

Acknowledgement

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Record Book Committee
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Dear Parent/Guardian of Individuals with Autism Spectrum Disorder:

As your son/daughter matures you will be asked to recall much specific information that is unique to their growing-up years. Some of this information may be recorded in a "baby book" or a school record book, but much is specific to having a child with a developmental disability and more specifically with Autism.

Hopefully, this book will lighten your load by providing a systematic way to document and update information that you may then photocopy when needed. This will allow you to supply accurate information without constant repetition. Undoubtedly, we have missed some vital information about your child; please use the backs of the sheets to record other important data.

You may find the first section useful in transmitting current information to various caregivers. We suggest that you make several copies of this section, so that you keep a current one available.

We hope this book will become a valuable resource for your son, daughter and you. It grew from parental suggestions.

Sincerely,

Ravi Ahluwalia
Thaia Jones
Leslie Styba
Sonia Tavares

Peel Autism Working Group

CURRENT INFORMATION

In order to keep this information current, please make several copies of this portion and keep them updated.

Name _____ Date of Birth _____

Address _____

Name of Parent/Guardian _____

Address of Parent/Guardian _____

Emergency telephone () _____

General physical condition _____

Current Physician _____

Telephone () _____ Health Card No. _____

Current Medications	Dosage	Time of day

Allergies: _____

Blood Type: _____

Wears glasses: Yes, Describe _____

Wears hearing aid: Yes, Describe _____

CURRENT SKILLS

Current Primary Means of Communications:

_____ Verbal _____ Signs _____ Communication Board/Book

Other (Points, takes hand of caregiver, etc.) _____

If primarily verbal how would you describe his/her language?

_____ Single Words _____ Phrases _____ Multiword

Describe his/her speech _____ Clear _____ Unclear

Comments:

How will s/he let his/her needs be known? _____

Gestures/signs s/he uses well _____

Communicates mainly with adults _____ with children _____

Communicates only when really needs/wants something _____

Enjoys talking/relating to familiar persons _____

When upset, will let you know by _____

Indicates choice by _____

Independent in bathroom? Yes _____ No _____

If not, what help is needed? _____

Can dress self? Yes _____ No _____

If not, what help is needed? _____

Prefers Shower _____ Tub _____

Special bathing/grooming rituals? _____

Has aversion to water? Yes _____ No _____

Has (good _____ fair _____ poor _____) appetite.

Eating or diet concerns _____

Favourite foods _____

Absolutely will not eat these foods _____

Should not eat these foods _____

At present, will s/he come to caregiver when hurt or sick? Yes _____ No _____

Sometimes, depending on _____

Tolerance to pain is high _____ average _____ low _____

Explain _____

At present, does s/he recognize obvious dangers such as cars in street, hot stove, heights, etc?

Yes _____

No _____

Explain _____

Can tell time?

Yes _____

No _____

If yes, how? _____

Can read function words?

Yes _____

No _____

Can ride a bike?

Yes _____

No _____

Enjoys swimming

Yes _____

No _____

Swims in deep water

Yes _____

No _____

Carries security object

Yes _____

No _____

What is it? _____

Usually sleeps all night

Yes _____

No _____

Other: _____

Fears _____

Favourite activities – can be used as motivators: _____

Other activities, foods, or items useful for reinforcement? _____

List of Special Skills/Strengths:

Will he/she run out of house, program, etc.? Yes _____ No _____ Sometimes _____

Will hit or injure self? Yes _____ No _____ Sometimes _____

Will hit or injure others? Yes _____ No _____ Sometimes _____

Will attack objects? Yes _____ No _____ Sometimes _____

Other? _____

DEVELOPMENTAL MILESTONES

Motor	Age in Months
Held head up	_____
Rolled over front to back	_____
Rolled over back to front	_____
Sat alone	_____
Pulled self to standing	_____
Crawled	_____
Stood holding on	_____
Walked alone	_____
Walked up stairs	_____
Walked down stairs	_____
Ran at least 10 feet	_____
Jumped	_____

Hand Preference _____ Left _____ Right _____ Age Established

Communication/Social	Age in Months
Smiled	_____
Babbled	_____
Reached to be picked up	_____
Played peek-a-boo	_____
Waved bye-bye	_____
Pointed to objects out of reach	_____
Said first word	_____
Shook head "No"	_____
Two word combinations	_____

Self-Help Skills

Age in Months

Fed self finger food (i.e. cheerios, crackers)	_____
Fed self with spoon	_____
Drank from a cup	_____
Held cup alone	_____
Undressed self	_____
Dressed self	_____
Brushed teeth	_____
Combed/brushed hair	_____
Washed face	_____
Showered or bathed alone	_____
Bowel control established	_____
Bladder control established	_____
_____ Day	_____
_____ Night	_____

Describe methods used to establish bladder and bowel control and how long it took to establish, if possible:

Slept through the night	_____
Stopped taking a daytime nap	_____

Describe any difficulty with sleeping, such as screaming, required little sleep, use of medication; etc:

MEDICAL HISTORY

Immunizations:

(Photocopy Immunization Record)

Routine Tests & Results:

<u>Test</u>	<u>Dates</u>	<u>Result</u>
Tuberculin	_____	_____
PKU Urine test	_____	_____
Metabolic screen urine test	_____	_____
Others:	_____	_____

Illnesses:

Age

(Include frequent ear infections, respiratory problems, frequent doctor visits)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Hospitalizations:

Hospital
Doctor
Reason
Date
Outcome

Hospital
Doctor
Reason
Date
Outcome

Hospital
Doctor
Reason
Date
Outcome

Hospital
Doctor
Reason
Date
Outcome

Genetic Workups:

Date

Results

Fragile X Test

Chromosome

Other

Allergies:

Allergies

Date noticed

Date no Longer
a problem

Type of Test Used to Determine
Allergy (Elimination diet, skin test,
ARREST)

How are allergies displayed?

