CENTRA
Autism & Developmental Services

Centra offers a wide variety of autism services. We hope that the following information will be helpful in completing the included application for our services. If you have questions about the process, please feel free to give our office a call at 434-200-5750 so we may assist you.

Once the application has been completed, including the section for the applicant's school, please fax or mail the packet to:

Fax: 434-200-1662

Centra Autism & Developmental Center

693 Leesville Road

Lynchburg, VA 24502

Included documents:

1. Patient Information (2 pages)
2. Family Questionnaire (10 pages)
3. The Child/Adolescent Psychiatry Screen (2 pages)
4. School Questionnaire (1 page) . . . to be completed by the child's school. Please return along with the completed application or instruct the school staff to return the document via instructions found at the bottom of the page which they will need to complete and return before the application can be processed.

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APPLICANT'S INFORMATION

PLEASE PRINT OR TYPE DIRECTLY ONTO THIS APPLICATION

Date: _____ Applicant's Name: _____
First MI Last

SSN: _____ Male: ____ Female: ____ DOB: _____

Home Phone: _____ Address: _____

City: _____ State: _____ Zip: _____

Check appropriate: __ Minor __ Single __ Married __ Divorced __ Widowed __ Separated

Race: __ African American/Black __ American Indian __ Asian __ Korean __ White __ Other

Ethnicity: __ Central American __ Hispanic/Latino __ Not Hispanic/ Latino

Applicant's or Parent's Employer: _____

Work Phone: _____ Business Address: _____

City: _____ State: _____ Zip: _____

Parent's Name: _____

Employer's Name: _____ Work Phone: _____

If applicant is a student, name of school: _____

City: _____ State: _____

Email Address: _____

Whom may we thank for referring you? _____

Person to contact in case of emergency: _____ Phone: _____

Current lives with:

Both biological parents	Biological father and stepmother
Biological mother and stepfather	Joint custody -- 2 separate homes
Foster parents	Adoptive parents
Biological father	Non-family care
Biological mother	Relatives, who? _____

Languages spoken at home: _____ Interpreter needed? Y N

Name of person responsible for this account: _____

Relationship to Applicant: _____ Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Driver's License #: _____ DOB: _____

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Employer: _____ Work Phone: _____

Insurance Information

Name of policy holder: _____ Relationship: _____

DOB: _____ SSN: _____ Date employed: _____

Name of Employer: _____ Work Phone: _____

Address of Employer: _____

City: _____ State: _____ Zip: _____

Insurance Company: _____ Group #: _____ ID #: _____

Insurance Company's Address: _____

City: _____ State: _____ Zip: _____

Ins. Co. Phone Number: _____ How much is your deductible? _____

How much have you used? _____ Max annual benefit? _____

DO YOU HAVE ADDITIONAL INSURANCE? Yes No

Name of policy holder: _____ Relationship to patient: _____

DOB: _____ SSN: _____ Date employed: _____

Name of Employer: _____ Work Phone: _____

Address of Employer: _____

City: _____ State: _____ Zip: _____

Insurance Company: _____ Group #: _____ ID #: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Ins. Co. Phone Number: _____ How much is your deductible? _____

How much have you used? _____ Max annual benefit? _____

Applicant's name: _____ Date of birth:_____

Address: _____City:_____State:____Zip:_____

Name(s) of parents or caregivers: _____

_____

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Phone: _____ Work phone: _____

Who referred the applicant for evaluation? _____

MARITAL STATUS

Are parents married to each other? Yes No Date of marriage: _____

Are parents separated or divorced? Divorced Separated

Date of separation or divorce: _____

If divorced or separated, please indicate custody arrangements: Joint Sole

Which parent has custody? _____

Other (please describe): _____

_____

Please indicate what specific questions you have and what information you are seeking from this evaluation: _____

_____

_____

_____

List the applicant's strengths: _____

_____

SIBLING(S) INFORMATION

First name only	Birth date	Gender	Relationship	Does sibling have an autism spectrum disorder?	Other developmental or health disorder
		Male Female	Full Step Half Foster	Yes No	
		Male Female	Full Step Half Foster	Yes No	
		Male Female	Full Step Foster Half	Yes No	
		Male Female	Full Step Foster Half	Yes No	
		Male Female	Full Step Foster Half	Yes No	

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OTHER CAREGIVER INFORMATION

First name: _____ Last name: _____

Suffix: Jr. Sr. III IV Relationship to child: _____

Street or mailing address: _____ Suite/Apt #: _____

City: _____ State: _____ Zip code: _____ County: _____

Email: _____ Primary phone: _____

Alternate phone 1: _____ Alternate phone 2: _____

Birth date: _____

MEDICAL HISTORY

Please check any of the following with whom you have had contact concerning your son/daughter.

