HEALTH, FAMILY, PREFERENCES, AND BEHAVIORAL HISTORY

Applicant's Name *(First, Middle Initial, Last.)*:		**GHA ONLY** **Date Received:** **Initials:**
Person Completing this Questionnaire:		
Date Completed	☐ **M** ☐ **F**	**DOB:**
Services Requested:	Residential: Apartment _____ Group Home _____ ICF/IDD _____ Morrow Valley _____ Day Program: _____ Supported Employment: _____ Special Consultation: _____	

APPLICANT HEALTH HISTORY		
Childhood Illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever	
Immunizations **Please Check box for *Immunizations Received*** ***and write in the Date of the Immunization***	☐ Tetanus	☐ Pneumonia
	☐ HPV	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*
	☐ Shingles	☐ Pneumonia
	☐ Hepatitis A	☐ Meningitis ACWY
	☐ Hepatitis B	☐ Meningitis B
	☐ Polio	Other:

Current Clinical Diagnoses (such as Autism Spectrum, Mental Retardation, Developmental Delay, Psychiatric Diagnosis)

Diagnosis of Autism Spectrum Disorder:

Age at Diagnosis:

Physician or Health Care Facility that made the diagnosis:

Labor and Delivery when the applicant was born:

List Prenatal Problems if any: ____

Birth Weight: ______ Premature _____(yes or no) Number of Weeks _______

Caesarian Delivery ________ (yes or no)

Development: Please indicate the approximate age that the applicant achieved the following milestones

Sat up: _______ Crawled _______________ Walked _____________ First Words: ______________ Sentences: _____________

Toilet Trained: ______________ Bladder ____________ Bowel ___________

Other significant developmental information:

Hospitalizations

Year	Reason	Hospital

Psychiatric Hospitalizations or Crisis Facility Placements

Year	Reason	Hospital or Facility

Has the applicant ever had a blood transfusion?	☐ Yes	☐ No

GHA Autism Supports PO Box 2487 Albemarle North Carolina 28002 Phone: 704-982-9600 Fax: 704-982-8155
www.ghaautismsupports.org

Prescription Drugs, Over-the-Counter Drugs, Vitamins, and Inhalers		
Drug Name and Strength	**Frequency Taken**	**Purpose**

Allergies to Medications	
Drug	**Reaction**

Other Allergies	
Food, Product, Plant, or other item	**Reaction**

APPLICANT: HEALTH SYSTEMS

Height:	**Weight:**

Check if applicant has, or has had, any serious problems in the following areas:

☐	Head/Neck	☐	Chest/Heart	☐	Ear infections
☐	Ears	☐	Circulation	☐	Frequent colds
☐	Nose	☐	Intestinal	☐	Recent changes in weight
☐	Throat	☐	Bladder	☐	Recent changes in energy level
☐	Lungs	☐	Bowel	☐	Recent changes in sleep pattern
☐	Swallowing or choking	☐	Arms	**Please explain any problems:**	
☐	Muscular	☐	Legs		
☐	Skeletal (abnormalities, broken bones)	☐	Hands		
☐	Skin	☐	Feet		
☐	Diabetes	☐	Thyroid Disorder		
☐	Cancer	☐	Dementia		
☐	Seizure Disorder	☐			

Seizure Frequency: ☐ None this past year ☐ Several times last year
☐ One time per month ☐ One time per week
☐ Several times per week ☐ Daily

Bruises easily: ☐ Yes ☐ No	Is bruising medication related? ☐ Yes ☐ No
Does he/she have pressure sores or skin breakdown at the present time? ☐ Yes ☐ No	Has the person had pressure sores in the past? ☐ Yes ☐ No
☐ Dental :	Date of last Dental Exam:

APPLICANT'S FAMILY

MOTHER NAME	**RESIDES CITY/STATE**	**INVOLVED?**	**LIVING?**
		☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**
FATHER NAME	**RESIDES CITY/STATE**	**INVOLVED?**	**LIVING?**
		☐ YES ☐ NO	☐ YES ☐ NO
STEP PARENT(S) NAME IF ANY	**RESIDES CITY/STATE**	**INVOLVED?**	**LIVING?**
		☐ YES ☐ NO	☐ YES ☐ NO
		☐ YES ☐ NO	☐ YES ☐ NO
GRANDMOTHER(S) NAME	**RESIDES CITY/STATE**	**INVOLVED?**	**LIVING?**
		☐ YES ☐ NO	☐ YES ☐ NO
		☐ YES ☐ NO	☐ YES ☐ NO
GRANDFATHER(S)NAME	**RESIDES CITY/STATE**	**INVOLVED?**	**LIVING?**
		☐ YES ☐ NO	☐ YES ☐ NO
		☐ YES ☐ NO	☐ YES ☐ NO

