

URBAN AUTISM SOLUTIONS



The information asked below allows us to get a better understanding of your needs and goals. However, we understand that you may not feel comfortable answering some of these questions at this point. For that reason, questions with an asterisk (*) are optional at this time.

Name: _____

Age: _____ Date: _____

Address: _____

Email: _____

Phone: _____

Date of Birth: _____

Gender:

School (current or last year completed):

Year:

Information given by:

Relationship to applicant:

Please take just a moment to answer some questions about yourself or the family member for whom you are interested in seeking services, so that we might begin to get to know you better.

Health

Diagnoses: _____

Current Medications:*

Past Medical Concerns:*

Medication Administration: (self, prompted, needs oversight, cannot manage without support, etc.)

Communication

Is Verbally fluent: _____ Uses Short Phrases: _____

Uses Augmented Communication Devices: _____

Does not have a Reliable Method of Communicating with Others _____

Does the applicant use smart phone technology? _____

Please describe. Does the applicant answer the phone consistently?

Social Media Use?

Are electronics problematic for your child?

Independent Living Skills

	Independent	Requires Some Assistance	Dependent on Assistance
Personal Care			
Cooking			
Cleaning			
Laundry			
Shopping			
Transportation			
Finances			

Medical Decisions			
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Personal Care Detail:

	Independent	Requires Some Assistance	Dependent on Assistance
Dressing			
Bathing/Showering			
Toileting			
Shaving			

Can the applicant be left out of the line of sight for 3-4 hours at a time?

Does your family member have any experience living away from you?

What best describes the sleeping habits of the applicant?

Are there any unusual toileting concerns or bathroom habits?

Please describe the applicant's sexual history

Does this applicant see a therapist? Is there a need for ongoing counseling?

Behavioral Issues History

Please respond as accurately as possible. An indication of "yes" will not disqualify you from further services, but will help us to better understand your needs.

_____ Physical Aggression	_____ Verbal Aggression
_____ Self Injurious Behaviors	_____ Property Abuse
_____ Elopement/Leaving Area	_____ Sexual Abuse
_____ Fire starting	

Mobility

_____ Navigates Independently on Community Streets

- _____ Able to safely use Public Transit (with practice/Smart Phone)
- _____ Navigates Independently within known public buildings
- _____ Navigates Independently within home
- _____ Needs close supervision at all times during waking hours

What does the ideal day look like for you or your family member for whom you are interested in obtaining services? Please tell us how a preferred schedule might look, if all conditions were ideal. Include any work, volunteer, leisure and rest time.

What have you tried so far? What works best?

What type of assistance or service are you seeking today or in the near future?

- Residential _____ Vocational _____
- Opportunities _____
- Social Outings/Activities _____ Help Creating a Meaningful
- Day _____

How did you hear about Urban Autism Solutions?

- Hospital _____ Web Search _____ Other _____
- Doctor _____ Friend _____

Please feel free to add any information that you would like us to know as we become acquainted.

Urban Autism Solutions
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