PEDIATRICIAN *Name:*	
City/State:	Sees currently Seen in the past
FAMILY DOCTOR *Name:*	
City/State:	Sees currently Seen in the past
NEUROLOGIST *Name:*	
City/State:	Sees currently Seen in the past
EAR, NOSE & THROAT SPECIALIST *Name:*	
City/State:	Sees currently Seen in the past
OPHTHALMOLOGIST *Name:*	
City/State:	Sees currently Seen in the past
SURGEON *Name:*	
City/State:	Sees currently Seen in the past

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DENTIST *Name:*	
City/State:	Sees currently Seen in the past
PSYCHIATRIST *Name:*	
City/State:	Sees currently Seen in the past
PSYCHOLOGIST *Name:*	
City/State:	Sees currently Seen in the past
AUDIOLOGIST *Name:*	
City/State:	Sees currently Seen in the past
SPEECH THERAPIST *Name:*	
City/State:	Sees currently Seen in the past
OCCUPATIONAL THERAPIST *Name:*	
City/State:	Sees currently Seen in the past
PHYSICAL THERAPIST *Name:*	
City/State:	Sees currently Seen in the past
SOCIAL WORKER *Name:*	
City/State:	Sees currently Seen in the past
DIETITIAN *Name:*	
City/State:	Sees currently Seen in the past
EARLY INTERVENTION SPECIALIST *Name:*	
City/State:	Sees currently Seen in the past
OTHER (specify) *Name:*	
City/State:	Sees currently Seen in the past

Has your son/daughter had any of the following? If so, please indicate age.

Check	Condition	Age		Check	Condition	Age

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	Meningitis and/or encephalitis				Bladder or kidney infection	
	Accidents				Headaches and/or migraines	
	Heart disease				Poisoning	
	Convulsions and/or seizure disorders				Diabetes	
	Measles				Head injuries	
	Whooping cough (pertussis)				Mumps	
	Recurrent ear infections				German measles	
	Chicken pox				Recurrent tonsillitis	
	Fainting spells				Pneumonia requiring hospitalization	
	Eye or visual problems				EEG	
	Severe diarrhea with dehydration				Chromosome studies	
	Allergies				Other genetic studies	
	Severe reaction to immunizations				Hospitalization	
	CNS (brain) studies (e.g. MRI, CT)				Chronic infections (e.g. TB, cytomegalovirus, herpes, HIV)	
	Surgery (please specify):					
	Other (please specify):					

What medication(s) and/or vitamin(s) has the applicant taken or is currently taking?

Medication:	Date(s):
Reason/Effectiveness:	
Medication:	Date(s):
Reason/Effectiveness:	
Medication:	Date(s):
Reason/Effectiveness:	

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Medication:	Date(s):
Reason/Effectiveness:	

PAST PSYCHIATRIC HISTORY

Current therapist or counselor: _____

Current psychiatrist: _____

Wraparound agency and services: _____

_____

Other clinical services: _____

_____

Current psychiatric medications: _____
Past psychiatric medication trials: _____

_____

Inpatient psychiatric hospitalizations: _____

_____

Reason(s) for hospitalization: _____

_____

Partial or day treatment programs: _____

_____

Reason(s) for participation: _____

_____

Drug rehabilitation services: _____

_____

PREVIOUS DIAGNOSES AND REPORTS

To serve you as effectively and as quickly as possible, we require that you send us copies of previous evaluations. We need all previous evaluation reports before we can schedule an appointment.

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1. Has your child ever received an evaluation for ASD, Autism, Asperger's Syndrome, or PDD-NOS made by a school system, psychologist or medical doctor? Yes No

If yes, who? _____ City/State: _____ Date: _____

Please check one: Report(s) attached Report(s) will be sent in a separate mailing.

2. Has your child ever received any developmental or IQ testing? Yes No

If yes, who? _____ City/State: _____ Date: _____

Please check one: Report(s) attached Report(s) will be sent in a separate mailing.

3. Has your child ever received any behavioral or mental health evaluations *(for concerns such as ADHD, depression, anxiety, psychosis, conduct, etc.)***?** Yes No

If yes, who? _____ City/State: _____ Date: _____

Please check one: Report(s) attached Report(s) will be sent in a separate mailing.

