

REGIONAL SUPPORT ASSOCIATES

"Enhancing the Lives of Individuals with Intellectual Disabilities through Specialized Clinical Services"

PAST HISTORY CHECKLIST

NAME OF CLIENT: _____

DATE OF BIRTH: _____

PERSON PROVIDING INFORMATION: _____

RELATIONSHIP TO CLIENT: _____

1. Does client have capacity to consent to treatment? Yes No
If no, name of substitute decision maker: _____
telephone # _____

2. Were any developmental milestones delayed as a child? Yes No

3. Has client been diagnosed with:
Mental Retardation Yes No Developmental Disability Yes No
Autistic Disorder Yes No Aspergers Disorder Yes No
Pervasive Developmental Disability Yes No

4. Does client have a Psychiatric/Mental Health illness? Yes No
If Yes, please describe _____

5. Has client had any previous assessments? Yes No
If yes, please list _____

If yes, have you enclosed the reports? Yes No
If you do not have copies, have you completed the enclosed Releases to send
the information to Regional Support Associates? Yes No

6. Is there any family history of Developmental Disability? Yes No

7. Did the client attend High School? Yes No
Last grade completed: _____

8. Was client ever enrolled in the DSE program? Yes No
Was client ever enrolled in special education program? Yes No

9. Can the client perform the following tasks independently? (*Without supervision or reminder*)

Calculate change	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Use the bus/taxi	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sometimes <input type="checkbox"/>
Count out change	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Cook <i>only</i> simple meals	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sometimes <input type="checkbox"/>
Clean living quarters	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Cook more complex meals	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sometimes <input type="checkbox"/>
Take own medications	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Understand correct dosages	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sometimes <input type="checkbox"/>
Make his/her own bed	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Does work on time	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sometimes <input type="checkbox"/>
Do laundry unassisted	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Budgets own money	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sometimes <input type="checkbox"/>
Others to their home	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Participate in groups	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sometimes <input type="checkbox"/>
Supported employment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Competitive employment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sometimes <input type="checkbox"/>
Makes small purchases	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sometimes <input type="checkbox"/>				

10. Any additional information you feel is important for this referral? _____

(please use reverse if additional space is requ