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## Intake Form

This form can be completed by yourself, a health professional, or a teacher/educator (with consent from you).

### Basic Information

Full name: \_\_\_\_\_

Age: \_\_\_\_\_

Date of Birth: \_\_/\_\_/\_\_

Occupation/School: \_\_\_\_\_

Grade: \_\_\_\_

Currently accessing additional support at school/work: Yes  No

Do you or your child identify as:  N/A  First Nations  Aboriginal  Torres Strait Islander

### Who lives at home:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Relation: \_\_\_\_\_

### Developmental History:

Walking/Talking (if known): \_\_\_\_\_

Labor/ Delivery issues (if known): \_\_\_\_\_

When did you first notice/ have concerns: \_\_\_\_\_

### Medical History:

Current medications: \_\_\_\_\_

Hearing/Vision tests: \_\_\_\_\_

Reoccurring Ear Infections: \_\_\_\_\_

Asthma/Allergies: \_\_\_\_\_

### Family History:

Have any of your siblings or family members been diagnosed with a developmental delay, intellectual disability, or autism spectrum disorder? (If applicable)

No  Developmental delay  Intellectual disability  Autism spectrum disorder

Other: \_\_\_\_\_

**Functional Behaviours:**

How do you wash yourself often:  Daily  3-4 times per week  Weekly

How do you dress yourself:  Independent  With Support  Haven't yet developed

Sleep:  No concerns  Some concerns  Significant concerns

If significant concerns, please specify: \_\_\_\_\_

Is there variety in their diet:  Yes  Some concerns  Significant concerns

If significant concerns, please specify: \_\_\_\_\_

**Previous Therapies**

Does you currently access, or have they previously accessed the following services (If none apply, please skip).

- Speech pathologist  Physiotherapist  Behaviour support/Psychologist  Occupational therapist
- Nutritionist/Dietitian