

Snapshot/Case History

Individual's Name: _____ M F Age: _____ Birthdate: _____

Referred by: _____ Date: _____

Person Completing this Form: _____ Relationship to individual: _____

Parent/Caregiver Phone Number & Email Address: _____

Individual's Phone Number & Email Address: _____

Who is legally responsible for the individual? _____

What languages does the individual use (List PRIMARY language first: _____

Why are you seeking these services?

CURRENT DIAGNOSIS AND CONCERNS ABOUT THE INDIVIDUAL

Primary Diagnosis: _____

Comorbid Diagnosis': _____

At what age was the diagnosis received? _____

From Whom and Where was the diagnosis received? _____

Please check all that apply:

___ aggression

___ self-injury

___ self-help skills

___ overactivity

___ inattentive

___ self-stimming

___ depression or anxiety

___ muscle tone

___ medications

___ appetite/food selections

___ explosive temper

___ peer relationships

___ motor skills

___ sleep problems

___ other: _____

CURRENT LIVING SITUATION

With whom does the individual currently reside? (please mark all that apply)

- lives independently
 spouse
 life partner
 sibling
 biological mother
 biological father
 step-mother
 step-father
 adoptive mother
 adoptive father
 group home
 other: _____

MEDICAL HISTORY

Has the individual ever had:

- Head injury Age _____ Describe _____
 Loss of consciousness(LOC) Age _____ Length of LOC _____
 Allergies to food/medications List: _____
 Surgery Age _____ Reason _____ Describe _____

Doctors seen now or in the past (check all that apply)

- General Physician – Date of last visit: _____ Diagnosis: _____
 Neurologist – Date: _____ Diagnosis: _____
 _____ suspected seizures, describe: _____
 _____ seizures diagnosed, type: _____
 Genetics – Date: _____ Diagnosis: _____
 Psychiatry – Date: _____ Diagnosis: _____
 Gastroenterology – Date: _____ Diagnosis: _____

Medication History

CURRENT medications:

Name of medication	Dose & Frequency	Date Started	Reason	Effectiveness

Who prescribes these medications? _____ Date of last visit: _____

Please also list any medications the individual has been on in the **PAST**:

Name of medication	Dose & Frequency	Date Started	Reason	Effectiveness

Family History

Have any members of the biological mother’s or biological father’s families had any of the following problems or disorders (check all that apply):

- | | | |
|--|---|--|
| <input type="checkbox"/> Chromosomal/genetic disorder | <input type="checkbox"/> Obsessive Compulsive Disorder | |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Sever head injury | <input type="checkbox"/> Migraine headaches |
| <input type="checkbox"/> Physical limits | <input type="checkbox"/> Nervousness/Anxiety | <input type="checkbox"/> Alzheimer’s disease |
| <input type="checkbox"/> Seizures/epilepsy | <input type="checkbox"/> Alcohol/drug abuse | <input type="checkbox"/> Physical/Sexual abuse |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Food allergies | <input type="checkbox"/> Other learning disabilities |
| <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Autism/PDD | |
| <input type="checkbox"/> Bipolar/manic-depressive disorder | <input type="checkbox"/> Emotional disturbance/mental illness | |

SCHOOL HISTORY

Individual’s Highest Level of Education

- | | |
|---|---|
| <input type="checkbox"/> 11th grade or less | <input type="checkbox"/> Bachelor’s Degree |
| <input type="checkbox"/> GED | <input type="checkbox"/> Graduate/Professional |
| <input type="checkbox"/> High School Graduate | <input type="checkbox"/> Vocational Certificate |
| <input type="checkbox"/> Associates Degree | |

Please list all of the schools, including college or community college, the individual has attended:

Name of School	Age/grade attended	Hours per day	Days per week

WORK HISTORY

Is the individual currently employed? Y or N

Current Employer: _____ **Job Title:** _____

Employed since: _____ #of hours per week: _____

Previous Employer(s)	Job Tasks/Job Title	Dates	#of hours

SERVICES

Are you currently receiving services from anyone/anywhere (i.e. counseling, speech/OT, day programs, etc.)? Y or N

If YES: (Please list information):

FROM WHOM	TYPE OF SERVICE	LOCATION	FREQUENCY

What services, interventions, and/or supports have been lasting and meaningful?

What services, interventions, and/or supports have **NOT** been lasting and meaningful?

FUNDING

Are you currently receiving any state funding (i.e. SSI, HCBS, disability, etc.)?

Additional Information: _____

**PLEASE ATTACH ANY PERTINENT
MEDICAL/DIAGNOSTIC/FORMAL ASSESSMENT
INFORMATION**