4. Has your child ever received any other type of evaluation for other disabilities orconcerns (*e.g. OT, medical evaluations)*? Yes No

If yes, who? _____ City/State: _____ Date: _____

Please check one: Report(s) attached Report(s) will be sent in a separate mailing.

PREGNANCY INFORMATION

Please check any of the following which occurred during the pregnancy with this child:

Excessive nausea & vomiting	Spotting or bleeding	German measles (rubella)
Other infectious disease, flu	Kidney or bladder infection	High blood pressure
Toxemia	Anemia (low iron)	Smoking
Alcohol use	Drugs (prescription, non-prescription)	RH incompatibility
Accidents	Medical problems unrelated to pregnancy	Hospitalization during pregnancy
Premature birth	Emotional strain	Physical strain
Difficulty conceiving	Regularly saw doctor, first visit in month #:	
Ultrasound	Other (please specify):	
Amniocentesis		
Other prenatal diagnostic studies		

Where there any problems during other pregnancies *(include items listed above as well as difficulty conceiving, miscarriages, stillbirths, premature births)*? No Yes

If yes, please specify: _____

_____

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APPLICANT'S BIRTH HISTORY

Hospital where child was born: _____

Birth weight: _____ lbs. _____oz. City/State _____

APGAR Scores: range 1-10			No complications	Multiple births	Breech
#1	**#2**	**Delivery:**	Cesarean section	Forceps	Cord around neck
			Other birth complications:		

NEONATAL HISTORY

Please check any of the following which applied during first month.

Breathing problem	Convulsions	Cyanosis (skin blue)
Excessive crying	Infections	Jaundice (skin yellow)
Sleeping problems	Received care in an intensive care nursery	Very inactive
Feeding problems	Any other neonatal problems? Please specify:	

DEVELOPMENTAL HISTORY

Milestones: As closely as you can recall, please indicate age when your child did the following things.

Milestone	**Age**	***Milestone***	**Age**
Eating		**Motor**	
Gave up bottle		Rolled over	
Drank from cup without help		Reached for objects	
Started eating solids		Sat without support	
Fed self with spoon		Crawled	
Toilet Training		Pulled to standing	
Bladder trained – daytime		Stood without support	
Bladder trained – nighttime		Walked using furniture as support	
Bowel trained – daytime		Walked alone	
Bowel trained – nighttime		Rode tricycle	

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Went to bathroom alone			**Social Communication**	
Dressing Skills			Smiled	
Undressed self			Followed with eyes	
Dressed self			Made single sounds (babbling)	
Buttoned clothes			Said first word	
Tied shoelaces			Used words every day	
			Combined words in short sentences	

Please estimate the child's present vocabulary size:

No words | 1 to 5 words: first words | 10 to 25 words | 25 to 50 words

50 to 75 words | 75 to 100 words | Over 100 words

EDUCATION HISTORY

School: _____ Teacher: _____

Classroom: Regular ___ grade Resource support Self-contained special education

Does your child have (check any that apply): IFSP IEP 504 Plan

My child is not currently enrolled in school.

Previous School Experience

Name of School	City	Special Education Services Received	Grades
Preschool:		Yes No	
Elementary:		Yes No	
Middle:		Yes No	
High:		Yes No	

Has your son/daughter had past or current difficulties in school? Yes No

If yes, please describe: _____

_____

_____

_____

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Contact person: _____ Title: _____

Other school personnel routinely working with the applicant: _____

_____

Indicate special classes or repeated grades the applicant has had: _____

_____

_____

_____

Ease of transition to school: _____

Age at which applicant entered kindergarten: _____
Typical academic performance: _____

Recent academic performance: _____

In-school suspensions: _____

Out-of-school suspensions: _____

Other disciplinary interventions: _____

_____

FAMILY HISTORY

Mother's age: _____ Occupation: _____
Highest Education Completed:

Graduate/professional degree	BA, BS or 4-year degree	Technical school degree
Associates degree	High school graduate	GED diploma
1-3 years of high school	Completed up to 9th grade	Completed less than 9th grade

Place of employment: _____

Employer's address: _____ Phone: _____
Father's age: _____ Occupation: _____
Highest Education Completed:

Graduate/professional degree	BA, BS or 4-year degree	Technical school degree
Associates degree	High school graduate	GED diploma
1-3 years of high school	Completed up to 9th grade	Completed less than 9th grade

Place of employment: _____

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Employer's address: _____ Phone: _____

FAMILY TREE

If any of your child's biological relatives have had any of the following conditions, please write the person's relationship to your child next to the condition. By relatives we mean your son's or daughter's grandparents, aunts, uncles, first cousins, siblings and/or parents.