SIBLINGS	RESIDES CITY/STATE	INVOLVED?	LIVING?
		☐ YES ☐ NO	☐ YES ☐ NO
		☐ YES ☐ NO	☐ YES ☐ NO
		☐ YES ☐ NO	☐ YES ☐ NO
		☐ YES ☐ NO	☐ YES ☐ NO
FRIEND OR OTHER FAMILY MEMBER NAME	**RESIDES CITY/STATE**	**REGULARLY INVOLVED?**	**RELATIONSHIP TO APPLICANT**
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	

FAMILY HEALTH HISTORY

Condition	Mother	Father	Sibling	Grandparent	Other Relative (Aunt, Uncle, Cousin)
Autism Spectrum Disorder					
Cardiac Problem					
High Blood Pressure					
Urinary Problem					
Cancer					
Respiratory Disorder(COPD- Cardio pulmonary disorder, other)					
Seizure Disorder					
Developmental Disability or Mental Retardation					
Mental Illness					
Hearing Impairment					
Diabetes					

Other conditions:

Applicant
Other Health Conditions and Concerns:

Signs and symptoms that the Applicant is not feeling well:

Please indicate any health problems that we have not asked about that the Applicant is prone to having such as headaches, seasonal allergies, constipation, etc.

Condition	How treated:

Dietary considerations:

Does the person choke easily or have other swallowing problems?
☐ Yes ☐ No

If yes, please describe:

Special dietary considerations as to how food is prepared (seasoning), and/or whether the food should also be cut into small pieces, blended or otherwise prepared for consumption:

Are special adaptive eating utensils needed? ☐ Yes ☐ No **If yes, please describe:**	
Favorite Foods:	**Favorite Drinks:**

FEMALES ONLY		
Does she menstruate? (have her period?)		
Age at onset of menstruation (first period):		
Date of last menstruation (period):		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Has she had a hysterectomy?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Does she get up at night to urinate?	☐ Yes	☐ No
If yes, how many times?		
Does she have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Has she had a mammogram?	☐ Yes	☐ No
If yes, date of last mammogram:		
Date of last pelvic exam?		

MALES ONLY		
Does he usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Does he feel pain or burning with urination?	☐ Yes	☐ No
Has the force of his urine flow decreased within the last 12 months?	☐ Yes	☐ No
Has he had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Date of last prostate and rectal exam?		

KNOWLEDGE, COMMUNICATION, AND ACTIVITIES OF DAILY LIVING

Self-Identification:		
Does he/she recognize his/her name when called?	☐ Yes	☐ No
Can he/she tell his first name when asked?	☐ Yes	☐ No
Can he/she tell his first and last name when asked?	☐ Yes	☐ No
Can he/she tell his/her age when asked?	☐ Yes	☐ No
Can he/she tell his/her address when asked?	☐ Yes	☐ No
Can he/she tell his/her phone number when asked?	☐ Yes	☐ No

General Knowledge:		
Does he/she recognize and name colors?	☐ Yes	☐ No
Can he/she count to 10?	☐ Yes	☐ No
Can he/she count objects up to 10?	☐ Yes	☐ No
Can he/she add single digit numbers?	☐ Yes	☐ No
Can he/she subtract single digit numbers?	☐ Yes	☐ No
Understands time of day: morning, afternoon, night	☐ Yes	☐ No
Can he/she tell time on the hour?	☐ Yes	☐ No
Can he/she tell time on the half hour?	☐ Yes	☐ No
Can he/she recognize and understand functional signs such as *Exit, Men's, Women's*?	☐ Yes	☐ No
Can he/she read and understand a basic sentence?	☐ Yes	☐ No
Can he/she read and understand simple stories?	☐ Yes	☐ No
Can he/she identify various coins and paper currencies?	☐ Yes	☐ No
Can he/she make change correctly?	☐ Yes	☐ No
Can he/she make a purchase independently?	☐ Yes	☐ No
Can he/she use a checking account?	☐ Yes	☐ No
Does he/she understand the concept of personal property of self and others: what is his/hers, vs. items that belong to others?	☐ Yes	☐ No