Allergy Medicine/Treatment

Dates

Effects

MEDICATION HISTORY

Antibiotics:
Drug & Dose

Date

Reason

Reaction

Seizure Medications:
Drug & Dose

Date

Reaction

Medicines for Constipation:
Drug & Dose

Date

Reaction

Medicines for Behaviour:
(Mellarial, Haldol, Thorazine, Stelazine, Navane, Ritalin, Tofranil, Lithium, Valium, Prozac, etc.)

Drug & Dose

Date

Reason

Reaction

Drug & Dose

Date

Reason

Reaction

Any Other Medications Taken Regularly:

Drug & Dose

Date

Reason

Reaction

Drug & Dose

Date

Reason

Reaction

DIAGNOSTIC HISTORY

Where/who first suggested autism/autistic characteristics? Age

Who confirmed Autism or Related Disorder Age

Other diagnoses: Age

What assessments and evaluations have been completed? (Insert copies of Reports)

Place
Date
Diagnosis
Recommendations

Place
Date
Diagnosis
Recommendations

Place
Date
Diagnosis
Recommendations

Place
Date
Diagnosis
Recommendations

Place
Date
Diagnosis
Recommendations

EDUCATIONAL HISTORY

Preschool Experiences

Place	Date	Successes	Problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Elementary School

Year	School	Class Placement Teachers	Special Services	Comments
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Middle/Junior High School Experiences

Educational Evaluations

Test

Name _____

Date _____

Results _____

Name _____

Date _____

Results _____

Name _____

Date _____

Results _____

HISTORY OF PLAY SKILLS DEVELOPMENT

	Age, if Occurred
Social Play	
a) Play with adults – (plays with parent or other adult)	_____
b) Imitative play – (imitates the actions of others play)	_____
c) Solitary play - (plays alone)	_____
d) Parallel play – (plays side by side, activities are unrelated)	_____
e) Associative play – (plays with same materials but not creating together with others)	_____
f) Co-operative play – (creates a play theme together with others)	_____
g) Games with rules – (plays games with shared rules)	_____

Play with Objects

a) Sensorimotor play – (explores properties of object)	_____
b) Constructive play – (uses materials to build)	_____
c) Imaginative play -	
i) representational skills (uses objects to pretend)	_____
ii) role playing (pretends to be someone else)	_____

Describe development in this area and what helped these skills to develop:

HISTORY OF COMMUNICATION THERAPY

History of Speech/Language Therapy

Date	Agency	Type of Intervention (e.g. consultation, therapy, PECS, parent workshop)	Progress

Was alternative/augmentative communication ever tried? (e.g., visual schedules, picture system, signing, voice output)

If yes, describe outcome:

Describe any unusual development in this area:

HISTORY OF MAJOR LIFE EVENTS AND STRESSES
(remember that happy events can be stressful as well as sad ones)

CHANGES WITHIN THE FAMILY:

Brother/sister born

Relative/family member moved in/moved out

Family member serious illness or death

Parent separation/remarriage

Other family changes

AGE OF CHILD:

CHANGES IN DAILY LIVING:

Moved to new home

Moved to new school

Change in long-term caregiver such as babysitter

Child living away from family

Other daily living changes

PERSONAL OR UNIQUE STRESSES:

Loss of a friend

Intrusive medical/dental procedures

Accident or medical restriction

Any other events that apparently led to
Sudden or lengthy behavioural changes

HISTORY OF SENSORY CONCERNS

Vestibular System

Did your child:

- Appear fearful of playground equipment or carnival rides
- Become sick easily in cars, elevators rides
- Appear fearful of heights or stair climbing
- Avoid balancing activities
- Seek fast moving activities
- Avoid participation in sports or active games
- Seem oblivious to risks of heights and moving equipment
- Engage in frequent spinning, jumping, bouncing, running

Tactile System

Did your child:

- Avoid touch or contact
- Dislike and avoid messy play
- Appear irritated by certain clothing or food textures
- Appear irritated when someone is in close proximity
- Often appear very active or fidgety
- Have difficulty manipulating small objects
- Use their hands to explore objects
- Mouth objects

Proprioceptive System

Did your child:

- Exert too much or not enough pressure when handling objects
- Assume body positions necessary go perform different tasks
- Enjoy rough and tumble play
- Seek deep pressure by sequencing between furniture
- Relax when given firm massages

Comments

Visual System

Did your child:

- Appear uncomfortable in strong sunlight
- Appear sensitive to changes in lighting
- Turn away from television or computer screens
- Focus on shadows, reflections, spinning objects
- Have difficulty scanning the environment
- Respond when new people enter a room

Auditory System

Did your child:

- Become upset with loud or unexpected noises
- Hum or sing to screen out unwanted noise
- Respond to voices

Olfactory (Smell) and Gustatory (Taste) Systems

Did your child:

- Dislike strong smells or tastes
- Smear their feces
- Eat non-edible foods
- Crave strong smells or tastes

HISTORY OF BEHAVIOURAL INTERVENTION

BEHAVIOUR

Ages Occurred:

Duration:

Successful Intervention:

BEHAVIOUR

Ages Occurred:

Duration:

Successful Intervention:

BEHAVIOUR

Ages Occurred:

Duration:

Successful Intervention:

BEHAVIOUR

Ages Occurred:

Duration:

Successful Intervention:

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