Condition	Biological mother's family	Biological father's family
Autism, Autism Spectrum Disorder, Asperger's Syndrome, PDD		
Communication disorder		
Convulsions, seizures, epilepsy		
Cerebral Palsy, muscular weakness		
Hearing loss		
Intellectual Disability (formerly known as Mental Retardation)		
School difficulties		
Severe visual impairment		
Slow development, slow talker		
Reading difficulty		
Emotional disorder (specify):		
Attention Deficit Disorder		
Depression		
Manic depression, bipolar disorder, mood disorder		
Alcoholism, substance abuse or dependency		
Autoimmune disorders (specify):		
Special education services		
Suicidal ideations, suicidal attempts		
Other (specify):		

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AGENCY INVOLVEMENT

Children and Youth: _____

Case worker: _____

MH/MR: _____

Juvenile probation: _____

Probation officer: _____

Other agencies: _____

Child/Adolescent Psychiatry Screen (CAPS)

Child's Name:_____ Date of Birth :_____ Male _____ Female _____ Form Completed By:_____ Relationship to Child:_____

For each item below, check the one category that best describes your child ***during the past 6 months*.**
None = the child never or very rarely exhibits this behavior. **Mild** = the child exhibits this behavior approximately once per week, and few others notice or complain about this behavior. **Moderate** = the child exhibits this behavior at least three times per week, and others notice or comment on this behavior. **Severe** = the child exhibits this behavior almost daily, and multiple others complain about this behavior. ***Past*** = the child used to have significant problems with this behavior, ***but not during the past 6 months*.** Mark answers with "x"

	None	**Mild**	**Moderate**	**Severe**	***Past***
1. Has difficulty separating from parents* (* = or major caregiver/guardian)	_____	_____	_____	_____	____
2. Worries excessively about losing or harm occurring to parents*	_____	_____	_____	_____	____
3. Worries about being separated from parent* (getting lost or kidnapped)	_____	_____	_____	_____	____
4. Resists going to school or elsewhere because of fears of separation	_____	_____	_____	_____	____
5. Resists being alone or without parents*	_____	_____	_____	_____	____
6. Has difficulty going to sleep without parent nearby	_____	_____	_____	_____	____
7. Physical complaints (headache, stomach ache, nausea) when anticipating separation	_____	_____	_____	_____	____
8. Has discrete periods of intense fear that peak within 10 minutes	_____	_____	_____	_____	____
9. Has excessive, unreasonable fear of a specific object or situation	_____	_____	_____	_____	____
10. Has recurrent thoughts that cause marked distress (e.g., fears germs)	_____	_____	_____	_____	____
11. Driven to perform repetitive behaviors (e.g., handwashing, doing things 3 times)	_____	_____	_____	_____	____
12. Has recurrent, distressing recollections of past difficult or painful events	_____	_____	_____	_____	____
13. Worries excessively about multiple things (e.g., school, family, health, etc.)	_____	_____	_____	_____	____
14. Goes to the bathroom at inappropriate times or places	_____	_____	_____	_____	____
15. Makes noises, and is often unaware of them	_____	_____	_____	_____	____
16. Makes repetitive, sudden, nonrhythmic movements	_____	_____	_____	_____	____
17. Fails to pay close attention to details or makes careless mistakes	_____	_____	_____	_____	____
18. Has difficulty sustaining attention during play or school activities	_____	_____	_____	_____	____
19. Does not seem to listen when spoken to directly	_____	_____	_____	_____	____
20. Does not follow through on instructions; fails to finish schoolwork/chores	_____	_____	_____	_____	____
21. Has difficulty organizing tasks and activities	_____	_____	_____	_____	____
22. Loses things necessary for tasks are activities (toys, pencils, etc.)	_____	_____	_____	_____	____
23. Is easily distracted easily by irrelevant stimuli	_____	_____	_____	_____	____
24. Is forgetful in daily activities	_____	_____	_____	_____	____
25. Is fidgety or squirms in seat	_____	_____	_____	_____	____
26. Has difficulty remaining seated	_____	_____	_____	_____	____
27. Runs or climbs excessively; is restless	_____	_____	_____	_____	____
28. Talks excessively	_____	_____	_____	_____	____
29. Blurts out answers before questions have been completed	_____	_____	_____	_____	____
30. Has difficulty waiting turn	_____	_____	_____	_____	____
31. Interrupts or intrude on others	_____	_____	_____	_____	____
32. Episodes of unusually elevated or irritable mood	_____	_____	_____	_____	____
33. During this episode, grandiosity or markedly inflated self-esteem (Superhero)	_____	_____	_____	_____	____
34. During this episode, is more talkative than usual/seems pressured to keep talking	_____	_____	_____	_____	____
35. During this episode, races from thought to thought	_____	_____	_____	_____	____
36. During this episode, is very distractible	_____	_____	_____	_____	____
37. During this episode, excessively involved in things (too religious, hypersexual)	_____	_____	_____	_____	____
38. During this episode, dangerous involvement in pleasurable activity (spending, sex)	_____	_____	_____	_____	____
39. Depressed or irritable mood most of the day, most days for at least 1 week	_____	_____	_____	_____	____
40. Loss of interest in previously enjoyable activities	_____	_____	_____	_____	____
41. Notable change in appetite (not when dieting or trying to gain weight)	_____	_____	_____	_____	____
42. Difficulty falling or staying asleep, or sleeping excessively through the day	_____	_____	_____	_____	____

