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):

____ Chromosomal/genetic disorder ____ Obsessive Compulsive Disorder

____ Cerebral Palsy ____ Sever head injury ____ Migraine headaches

____ Physical limits ____ Nervousness/Anxiety ____ Alzheimer's disease

____ Seizures/epilepsy ____ Alcohol/drug abuse ____ Physical/Sexual abuse

____ Depression ____ Food allergies ____ Other learning disabilities

____ Schizophrenia ____ Autism/PDD

____ Bipolar/manic-depressive disorder ____ Emotional disturbance/mental illness

SCHOOL HISTORY

Individual's Highest Level of Education

____ 11th grade or less ____ Bachelor's Degree

____ GED ____ Graduate/Professional

____ High School Graduate ____ Vocational Certificate

____ 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