

Pacific Autism Center, Inc.

Helping children reach their potential...one child at a time.

670 Auahi St. Suite A-6 Honolulu, HI 96813 Phone:(808) 523-8188 Fax:(808) 523-1687

PLEASE PRINT CLEARLY

Child's Name: _____ Today's Date: _____
 Birthday: _____ Age: _____ Male Female Referred by: _____

Contact & Family Information:

Mother's Name: _____ Home Phone: _____
 Address: _____ Cell Phone: _____
 _____ Work Phone: _____
 Email: _____
 Occupation: _____ Employer: _____ SS# _____

Father's Name: _____ Home Phone: _____
 Address: _____ Cell Phone: _____
 _____ Work Phone: _____
 Email: _____
 Occupation: _____ Employer: _____ SS# _____

Siblings: _____	Age: _____	dx: _____	<u>Marital Status</u>
Siblings: _____	Age: _____	dx: _____	Married <input type="checkbox"/>
Siblings: _____	Age: _____	dx: _____	Separated <input type="checkbox"/>
Siblings: _____	Age: _____	dx: _____	Divorced <input type="checkbox"/>

What are your child's favorite foods? _____

What are your child's favorite toys? _____

What is your child's favorite activity? _____

What are your child's strengths? _____

List three goals you have for your child.

1. _____
2. _____
3. _____

What do you consider the most pressing issue?

Diagnostic Information: Please attach all current evaluation reports to application.

Has your child been officially diagnosed? No Yes

If yes, what is the current diagnosis? _____ Date of diagnosis: _____

Who was your child diagnosed by? _____ of _____

Medical Information:

Child's
Physician: _____ Address _____ Phone# _____

Are your child's immunization shots current? _____

What are the medications you child is currently taking?

Medication	Dosage	Prescribing Physician	Purpose
_____	_____	_____	_____
_____	_____	_____	_____

Has your child had any allergy testing done? Yes No If yes, please explain when and the results of the test. _____

Has your child been on any particular diet? Yes No If yes, please explain. _____

Has your child been on any supplements? Yes No If yes, please list. _____

Developmental Information:

Please describe your child's skill level in the following areas:

Eating: _____

Play: _____

Sleeping: _____

Communication: _____

Self Help & Toileting: _____

Academics:

Where does your child attend school? _____

Please attach current IEP to application.

What services does your child currently receive? _____

Please describe where your child is at academically in the following areas:

Reading: _____

Math: _____

Science: _____

Does your child have any experience in the following enrichment activities:

Art: _____

Tae Kwon Do: _____

Drama: _____

Dance: _____

Sports: _____

What type of classroom is your child in? (SpEd., Resource Room, etc.) _____

How much 1:1 service time does your child receive? _____

Have you had ABA services before? _____ If so, for how long? _____

Please describe the program and what was targeted. _____

Speech / Language:

Does your child understand simple instructions? (i.e. throw away...) _____

How does your child express his/her desires, needs, and wants? _____

Does your child maintain eye contact when spoken to? Yes No If no, when does your child give eye contact? _____

Does your child imitate words? Yes No If yes, explain? _____

Does your child use any other form of communication? Yes No If yes, explain? _____

What is your child's typical daily routine? _____

What are the rules and responsibilities at home for your child? _____

Behaviors - Please list what you consider to be the 5 most disruptive behaviors.

1. Behavior: _____

When does this behavior happen? _____ How long does it last? _____

How often does this occur? _____

Describe the severity of the behavior _____

What is the believed cause of the behavior? _____

How do you currently respond to the behavior? _____

Is there anyone else that responds to the behavior? _____

2. Behavior: _____

When does this behavior happen? _____ How long does it last? _____

How often does this occur? _____

Describe the severity of the behavior _____

What is the believed cause of the behavior? _____

How do you currently respond to the behavior? _____

Is there anyone else that responds to the behavior? _____

3. Behavior: _____

When does this behavior happen? _____ How long does it last? _____

How often does this occur? _____

Describe the severity of the behavior _____

What is the believed cause of the behavior? _____

How do you currently respond to the behavior? _____

Is there anyone else that responds to the behavior? _____

4. Behavior: _____

When does this behavior happen? _____ How long does it last? _____

How often does this occur? _____

Describe the severity of the behavior _____

What is the believed cause of the behavior? _____

How do you currently respond to the behavior? _____

Is there anyone else that responds to the behavior? _____

5. Behavior: _____

When does this behavior happen? _____ How long does it last? _____

How often does this occur? _____

Describe the severity of the behavior _____

What is the believed cause of the behavior? _____

How do you currently respond to the behavior? _____

Is there anyone else that responds to the behavior? _____

Please list if your child exhibits any of the below maladaptive behaviors and their frequency.

<u>Behaviors:</u>	<u>NO</u>	<u>YES</u>	<u>Frequency</u>	<u>Examples</u>
Non-Compliance	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Tantrums	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Self Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Aggressiveness to others	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Ritualistic behaviors	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