Child/Adolescent Psychiatry Screen (CAPS) - continued

Mark answers with "x"

	None	Mild	Moderate	Severe	*Past*
43. Others notice child is sluggish or agitated most of the time					
44. Loss of energy nearly every day					
45. Feelings of worthlessness or inappropriate guilt nearly every day					
46. Thinks about dying or wouldn't care if died					
47. Smokes cigarettes, drinks alcohol, OR abuses drugs (Circle all that apply)					
48. Has bad things happen when under the influence of substances					
49. Has made unsuccessful efforts to stop using a substance					
50. Is excessively worried about gaining weight, even though underweight					
51. If female, has stopped having menstrual cycles (after regularly having)					
52. Thinks he/she is fat, even though not overweight (pulls skin and claims is fat, etc.)					
53. Engages in binging and purging (eats excessively, then vomits or uses laxatives)					
54. Bullies, threatens, or intimidates others					
55. Initiates physical fights					
56. Uses weapons that could harm others					
57. Has been physically cruel to animals					
58. Has shoplifted or stolen items					
59. Has deliberately set fires					
60. Has deliberately destroyed others' property					
61. Lies to obtain goods or to avoid obligations					
62. Stays out at night despite parental prohibitions					
63. Has run away from home overnight on at least two occasions					
64. Is truant from school					
65. Loses temper					
66. Actively defies or refuses to comply with adult rules					
67. Deliberately annoys others					
68. Blames others for his/her mistakes or misbehavior					
69. Easily annoyed by others					
70. Is spiteful or vindictive					
71. Has unusual thoughts that others cannot understand or believe					
72. Hears voices speaking to him/her that others don't hear					
73. Does poorly at sports or games requiring physical coordination skills					
74. Has difficulty at school with: reading, writing, math, spelling (Circle all that apply)					
75. Had delayed speech or has limited language now					
76. Avoids eye contact during conversations					
77. Does not follow when others point to objects					
78. Shows little interest in others; emotionally out of sync with others					
79. Difficulty starting, stopping conversation; continues talking after others lose interest					
80. Uses unusual phrases, possibly over and over (speaks Disney or movie lines)					
81. Does not engage in make-believe play; plays more alone than with others					
82. Unusual preoccupations with objects or unusual routines (lines up 100's of cars, etc.)					
83. Difficulty with transitions; may be inflexible about adhering to routines or rules					
84. Shows unusual physical mannerisms (hand-flapping, shrieks, objects in mouth, etc.)					
85. Unusual preoccupations (schedules, own alphabet, weather reports, etc.)					

Thank you for answering each of these items. Please list any other symptoms that concern you:

_____

_____

_____

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SCHOOL QUESTIONNAIRE

Student's Name: _____ Date: _____

This form was completed by: _____ Title: _____

Name of School: _____

Grade in School: _____ Has he/she ever repeated a grade? _____ If so, which? _____

Type of school program: _____ General _____ Special Education

If special education, please describe: _____

_____

Academic Subject/ Developmental Area	Far Below Average	Below Average	Average	Above Average	Far Above Average
Student's Level of Effort					

What concerns you most about your student? _____

_____

_____

_____

_____

_____

Describe your student's strengths and what you like best about your student:

_____

_____

_____

_____

_____

_____

Please return this document to the address or fax number provided at the top of the page