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Child Name:__________________________________ **DOB:**____________________________________

REASONS FOR EVALUATION

Referrring Agency: **Autism Treatment Assistance Program (ATAP)**

When Autism Spectrum Disorder was made?____

Diagnosed by doctor/agency______________________________

Received services from Nevada Early Intervention?________________ **When**______________________________

ATAP services start date____

Services your child receiving thorugh ATAP____

FAMILY HISTORY

Language spoken at home______________________________

Mother's name____ **Age** _________

Occupation____ **Marital status**_____________

Check which applies: ☐ Biological/birth ☐ Adoptive ☐ Step ☐ Foster ☐ Other ______________

Father's name____ **Age** _________

Occupation____ **Marital status**___________

Check which applies: ☐ Biological/birth ☐ Adoptive ☐ Step ☐ Foster ☐ Other _______________

If parents are separated or divorced, who has custody of this child?_______________________

With whom is child currently living (list members of household and primary caregivers)?

Name	Age	Relationship to patient
____________________	____	__________________________
____________________	____	__________________________
____________________	____	__________________________
____________________	____	__________________________
____________________	____	__________________________

Additional Information____

____

DEVELOPMENTAL/HEALTH HISTORY

Note: This information relates to birth (biological) parent.

Mother's age at delivery? ____________________ **Did you recevie prenatal care?** ☐ No ☐ Yes

Mother's health during pregnancy (check) ☐ Good ☐ Fair ☐ Poor

Were there any pre/postnatal problems?☐Yes ☐No
If Yes, explain: ____

Length of Pregnacy:_____________ **Birth: Natural** _______ **C-section**_________

Birth weight: __________ **Length:** _______________ **Head circumference** ____________________

Current Weight:__________________________________ **Height**:___________________________

Hearing
☐ Ear infections
☐ Ear tubes
☐ Hearing problems

Vision
☐ Vision problems
☐ Wears glasses or contacts
☐ Eyes turning in or out

List any PAST accidents chronic or severe medical problems your child required frequent care by a doctor or follow-up by a specialist:

Reason	Date	Age	Doctor / Specialist

List all CURRENT medical problems and medications your child is taking at this time:

Medical Problem	Dosage	Name of medication	Doctor/Specialist

Early delays:
Motor:__________ Speech/langauge____________ Self-help:______________ Cognitive:_____________
Social:__________ Stereotpyic behaviors____
Behavioral problems:____

CURRENT SKILLS

Please check the column that best describes your child compared to other children of the same age:(for school age / preschool children):

Skill or Ability	Below Average	Average	Above Average	Not Sure
Throwing/catching				
Running, jumping				

Imaginary Play				
Balance				
Understanding spoken instructions				
Expressing self verbally				
Speaking clearly				
Reading				
Handwriting				
Spelling				
Math				
Completing homework				
Building things				
Self help, Dressing self				
Tying shoes, buttoning, zipping				
Ability to make friends				
Ability to keep friends				

SCHOOL HISTORY

Current School:____ Grade:______________________________________

Main Teacher:____ Email:______________________________________

Resource Room Teacher:_______________________________________ Email:______________________________________

What special services he/she is receiving?________________________________ GPA:_____________________________

Has child ever been retained a grade or held back? ☐ No ☐ Yes (explain)_________________________________

Has child ever been suspended? ☐ No ☐ Yes
(explain)____

Any school problems?

____
____
____

Child's strengths:

____
____
____