the child (or circle "Not Yet"):

Roll Over	______months old	Not Yet	Dressed Independently	______years old	Not Yet
Sat Up	______months old	Not Yet	Ate with a spoon	______years old	Not Yet
Walked alone	______months old	Not Yet	Could speak 4-5 single words	______years old	Not Yet
First combined words	______months old	Not Yet	Spoke so others could understand	____years old	Not Yet
Toilet Training – Urine	______years old	Not Yet	Toilet Training – Bowel	______years old	Not Yet
Dry at night	______years old	Not Yet			

Has the child had an evaluation? No___ Yes___ When?______________________ Result?________________________________

Reason for evaluation?____

Do you expect your child to have any difficulty with the physical and neurological examinations? No _____ Yes_____

If yes, please check the reason: Fear of doctors/dentists/medical procedures____ Fear of new situations ____

Difficulty understanding/following directions____ Oppositional/defiant behavior____

Other:____

Do you feel that your child needs special assistance for examinations for one of the above reasons? No____ Yes____

FAMILY HISTORY

Has anyone in your family ever been diagnosed with:

	Yes	No	Who
ADD/ADHD			
Autism/ Aspergers / PPD NOS			
Developmental Delay			
Genetic syndrome			
Birth defect			
Intellectual Disability			
Speech/ language problems			
Learning disability/ Dyslexia			
Hearing problems			
Vision problems			
Depression			
Anxiety			
Bipolar			
Heart problems			
Substance Use			
Suicide			
Schizophrenia/ Schizoaffective Disorders			

PARENT/GUARDIAN HISTORY

Parent/Guardian #1	Occupation	Age
Health Problems	Highest school level completed: K-8th Grade____ 9th____ 10th____ 11th____ 12th___ Technical School____ Some College____ Graduated College____ Post College____	
Parent/Guardian #2	Occupation	Age
Health Problems	Highest school level completed: K-8th Grade____ 9th____ 10th____ 11th____ 12th___ Technical School____ Some College____ Graduated College____ Post College____	

Child's Brother(s) Age(s) ____ ____ ____ ____ General Health ________________________________
Child's Sister(s) Age(s) ____ ____ ____ ____ General Health ________________________________

REVIEW OF SYSTEMS

	Yes	No	Comments
Problems playing with peers			
Headaches			
Vision Problems			
Hearing problems			
Allergies			
Asthma			
Chest pain			
Stomach ache			
Constipation			
Diarrhea			
	Yes	No	Comments
Joint Pain			
Problems falling asleep			
Snoring			
Muscle Pain			
Tired during the day			
Seems sad, unhappy, depressed			
Cries or whines easily			
Seems nervous or irritable			
Tics or twitches			

What time does the child go to sleep at night? ______________ PM What time does the child wake up? ________________ AM
What kind of eater is the child? Good____ Picky____ Overeats____ Poor____ Comments: ____________________________________
Special Diet? Yes____ No____ If Yes, describe:____
Media hours per day: TV______ Computer______ Video Games______

Please list any:

•**Current Medications:**

Medication Name	Dosage	Prescribing Provider

•**Other doctors seen:**

Pediatrician ___________________ Neurologist ___________________ Psychiatrist ___________________ Other __________________

SCHOOL PERFORMANCE (Grade 1 & above)

Is your child receiving special services in school? No____ Yes____ If yes, please describe/list below: ________________________
____
____
____

*****Please provide a copy of all evaluations and IEP*****

Has your child ever repeated a grade? No ____ Yes ____ If yes, please list the grades repeated ____________________________

How long does homework take to complete? _________

School Skills: Please check the correct level				
	Don't Know	Below Grade	At Grade	Above Grade
Reading				
Spelling				
Written				
Oral				
Math				
Calculation (can they +/-)				
Application (when to +/-)				
Writing				
Speed				
Neatness (how to form letters)				
Content (what they write about)				
Study Skills				
Completing homework				
Remembering homework				
Knowing what & how to study				
Handling it in the next day				
Organizational Skills				
Loses school materials				
Forgets notes, papers, & projects				
Waits until the last minute to do things				

What time is homework usually done? Never____ Before dinner ____ After dinner ____
After school program ____ As soon as he/she gets home from school____

How long does homework usually take? 15 minutes____ 30 minutes____ 1 hour____ 1-2 hours____ 2-3 hours____
More than 3 hours____

BEHAVIOR INVENTORY

Inattention	Never	Just a Little	Often	Almost Always
Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.				
Often has difficulty sustaining attention in tasks or play activities.				
Often does not seem to listen when spoken directly to.				
Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions).				
Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort such as schoolwork or homework.				
Often distracted by extraneous stimuli.				
Often forgetful in daily activities.				

Hyperactivity	Never	Just a Little	Often	Almost Always
Often fidgets with hands or feet or squirms in seat				
Often leaves seat in classroom or in situations in which remaining seated is expected				
Often runs about or climbs excessively during situations in which it is inappropriate (in adolescents, it may be feelings of restlessness)				
Often has difficulty playing or engaging in leisure activities quietly				
Is often “on the go” or often acts as if “driven by a motor”				
Often talks excessively				
Impulsivity	Never	Just a Little	Often	Almost Always
Often blurts out answers before questions have been completed.				
Often has difficulty awaiting turn.				
Often interrupts or intrudes on others (i.e. butts into conversations or games, or talks out of turn)				
Oppositional	Never	Just a Little	Often	Almost Always
Loses temper				
Argues with adults				
Refuses to obey rules or commands				
Deliberately annoys people				
Blames others for personal mistakes or misbehaviors				
Is touchy or easily annoyed by others				
Seems angry/spiteful or warns revenge				
Peer Interactions/ Social Skills	Never	Just a Little	Often	Almost Always
Has a friend				
Makes friends easily				
Keeps friends				
Is bossy- needs to be in control				
Shows good sportsmanship				
Is physically aggressive				
Prefers to play alone				
Gets teased				
Teases others				
Prefers peers who are (circle which apply): younger, older or same aged				

Additional comments or concerns:
____
____
____
____
____

Parent/Guardian Signature:_______________________________ Date:_______________________