



## Client Application

Date: \_\_\_\_\_ Child's Name: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Child's DOB: \_\_\_\_\_  
 Primary Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_

### Parent Information:

Mother:	Father:
DOB:	DOB:
Address:	Address:
Phone (home)	Phone (home)
(cell)	(cell)
Email	Email

## Family Information

Does either parent's job require him/her to be away from home long hours or extended periods?  
 \_\_\_\_\_

If married, how long have you been married? \_\_\_\_\_

If divorced, how long have biological parents been divorced? \_\_\_\_\_

Has either parent been married before or since? Mother: \_\_\_\_\_ Father: \_\_\_\_\_

Please list the name(s) of all stepparents: \_\_\_\_\_

Is there a birth parent living outside the home:      Mother                  Father

Name: \_\_\_\_\_ Where do they live? \_\_\_\_\_

If birth parent(s) do not live in the home with the child, how frequently does the child have contact with the parent not having custody, or with sibling, stepsiblings, etc?  
 \_\_\_\_\_  
 \_\_\_\_\_

**Siblings:**

<u>Name</u>	<u>Age</u>	<u>Relationship</u>	<u>Living in home?</u>	<u>School</u>	<u>Grade</u>
			Y/ N		
			Y/ N		
			Y/ N		
			Y/ N		
			Y/ N		

Please indicate if there are any special needs of concerns regarding the other children living in your home:

\_\_\_\_\_

Please indicate any relational concerns between siblings the child whom you are seeking services for:

\_\_\_\_\_

List any other people who currently, or in the child's lifetime, have lived in your home:

<u>Name</u>	<u>Age</u>	<u>Relationship to child</u>	<u>Years/ Months in home</u>

Are there any other people who have a significant role on how your child is raised?

\_\_\_\_\_

**Child Information**

Current weight: \_\_\_\_\_lbs

Current height: \_\_\_\_Ft. \_\_\_\_Inches

With which hand does your child write?    Left                      Right                      Both

**Current Medical Diagnosis (es):**

(Attach copies of all previous evaluations)

Autism

Aspergers

PDD-NOS

Child Disintegrative Disorder (CDD)

Rett's Syndrome

Down Syndrome

Not diagnosed

Epilepsy/Seizures

heart disorder

Vision difficulties

Hearing difficulties

Physical difficulties

\_\_\_\_\_

Other \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Current Psychological findings:**

(Attach copies of all previous evaluations)

Attention Deficit Disorder

Hyperactivity Disorder

Adaptive functioning difficulty

ADD/HD

OCD

Conduct disorder

Other \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Previous Evaluations:**

(Attach copies of all previous evaluations)

Vision

Hearing

Well baby checkup

Occupational

Speech/Language

Physical Therapy

Other \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medications/Supplements:**

Medications	Supplements	Other
Prozac _____mg		
Zyprexa _____mg		
Risperdal _____mg		
Adderall _____mg		
Dexedrine _____mg		
Dextrostat _____mg		
Haldol _____mg		
Mellaril _____mg		
Depakote _____mg		
Tegretol _____mg		

Have there ever been any hospitalizations/surgeries?:      Yes                  No  
If yes, please provide additional information

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Name of child's physician(s)**

Physician/Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

Physician/Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

**Birth History**

Were there any complications with the Pregnancy?      Yes                  No  
If Yes, please provide additional information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Was your child born premature?      Yes                  No

If yes, early in weeks? \_\_\_\_\_

Birth Weight: \_\_\_\_lbs \_\_\_\_oz

Is there any additional birth information that might be of assistance to us?      Yes      No  
 If Yes, please provide additional information:

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**Developmental Milestones**

Please indicate at what age (in months or years) your child did the following

<u>Milestone</u>	<u>Age</u>
Rolled over consistently	
Sat up unsupported	
Crawled	
Stood unsupported	
Walked unassisted	
Grasped crayon/pencil	
Climbed on stairs	
Jumped	
Babbled	
Used single words meaningfully	
Began combing words meaningfully	
Toilet trained during the day	
Dry through the night	

Please indicate if your child does any of the following

Does your child:	YES	NO
Choke on food or liquids?		
Currently put toys/objects in his/her mouth?		
Brush his/her teeth or allow brushing?		
Use a pacifier/or put thumb in mouth?		
Drink from a bottle?		
Drink from a sippy cup?		
Drink from an open cup?		
Self-feed?		
Use utensils?		

Does your child experience any of the following?

Have difficulty:	YES	NO
Getting to sleep?		
Controlling temper?		
Sleeping through the night?		
Trouble waking up?		
Staying alert during the day?		
With frequent ear infections?		

Is there any history of abuse?      Yes      No  
 If yes, please provide additional details:

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## Language Skills

Please indicate, how your child communicates using the chart below.

### Communication Responses

Communication Function	Complex Speech (sentences)	Multiple words (not sentences)	One word utterance	Other utterances (whine, shout)	Complex signing	Single signs	Shakes head	Echolalia	Pointing	Leading (pulls hand)	Grab/Reach	Gives objects	Increased Movement (hyperactivity)	Moves close to you	Move away/leave situation	Fixed gaze	Facial expression	Aggression	Self-injury	Other
Request attention																				
Request help																				
Request preferred food/ objects/activities																				
Request a break																				
Show you something or someplace																				
Indicate physical pain (headache, cut, sickness)																				
Indicate confusion																				
Protest or reject situation that you have created																				

Is English the Primary language at home? \_\_\_\_\_

Yes

No

If no, what is the primary language: \_\_\_\_\_

What language(s) does the child speak? \_\_\_\_\_

What language (s) does the child understand? \_\_\_\_\_

## Previous Interventions

Intervention	Organization/Company Name	Date services began	Will you be continuing these services after enrollment at The Brown Center?
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No

Please attach copies of all discharge notes, plans of care, goals, etc. from all previous interventions.

Does your child attend any Mother's Day Out or Preschool Programs? \_\_\_\_\_

If so, provide the following:

School/Program: \_\_\_\_\_

Address: \_\_\_\_\_

Program Director: \_\_\_\_\_ Phone: \_\_\_\_\_

Does your child need an aide in their class?      Yes              No

If yes, who provides these services?

\_\_\_\_\_

\_\_\_\_\_

What are your greatest concerns regarding your child's development?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What things would you your child to do more or less often?

More often	Less often
1.	1.
2.	2.
3.	3.
4.	4.

How would you like The Brown Center for Autism to help you address your concerns?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I will be involved in my child's program in the following ways:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What kind of activities does your child find enjoyable?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any special abilities, skills, or strengths you see in your child:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Please include the \$125 application processing fee payable to The Brown Center for Autism.*