



EHC Buffalo

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Specialist in Autism, Child Development, Brain Injury and Stroke

Date: ____/____/____

Last Name: _____ MI _____ First name: _____

Date of Birth ____/____/____ Sex: M F

Address: _____

Home Phone (____) ____-____ Primary E-mail Address: _____

Primary language: _____ Other language (s) _____

Caretaker 1:

Relationship: _____

Last Name: _____

First Name: _____

Cell Phone: (____) ____-____

Work Phone: (____) ____-____

Occupation: _____

E-Mail Address _____

Caretaker 2:

Relationship: _____

Last Name: _____

First Name: _____

Cell Phone: (____) ____-____

Work Phone: (____) ____-____

Occupation: _____

E-Mail Address _____

Who referred you to our medical office? _____

Primary Physician: _____ Phone # _____

Other children in the Family:

Name	Age	Grade
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_____	_____	_____
_____	_____	_____

BIRTH HISTORY

Conception: ☐ Normal ☐ IVF ☐ Hormone Therapy

Was there anything unusual about the pregnancy or birth?

☐ Yes ☐ No

If yes, please describe: _____

Was the mother sick during the pregnancy?

☐ Yes ☐ No

If yes, please describe: _____

How many months was the pregnancy? _____

Did the child go home with his/her mother from the hospital?

☐ Yes ☐ No

If the child stayed in the hospital, please describe why and how long: _____

Was the delivery vaginal or by caesarean section? _____

What was the child's weight and general condition at birth? _____

MEDICAL HISTORY

Medical Diagnosis (if applicable): _____

Has your child had any of the following?

☐ Adenoidectomy

☐ Encephalitis

☐ Seizures

☐ Allergies

☐ Flu

☐ Sinusitis

☐ Breathing difficulties

☐ Head injury

☐ Sleeping difficulties

☐ Chicken pox

☐ High fevers

☐ Thumb/finger sucking habit

☐ Colds

☐ Measles

☐ Tonsillectomy

☐ Ear infections

☐ Meningitis

☐ Tonsillitis

how often? _____

☐ Mumps

☐ Vision problems

☐ Ear tubes

☐ Scarlet fever

If your child has allergies, please list: _____

Other serious injuries/surgeries: _____

Is your child currently (or recently) under a physician's care? ☐ Yes ☐ No

If yes, why? _____

Please list any medications your child takes regularly: _____

DEVELOPMENTAL HISTORY

Please state the approximate age your child achieved the following developmental milestones:

_____ Rolling
 _____ Sat up alone
 _____ Stood up
 _____ Crawled
 _____ Walked
 _____ Babbled

_____ Grasped crayon/pencil
 _____ Stopped using pacifier
 _____ Self-fed with utensils
 _____ Said first words
 _____ Spoke in short sentences
 _____ Toilet trained

Does your child...

- ☐ Choke on food or liquids?
☐ Currently put toys/objects in his/her mouth?
☐ Brush his/her teeth and/or allow brushing?

SPEECH-LANGUAGE HISTORY

Is there a language other than English spoken at home?

☐ Yes ☐ No

If yes, please specify: _____

Does the child speak the language?

☐ Yes ☐ No

Does the child understand the language?

☐ Yes ☐ No

What language does the child prefer to speak at home? _____

Do you feel your child has a speech-language disorder?

☐ Yes ☐ No

If yes, please describe: _____

Do you feel your child has a hearing disorder?

☐ Yes ☐ No

If yes, please describe: _____

Has your child ever had a speech evaluation/screening?

☐ Yes ☐ No

If yes, when and where? _____

What were you told? _____

Has your child ever had speech therapy?

☐ Yes

☐ No

If yes, when and where? _____

What was he/she working on? _____

Has your child received any other evaluation/therapy (e.g. physical therapy, occupational therapy, vision therapy)?

☐ Yes

☐ No

If yes, please describe: _____

Is your child aware of, or frustrated by, any speech/language difficulties? _____

What are your child's preferred activities/toy(s)? _____

What are your primary concerns/goals? _____

CURRENT SPEECH-LANGUAGE

Does your child...

