Intake Form

This form is designed to gain information necessary for us to provide you and your child with the most effective and efficient treatment. While it may be time consuming, please do your best to complete it fully. If you feel uncomfortable completing any sections, feel free to leave those blank.

Today's Date: _____ Client Start Date: _____
(Office to complete)

Client Legal Name: _____
Last Name First Name Middle Initial

Name Client goes by: _____ Date of Birth: _____ Gender: M / F

Home Address: _____

City: _____ State: _____ Zip: _____

Family Information

Parent/Guardian 1

Name: _____Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail Address: _____

Employed by: _____ Occupation: _____

Parent/Guardian 2

Name: _____Relationship: _____

Address: *(if different)* _____ City: _____ State: _____ Zip: _____

Home Phone: *(if different)* _____ Cell Phone: _____

E-mail Address: _____

Employed by: _____ Occupation: _____

Insurance Information

Provider: _____ Policy Holder: _____

Policy # :_____ Is ABA Covered?(*circle one)* Yes No Unsure

Medicaid Information

Type/Provider:: _____ ID #: _____

Case Worker: _____ Email: _____

Phone Number: _____

Medical Information

**Attach a copy of comprehensive assessment*

Date of Initial Assessment: _____ Diagnosing Provider: _____

Secondary Diagnoses/ Other Diagnoses:_____

Primary Care Physician: _____ Phone #:_____

Is your child taking any medication? _____ If yes, type & dosage: _____

Reason for medication _____ For how long? _____

Has your child experienced any of the following medical problems?

☐ Serious Accident	☐ Hospitalization	☐ Surgery	☐ Asthma	☐ Head Injury
☐ Seizures	☐ Allergies	☐ Eye/Ear Problems	☐ Meningitis	☐ Other:_____ __

Has your child ever been hospitalized for a physical illness? Yes No

Describe _____

Has your child ever been hospitalized for a mental illness? Yes No

Describe _____

Any recent major illnesses or surgeries? _____

Any recurrent or chronic conditions? _____

Allergies / Dietary restrictions: _____

Education History:

Current School: _____Phone:_____

Teachers Name:_____ Grade:_____

Other schools attended (including Pre-school)_____

Has your child ever repeated a grade? If so which one(s)_____

Has your child ever received special education services?(circle one) yes no

**If Yes, please attach a copy of most recent IEP or 504 Plan*

Has your child experienced any of the following problems at School?

☐ Fighting	☐ Detention	☐ Few Friends	☐ Behavior Probems	☐ Bullying
☐ Suspension	☐ Bullying	☐ Learning Disabilities	☐ Poor Grades	☐ Incomplete Work

Other Services:

	Provider	**Start Date**	**End Date**	**Frequency of Services (i.e. 2x weekly 30mins)**
Speech				
OT				
PT				
BabyNet				
ABA				

**Provide a copy of latest assessment*

Current Client Schedule:

	Monday	Tuesday	Wednesday	Thursday	Friday
AM					
PM					

Emergency Contact (2 individuals incase parent/guardian cannot be reached)

1. Name:_____Relationship:_____Phone Number:_____

2. Name:_____Relationship:_____Phone Number:_____

Family Information

Please indicate who lives in the child's household and their relationship to the child. Provide the age of siblings or other children included in the household. Also list household pets and other significant individuals in the child's life (those the child interacts with on an almost daily basis)

Name Relationship to child Additional information

_____

_____

_____

Is there any information in regards to your child's home environment you feel is important for us to know in order to provide services for your child? (i.e. grandparent involvement, parent separation)

_____

_____

_____

Child Information

	Likes	Dislikes	Not Sure	Explain/Examples
Movies	☐	☐	☐	_____
Swinging	☐	☐	☐	_____
Slides/Climbing	☐	☐	☐	_____
Pretend Play	☐	☐	☐	_____
Cause & Effect Toys	☐	☐	☐	_____
Physical Play (i.e. tickles)	☐	☐	☐	_____
Social Praise	☐	☐	☐	_____
Animals	☐	☐	☐	_____
Loud Noises	☐	☐	☐	_____
Specific Textures	☐	☐	☐	_____
Food	☐	☐	☐	_____

Please list your child's MOST preferred items and activities. These would be things your child spends most of their free time doing or requesting. This can include particular food items, people, TV shows/Movies, iPad games, playing with toys/items in a specific manner.

_____

_____

_____

Communication

What communication skills does your child have? (Select all that apply)

□ Verbal(Full Sentences) □ Verbal(Short phrases) □ Verbal(1-2 words)

□ Gestures (pointing, pulling) □ Sign Language

□ Picture Exchange Communication System (PECS)

□ Augmentative/Alternative Communication Device

□ Other _____

Please explain:

_____

_____

Behavioral Concerns

What, if any, behavior issues does your child have? (i.e. self-injurious, hits peers, tantrums, etc.)

_____

_____

_____

Problem Behaviors:

What events typically trigger problem behaviors (some examples may be asking them to complete a task, telling them they cannot have a toy or activity, periods of low attention when they need to entertain themselves)?

_____

_____

_____

What do the behaviors typically look like (some examples may be crying, laying on the floor, hitting, kicking, yelling, throwing items, head banging)

_____

_____

_____

How long to these behaviors typically last?

_____

_____

_____

How many times per week does your child typically engage in problem behaviors?

_____

_____

_____

Does your child engage in any self-injurious behaviors?

_____

_____

_____

Toileting

Is your child currently toilet trained (i.e. wearing underwear without accidents throughout the day)?
□ Yes □ No

If yes, does your child have any difficulties with the toileting process?
□ Yes □ No

Please explain: (i.e. My child does not like to wash his hands, only use the bathroom at home, does not request to use the toilet and/or has frequent accidents)

_____

_____

_____

Is your child currently toilet trained at night (i.e. sleeps through the night without accidents)?
□ Yes □ No

Are you currently trying to toilet train or have you attempted to do so in the past?
□ Yes □ No

Please explain: (My family is currently working on toilet training my child with the following procedures...; My family would like to toilet train my child within the next 6 months)

_____

_____

_____

Feeding

Please explain your child's current food preferences (i.e. My child has no feeding problems; My child will only eat specific foods such as...; My child has a tantrum anytime I try to offer him food he has had before and new foods)

_____

_____

_____

Sleeping

Please explain your child's current sleeping habits (i.e. My child has no bedtime routines, my child will not sleep in their room, my child does not sleep through the night, my child has difficulty with the bed time routine, etc)

_____

_____

_____

Goals/Expectations

What are your top 3 goals for your child this year? (i.e. toilet trained, decrease self-injurious behavior, school, etc)

1	
2	
3	

What are your goals for your child as he/she grows into adulthood?

_____

_____

_____

What are your child's strengths?

_____

_____

_____

What are your expectations for your child's treatment?

_____

_____

_____

Is there anything else you would like us to know about your child or that you find important for us to know before we begin services?

_____

_____

_____

Do you have any worries or concerns about moving forward with assessment / treatment?
If yes, please describe

_____

_____

_____

I understand that it is important to provide accurate information in order to tailor treatment and assessment to best meet my child's needs. The undersigned hereby acknowledge that the information contained on this form is accurate in all respects.

Parent/Guardian (print name) _____

Parent/Guardian Signature _____ Date _____