A & P Institute

Foundation

World Class Mental Healthcare for All

AUTISM EVALUATION APPLICATION

Please complete this form in full to help expedite scheduling your ADOS test.

Clients Legal Name: _____

Client's Preferred Name: _____

Date of Birth: _____

Person filling out questionnaire: _____

Date form filled out: _____

Parent/Guardian Information (Please provide information for both parents)

1st Parent/Guardian		2nd Parent/Guardian	
Name:		Name:	
Phone:		Phone:	
Email:		Email:	
Address:		Lives with child:	Yes ☐ No ☐
Lives with child:	Yes ☐ No ☐	Job:	
Job:			

Name of Insurance (just for our records as we never bill insurance):

How many people live in your house (both parents and dependents)?

What is your annual family income?

$10,000-$50,000 ☐ $50,000-$70,000 ☐ $70,000-$80,000 ☐ $80,000-$100,000 ☐

$100,000+ ☐

Who referred you for testing and why did they refer you?

Do you have any pending, expected, or active legal cases (i.e. divorce, custody issues, guardianship, pending charges, DCF cases, etc)? If yes, please explain.

What symptoms have you noticed that led to you wanting your child evaluated for autism (i.e. delayed in milestones [explain which], social awkwardness, repetitive behaviors, etc.)? Please explain fully.

What places have you called to try to get them evaluated and what was the outcome of that call?

	Facility	Spoke with them?	Appointment Date or Reason Not Scheduled
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Diagnosis Information (Medical and Mental Health)

	Diagnosis	Year Diagnosed	Currently Receiving Treatment (Y/N)
1.			
2.			
3.			
4.			
5.			

Medications your child currently takes or has taken in the last year

	Medication Name	Dosage	Date Started	Date Ended	Reason for Taking
1.					
2.					
3.					
4.					
5.					

Has your child ever been evaluated in the past, including school evaluations? If yes, list below:

	Type of Evaluation	Who Completed It	Date	Copy Available?
	e.g. Speech evaluation	SLP	January 2, 2022	Yes
1.				
2.				
3.				
4.				
5.				

Is your child currently or have they ever received therapy services? If yes, please indicate below:

Service	Provider	Frequency	Date Started	Date Stopped
ABA Therapy				
Occupational Therapy				
Physical Therapy				
Speech Therapy				
Psychotherapy/Counseling				

Signature of Person Completing Questionnaire: _____

Relationship to Client: _____

Date Completed: _____