URBAN AUTISM
SOLUTIONS

The information asked below allows us to get a better understanding of your needs and goals. All information will be kept in confidence.

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: □Yes □ No
Does not have a Reliable Method of Communicating with Others_____
Does the applicant use smart phone technology? □Yes □ No
Please describe: _____
Does the applicant answer the phone consistently? □Yes □ No
Social Media Use? _____
Are electronics problematic for your child? □Yes □ No
Explain: _____

Independent Living Skills

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

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? □Yes □ No
Does your family member have any experience living away from you? □Yes □ No
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?__ □Yes □ No

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.

□Yes □ No Physical Aggression
□Yes □ No Self-Injurious Behaviors
□Yes □ No Elopement/Leaving Area
□Yes □ No Fire starting
□Yes □ No Verbal Aggression
□Yes □ No Property Abuse
□Yes □ No Sexual Abuse

Mobility

□Yes □ No Navigates Independently on Community Streets
□Yes □ No Able to safely use Public Transit (with practice/Smart Phone)
□Yes □ No Navigates Independently within known public buildings
□Yes □ No Navigates Independently within home
□Yes □ No 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?

□Yes □ No Residential
□Yes □ No Social Outings/Activities
□Yes □ No Vocational
□Yes □ No Help Creating a Meaningful Day

How did you hear about Urban Autism Solutions?
□ Hospital (name) _____
□ Doctor (name) _____
□ Friend (name) _____
□ Web Search

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

Please return this form to:
Urban Autism Solutions
Attn: Clinical Director
1212 West Flournoy Street
Chicago, IL 60607

What you can expect next:

Upon review of the documentation the UAS Clinical Director will determine if your young adult may be a good fit for our program(s).