Autism-Focused Pediatric Primary Care Form

Visit Date: _____

Patient Name: _____ Parent/Guardian Name: _____
Phone Number: _____ Email: _____
School Name: _____ Grade _____ IEP: Y/N PCP Name: _____

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

Headaches	NO YES	Picky eater/limited diet/loss of appetite		NO YES
Staring Spells/Tics/Seizures	NO YES	Blood Sugar/Thyroid/Growth Problems		NO YES
Hearing or Vision Concerns	NO YES	Skeletal/Bone/Muscle Problem/Toe Walking		NO YES
Dental Problem	NO YES	Environmental Allergies		NO YES
Heart Problems	NO YES	Skin Problems (rash, eczema)		NO YES
Lung Problems (asthma)	NO YES	Sleep Problems (falling/staying asleep/snoring)		NO YES
Urinary/Genital Problems	NO YES	Psychiatric Hospitalizations (last year)		NO YES
Diarrhea/Constipation	NO YES	Toilet Trained:	**Day:** NO / YES **Night:** NO / YES **BM:** NO / YES	
Stomachache/Pain/Reflux	NO YES	Do you worry your child may run away from you?		NO YES
Are there concerns about bullying?	NO YES	At home, is your child safe from abuse/neglect?		NO YES
Have you had an EEG or MRI since your last visit? If yes, please circle which one.				NO YES

Please explain any current health problems/concerns: _____

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

Annual doctor visits (check-ups)	NO YES
Regular visits to the Dentist (every 6 months or yearly)	NO YES
Brushes teeth (at least once a day)	NO YES
Vision checks (at least yearly)	NO YES
Flu shot (yearly)	NO YES
Immunizations up to date	NO YES

3. Please circle the services, therapies, or resources your child is receiving.

Birth-Three Early Intervention	Speech Therapy (SLT)	Community activities – Adaptive Sports/Theatre/Scouts/Equine
Special Education	Physical Therapy (PT)	Parent Training/Support
Parents As Teachers	Occupational Therapy (OT)	Family Therapy / Counseling
Respite Support	ABA Therapy	Individual Therapy/Counseling
SSI/Disability	Feeding Therapy	Social Skills/Peer Social Group
State Waiver Services	Other:	

4. If your child IS on medications for behavior, please circle your goals for today's visit:

Stay the same Decrease Medication Increase Medication Change Medication Unsure

5. If your child is NOT on medication, are you considering medications as a treatment option? No Maybe Yes

6. List supplements or special diets: _____

7. Share one GREAT thing your child did last week: _____

8. Share your child's developmental progress since last visit _____

9. What questions would you like to discuss today?

1. _____
2. _____
3. _____

10. Is behavior a concern today? YES (complete back of form) No

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DIRECTIONS: For each behavior that applies to your child, mark the boxes that best describe its intensity, frequency, and location, and then rank your top 3 priorities for discussion.

BEHAVIORS	How intense is the behavior?					How often does this behavior happen?					Where does the behavior happen?		Which behavior is the priority?
	Not Intense	Mild	Moderate	Severe	Extreme	**Less than once per week**	**1-2 times per week**	**3-5 times per week**	**Every Day**	**Many times per day**	At Home	At School	**Number your top 3 behaviors #1, # 2, # 3**
Hyperactivity High activity level; often moving, fidgeting													
Impulsivity Acts or responds quickly without stopping to think first													
Attention Difficulties Has difficulty staying focused or shifts attention frequently													
Anxiety Appears worried, fearful, nervous, or seeks frequent reassurance													
Mood Changes gets upset easily or noticeable changes in mood													
Repeating behaviors Repeats thoughts, movements, sounds, questions, or routines													
Depression Seems sad or less engaged than usual.													
Difficulty Following Directions Has trouble following requests, routines, rules, or expectations													
Self-Injury Hurts their own body (e.g., hitting, biting, head banging)													
Outbursts Experiences emotional outbursts (e.g., yelling, hitting, kicking, biting, or property damage)													
Elopement Wandering Leaves a safe area or caregiver unexpectedly													
Other behaviors, not listed above: _____ _____													

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