Contact Information and Preferences

Name: ____________________________________________________________

Home Phone: ______________________________________________________

Cell phone: ________________________________________________________

Work phone: _________________________________________________________

E-mail address: _____________________________________________________

Please indicate how you would like to be contacted (Select all that are applicable):

___ Home Phone
___ Cell phone
___ Work phone
___ E-Mail

Best time of day to be contacted (Select all that are applicable):

___ Morning (8 am -11 am)
___ Early Afternoon (11 am – 2 pm)
___ Afternoon (2 pm- 5 pm)
___ Evening (5 pm – 8 pm)
For use by CDD staff only:

Referral Date: _______________        Autism Client #: ______________
Intake Date: _______________

Childs Initials: _______________

How did you hear about the Parent Home Training Program?
______________________________________________________________________________

Where and when was your child diagnosed with an autism spectrum disorder?
______________________________________________________________________________

When did you first become concerned about your child’s development?
______________________________________________________________________________

Family History

What languages are used in your child’s home?
______________________________________________________________________________

Who lives in your child’s home?
______________________________________________________________________________

Does anyone else regularly provide care for your child?
______________________________________________________________________________

Has your child recently been impacted by any major family changes?

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adoption</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serious Illnesses</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Foster Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remarriage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moving</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Divorce</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse</td>
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<tr>
<td>Divorce</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse</td>
<td></td>
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</tr>
</tbody>
</table>
Does anyone in the child’s immediate family have any developmental problems?

__________________________________________

Does anyone in the child’s immediate family have any mental health or psychiatric issues?

__________________________________________

**Education**

Does your child currently receive educational/therapeutic services from and of the following?

An early intervention program Y N
A school program Y N

If so, what services does your child receive and how often does he/she receive them?

__________________________________________

__________________________________________

**Current Concerns**

Do you have any concerns about your child’s communication? How does your child currently communicate with you?

__________________________________________

__________________________________________

__________________________________________

Do you have any concerns about your child’s behavior? If so, what are your concerns?

__________________________________________

__________________________________________

__________________________________________

How does your child play and get along with others?

__________________________________________

__________________________________________
Does your child display any sensory concerns? Does your child seem over or under responsive to certain stimuli?

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Have you started toilet training yet?

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Are they any other concerns that you would like to share?

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________
Medical Concerns

Does your child have any medical diagnoses other than an autism spectrum disorder?

Is your child currently on medication? (If so please list with milligrams)

Has your child ever had any of the following?

<table>
<thead>
<tr>
<th>Hospitalization</th>
<th>Y</th>
<th>N</th>
<th>Seizures</th>
<th>Y</th>
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<tr>
<td>Allergies</td>
<td>Y</td>
<td>N</td>
<td>Significant Illnesses</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Injuries</td>
<td>Y</td>
<td>N</td>
<td>Vision problems</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Hearing problems</td>
<td>Y</td>
<td>N</td>
<td>Sleeping problems</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Eating problems</td>
<td>Y</td>
<td>N</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Please describe any items marked “Yes” below:

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PLEASE INCLUDE ANY ON HAND/AVAILABLE COPIES OF YOUR CHILD’S IFSP’S OR IEP’S AND ANY OTHER MEDICAL, SCHOOL OR THERAPY REPORTS

Please send or scan and email your completed application to:
University of New Mexico HSC
The Autism Programs Center for Development and Disabilities’ Division
Parent Home Training Program
2300 Menaul NE
Albuquerque, New Mexico 87107

Your family will be placed on the waiting list as soon as we receive your application, so please do not delay.
If you have any questions about this application or this program, please contact Sylvia Acosta 505-272-4725 or SyAcosta@salud.unm.edu