Communication:

How does he/she primarily communicate? (expressive communication):
- ☐ Verbally
- ☐ Gesturally
- ☐ Using Sign Language
- ☐ Using pictures or language board

Other:

How does he/she best understand communication from others? (receptive communication):
- ☐ Verbal
- ☐ Gestural
- ☐ Sign Language
- ☐ Pictures or language board

Other:

What is the best way to approach the applicant? (Getting the person's attention without a negative response, enlisting applicant's cooperation).

Please respond to the following regardless of the Applicant's primary means of communication: (verbal, sign, or pictoral)		
Can he/she ask a question that is appropriate to the situation?	☐ Yes	☐ No
Can he/she tell about an experience?	☐ Yes	☐ No
Does he/she understand the meaning of "no"?	☐ Yes	☐ No
Can he/she follow one step directions? ("come here", "go to your room", "go get your father")?	☐ Yes	☐ No
Can he/she follow multiple step directions ("Get your coat and hang it up", "put on your pajamas and brush your teeth")?	☐ Yes	☐ No
Does he/she make requests for things wanted or desired?	☐ Yes	☐ No
Does he/she indicate refusal of things not wanted?	☐ Yes	☐ No
Does he/she spontaneously make comments during an activity?	☐ Yes	☐ No
Is he/she able to provide information that is not known to the recipient of the communication? (tell about something that happened in another location? report about the behavior of another person?)	☐ Yes	☐ No
Does he/she seek information from others? (ask questions to gain information)	☐ Yes	☐ No
Response to People and the Environment:		
He/she is uncomfortable when in crowds or close proximity to others? (may avoid crowd or verbally indicate discomfort)	☐ Yes	☐ No
He/she has unusual fears; exhibits fear of common sounds, objects or environments.	☐ Yes	☐ No
Person resists changes in schedule, people or environment. (attempts to avoid, protests verbally, runs away)	☐ Yes	☐ No
He/she is hypersensitive to being touched by others.	☐ Yes	☐ No
Avoids physical demonstration of affection such as hugs and kisses.	☐ Yes	☐ No
Avoids making eye contact.	☐ Yes	☐ No
Danger Awareness:		
Does he/she recognize items that present dangers, such as a hot stove, knife, inedible objects?	☐ Yes	☐ No
Does he/she recognize environmental dangers such as a busy street, steep staircase, thunder/lightening?	☐ Yes	☐ No
Does he/she recognize strangers from known persons?	☐ Yes	☐ No
Does he/she demonstrate caution around unknown persons?	☐ Yes	☐ No
Does he/she demonstrate caution in new environments?	☐ Yes	☐ No
He/she adheres to verbal commands of caution such as "stop', "come back", "put that down"?	☐ Yes	☐ No
Level of Supervision Required:		
He/she requires close *visual* supervision in new or dangerous environments.	☐ Yes	☐ No
He/she requires *hands-on* or *arms-length* supervision in new or dangerous environments?	☐ Yes	☐ No

He/she requires special planning for new environments, schedules or situations.	☐ Yes	☐ No

LEVEL OF INDEPENDENCE Check One In Each Section	
Medication (adults only)	☐ Independent. (Medication is pre-organized into days/times per day, and person remembers and takes independently)
	☐ With minimal assistance such as verbal reminder to take medication. (Medication is pre-organized into days/times per day)
	☐ Partial assistance; other person presents medications.
	☐ Complete assistance; other person administers the medication.
Bathing or Showering	☐ Independent
	☐ With minimal assistance such as verbal reminders
	☐ Partial assistance, including hands on.
	☐ Complete assistance.
Washing Hair	☐ Independent
	☐ With minimal assistance such as verbal reminders.
	☐ Partial assistance, including hands on.
	☐ Complete assistance.
Styling Hair Male ☐ Female ☐	☐ Independent
	☐ With minimal assistance such as verbal reminders.
	☐ Partial assistance, including hands on.
	☐ Complete assistance.
Brushing Teeth	☐ Independent.
	☐ With minimal assistance such as verbal reminders.
	☐ Partial assistance, including hands on.
	☐ Complete assistance.
Toileting	☐ Independent
	☐ With minimal assistance such as verbal reminders.
	☐ Partial assistance, including hands on.
	☐ Complete assistance.
Females: ability to manage when having menstrual cycle.	☐ Independent.
	☐ With minimal assistance such as verbal reminders.
	☐ Partial assistance, including hands on.
	☐ Complete assistance.
Dressing: including selection of clothing.	☐ Independent.
	☐ With minimal assistance such as verbal reminders.
	☐ Partial assistance, including hands on.
	☐ Complete assistance.
Self-Feeding	☐ Independent.
	☐ With minimal assistance such as verbal reminders.
	☐ Partial assistance, including hands on.
	☐ Complete assistance.

