

WOODY'S SONG

FOR KIDS ON THE AUTISM SPECTRUM



Student Information:

Student Name: _____ Age: _____

DOB: _____ Sex: Male or Female SSN: _____

Home Address: _____
Street City State Zip

Family Information:

Parent/Guardian Name: _____ **Relation:** _____

Home Address: _____
Street City State Zip

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Email: _____

Employer: _____

Parent/Guardian Name: _____ **Relation:** _____

Home Address: _____
Street City State Zip

Home Phone: (____) _____ Work Phone: (____) _____

Cell Phone: (____) _____ Email: _____

Employer: _____

Siblings:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Medical Information:

Your child's current medications (please include dosage and times administered):

What is your child's primary diagnosis and when did your child receive this diagnosis?

What is your child's secondary diagnosis and when did they receive this diagnosis?

Who is your child's primary care physician?

Is your child allergic to any medications/environmental allergens/foods?

Does your child have any medically ordered dietary restrictions?

Were there any health complications or maternal illness during the pregnancy?

Was your child delivered at full term?

Were there any complications immediately following birth?

Has your child ever had a seizure? If yes, explain.

Does your child currently have seizures? If yes, what do they look like? How frequent?

Has your child ever been hospitalized under emergency situations? If yes, please explain?

Has your child had any surgeries?

Does your child have any fine or gross motor difficulties?

Educational History:

Please list any previous educational placements (include all schools and dates):

Treatment/Intervention:

Has your child received any physical, occupational, or speech therapy? Please list.

Please list any previous interventions that you have tried with your child.

Has your child ever been in or had an ABA-based program?

Previous Assessments:

Please list any previous assessments that have been conducted on your child. (ABLLS-R, Vineland, Checklist of Adaptive Living Skills, Brigance, etc.)

Communication:

Does your child make vocalizations currently? (Frequently or few times per day)

Please describe your child's functional verbal communication?

Does your child use sign language?

Does your child use pictures to communicate?

How does your child make wants and needs known?

Behavior:

What are your child's strengths?

Does your child engage in aggression towards others? If yes, describe.

Does your child engage in aggression towards self? If yes, describe.

Does your child engage in destruction of property? If yes, describe.

Does your child ingest inedible objects? If yes, describe.

All other behavior problems, including minor ones:

When are these behaviors **most** likely to occur?

When are these behaviors **least** likely to occur?

What behaviors would you like to see increased?

Eating:

What foods does your child prefer?

What foods does your child dislike?

Is your child a picky eater?

Sleeping:

Does your child have a normal sleep schedule? If no, please describe.

How many hours does your child sleep on average?

Other:

Is your child toilet trained?

Is he/she on a schedule? If so, please describe.

Please describe your child's current social or play skills

Please list things that seem to motivate your child in the following areas:

1. Edibles (candy, chips, etc.):
2. Tactile (toys, swings, etc.):
3. Social (tickles, hugs, etc.):

Goals:

Please list 5 goals that you would like to see accomplished by your child:

1. _____
2. _____
3. _____
4. _____
5. _____

Submit Application:

Please mail the completed application to:

PO Box 1306
Semmes, AL 36575
Attention: Julia Starr