Initial Intake Document

Services Requested

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How did you hear about us?

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Client information

Client Name: ____________________________ Client DOB: ________________

Street Address: __________________________ Town/City: _____________________________

State: ________ Zip Code: ___________

Client Gender (circle one): Male Female Other

Diagnosis(es):

Parent/Guardian Information

Name: ___________________________ Phone #: _________________________

Email: ___________________________

Eligibility

Primary Insurance Provider: _________________

Insurance Member ID #: ____________________

Secondary Insurance Provider (when applicable): ____

Secondary Member ID #: ____________________

Primary Insured Name: __________________________ Date of Birth: _____________________

Phone #: __________________

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Reason for services

Presenting Problem Behavior: Self-Injurious Behaviors Physical Aggression Property Destruction

Other (Explain): ___________________________

Does youth communicate using spoken words?	Yes	No
Feeding difficulties (picky eater, restricted diet)?	Yes	No
Sleeping difficulties (falling asleep, staying asleep)?	Yes	No
History of brain trauma (e.g. significant falls)?	Yes	No
Issues with emerging sexuality (e.g. puberty)?	Yes	No
Any preferences with providers (e.g. female BT only)?	Yes	No
Any cultural or religious practices we should be considerate of?	Yes	No
Do you have any pets?	Yes	No

Family Availability for Services (enter to/from times or n/a if no availability):

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

I have completed this form to the best of my knowledge and confirm all information entered are true. I confirm that I am the parent and or legal guardian for the individual seeking services.

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Parent/Guardian Signature Date