Prepares simple meal such as sandwich or heats meal in microwave.	☐ Independent
	☐ With minimal assistance such verbal reminders.
	☐ Partial assistance, including hands on.
	☐ Complete assistance.
Participates in simple household chores such as making bed.	☐ Independent in carrying out simple chore
	☐ Requires minimal assistance such as verbal reminders.
	☐ Requires partial assistance such as hands on to complete chore.
	☐ Unable to complete any chores.

Behavioral Information

Check ONE box to the right for each behavior:	**Never**	**Not this past year**	**A few times this past year**	**About 1x per Month**	**About 1x per Week**	**Several times per Week**	**One time per Day**	**More than one time per Day**
Tantrum or Emotional Outburst								
Damages own or other's property								
Disrupts activities of others								
Bites him/her self								
Pinches him/her self								
Scratches him/her self								
Hits him/her self								
Bangs head								
Bites others								
Pinches others								
Scratches others								
Hits others								
Kicks others								
Runs or wanders away								
Takes things from others/stealing								
Eats or mouths inedible objects								
Exhibits self-stimulatory behavior (flapping or other)								
Displays sexually inappropriate behavior. (public masturbation, touching others inappropriately) Ages 12 and older								

Other Behavioral Information

Sleep Habits:		
Person usually sleeps all night.	☐ Yes	☐ No
Person gets up during the night to use the toilet.	☐ Yes	☐ No
Person gets up during the night asking for food or water.	☐ Yes	☐ No
Person gets up during the night for other reasons.	☐ Yes	☐ No
Sleeps 7-8 hours per night.	☐ Yes	☐ No
Sleeps 5-6 hours per night.	☐ Yes	☐ No
Sleeps 3-5 hours per night.	☐ Yes	☐ No
Frequently takes a nap.	☐ Yes	☐ No
Person falls out of bed.	☐ Yes	☐ No
Person requires bed rails.	☐ Yes	☐ No
Person requires a special bed (hospital bed or other)	☐ Yes	☐ No

Pain

Is the person hypersensitive (extra sensitive) to pain?	☐ Yes	☐ No
Does the person have a high pain tolerance (is not as sensitive to pain as others)?	☐ Yes	☐ No
Does the person require special planning/precautions prior to medical or dental procedures?	☐ Yes	☐ No

Comments about how person tolerates treatment that results in pain:

Fear and Anxiety:

Unusual Fears: (fears of people, events, objects or environment that are uncommon). **If the person is afraid of animals please list type of animal).**	**Source of fear:**	**Reaction:**

Anxiety:	**What causes anxiety?**	**Reaction:**

Self-Stimulatory Behavior: **(Please complete if Applicant exhibits this behavior)**	
Describe Self Stimulatory Behavior:	**When does this behavior usually happen? What seems to cause it?**

Preferences:		
Favorite Places and Activities:	**Favorite People:**	**Favorite Things:**

Healthcare-Related Fears and Reactions:			
Does person have a fear or negative reaction to the following procedures and devices?			**Person's Reaction:**
Injections:	☐ Yes	☐ No	
Having blood drawn:	☐ Yes	☐ No	
Taking medications orally:	☐ Yes	☐ No	
Medical equipment: blood pressure, x-ray, IV	☐ Yes	☐ No	
Bandages:	☐ Yes	☐ No	
Oxygen	☐ Yes	☐ No	

C-PAP Machine	☐ Yes	☐ No	
Other:		Other:	
Other:		Other:	

Please describe a typical day for the Applicant in his/her current residence: (Routine schedule: waking up, going to bed, meals, and activities that happen during the day).