- ☐ Repeat sounds, words or phrases over and over?
- ☐ Understand what you are saying?
- ☐ Retrieve/point to common objects upon request (ball, cup, shoe)?
- ☐ Follow directions ("Get your shoes" or "Bring the ball")?
- ☐ Respond correctly to yes/no questions?
- ☐ Respond correctly to who/what/where/when/why questions?

Your child currently communicates using...

- ☐ Body language/gestures
- ☐ Sounds (vowels, grunting)
- ☐ Words Sounds (vowels, grunting)
- ☐ Two to four word sentences
- ☐ Sentences longer than four words
- ☐ Augmentative and Alternative Communication (AAC) device
- ☐ Other _____

Behavioral characteristics:

- | | |
|--|--|
| <input type="checkbox"/> Cooperative | <input type="checkbox"/> Restless |
| <input type="checkbox"/> Attentive | <input type="checkbox"/> Poor eye contact |
| <input type="checkbox"/> Willing to try new activities | <input type="checkbox"/> Easily distracted/short attention |
| <input type="checkbox"/> Plays with a variety of toys | <input type="checkbox"/> Destructive/aggressive |
| <input type="checkbox"/> Separation difficulties | <input type="checkbox"/> Withdrawn |
| <input type="checkbox"/> Easily frustrated/impulsive | <input type="checkbox"/> Inappropriate behaviors |
| <input type="checkbox"/> Stubborn | <input type="checkbox"/> Self-abusive behaviors |

BACKGROUND INFORMATION

What does your child eat/drink for...

Breakfast	Lunch	Dinner
Snacks:		
Drinks:		

What other therapies does your child currently receive? _____

What are your primary concerns/goals? _____

Self-Help Skills:

	Independent	75%	50%	25%	Dependent	Additional Comments
Feeding						
Pullover shirt						
Pants						
Coat						
Socks						
Shoes						
Shoe tying						
Buttons						
Zippers						
Toileting						

Social-Emotional Behavior Characteristics:

Response to environment: ☐ Poor safety awareness ☐ Appropriate response to stimuli
☐ Appears unaware of objects ☐ Appears aware of objects
☐ Appears unaware of people ☐ Appears aware of people
☐ Brief eye contact ☐ Provides eye contact

Approach to task: ☐ Independent play ☐ Impulsive
☐ Says "I can't" ☐ Disorganized

Direction following:

☐ Follows verbal directions

☐ Follows visual directions

☐ Follows physical directions

☐ Unable to follow directions

☐ Follows 1 step directions

☐ Follows 2 step directions

Attention to task:

☐ Appropriate

☐ Distractible

☐ Not focused

Alertness:

☐ Engaged by environment

☐ Not engaged by environment

Transitions:

☐ Able to transition easily

☐ Unable to transition easily

My child's repetitive behaviors consist of: _____

SCHOOL HISTORY

If your child is in school, please answer the following:

Name of the school and grade: _____

Teacher's name: _____

Has your child repeated a grade? _____

What is your child's favorite subject? _____

Is your child having difficulty with any subjects? _____

ADDITIONAL COMMENTS

Autism Symptoms- Mark0-10

1	Language
2	Socialization with peers
3	Stimming Behaviors (hand flapping/toe walking)
4	Hands Over Ears
5	Feeding sensitivities (texture)
6	Eye contact
7	Reciprocal play
8	Imaginative play
9	Socialization with adults

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Autism Symptoms Monitoring

AE	SYMPTOMS TO BE FOLLOWED AS PARENTS DESCRIBED THEM
1	Lack of relevant and spontaneous speech (Answering who, what, when, why, where, and why questions)
2	Lack of back and forth communication (only talks to get needs met.)
3	Lack of relevant and spontaneous speech when communicating with peers
4	Lack of interest in others
5	Lack of general awareness of surroundings
6	Appetite; picky eater
7	Following directions
8	Potty Training
9	Doesn't greet others - Hi or Bye
10	Doesn't ride a bike
11	Echolalia
12	Inability to move on - gets stuck on one activity
13	Temper Tantrums
14	Whining/ Crying (not using words)
15	Toe Walking
16	Doesn't use a spoon or fork
17	Doesn't dress himself
18	Hard to motivate (not willing to try)