ECHO Autism Communities Adult Patient Form

Date:_____

Patient's Name: _____College/Vocational School: _____
Employed or volunteering: (Name of Employer & City) _____
Self/Parent/Guardian Here Today:_____Best Contact Number: _____
Email: _____ Primary Care Physician (PCP): _____
Are you your own Guardian? NO YES

1. Please circle YES or NO regarding CURRENT health problems/concerns.

Headaches	NO	YES	Picky eater/limited diet/loss of appetite/over eating	NO	YES
Staring Spells/Tremors/Tics/Seizures	NO	YES	Blood Sugar/Thyroid/Growth Problems	NO	YES
Hearing or Vision Concerns	NO	YES	Easy Bruising/Bleeding/Anemia	NO	YES
Dental Problem	NO	YES	Skeletal/Bone/Muscle Problem/Toe Walking	NO	YES
Heart Problems	NO	YES	Environmental Allergies	NO	YES
Lung Problems (asthma)	NO	YES	Skin Problems (rash, eczema)	NO	YES
Urinary/Genital Problems	NO	YES	Sleep Problems (falling/staying asleep/snoring)	NO	YES
Diarrhea/Constipation	NO	YES	Hospitalizations (since last seen)	NO	YES
Stomach Ache/Pain/Reflux	NO	YES	Surgeries (since last seen)	NO	YES

If yes or if you have other health problem(s) not listed above, please explain:_____
_____

2. Please circle YES or NO for the following preventative care questions.

Regular well visits with Primary Care Doctor (Family Physician at least yearly)	NO	YES
Regular visits with Dentist (every 6 months or yearly)	NO	YES
Flu shot (yearly)	NO	YES

3. Please circle the services or resources you are receiving.

Vocational Rehabilitation (Voc-Rehab)
Regional Office (ie. SB40)
Housing Assistance
Counseling
Division of Family Services (DFS)
Thompson Center Family Resource Services (FRS)
Individual Counseling
Family/Marriage Counseling
Job Supports
Support Group
SSI
Medicaid Group
Food Stamps
Disability funding
Other: _____

4. **Supplements/Special Diets*:***_____

5. If you are on medications, please circle your goals for today's visit:

Stay the same / Decrease Medication / Increase Medication / Change Medication / Unsure

6. Please rate (from 1-5) your level of concern over the past 2 weeks.
(1= No Concern; 2= Slight Concern; 3 = Some Concern; 4 = Significant Concern; 5= Extreme Concern)

	Feeling Hopeless	Impulsive	Anxious	Obsessive/ Compulsive	Communication	Social Relationships	Poor Focus	Frustration	Moody/ Depressed	Other
Job/ school										
Home										

7. **Tell me one thing you did this week that made you feel good about yourself?** _____
_____

8. What questions would you like for us to try to answer today?
1. _____
2. _____