Beehavioral Solutions LLC

A B A   T H E R A P Y

Intake Form

Child & Family Information

Child's Name: ______________________________ **Date of Birth:** ________________

Sex: _____ **Parent/Guardian Name:** ____________________________

Relationship to Child: ________________________ **Phone:** ______________________

Person Completing Form: ______________________ **Date Completed:** ________________

Reason for Referral

Background Information

Current Diagnosis Information

Diagnosis: ____

Diagnosis Physician: ______________________ **Date of Diagnosis:** __________________

Referring Physician: ______________________ **Date of Referral:** __________________

Who is the child's pediatrician? ________________________________

Who is the child's neurologist? ________________________________

Please list any medical or psychiatric diagnoses that your child has received; his/her age when diagnosed; and the name of the physician who diagnosed your child.

Child's Strengths

What are your child's greatest strengths (e.g., skills, interests? What is he/she good at?)

Primary Caretakers

Please list family members who live with your child:

Name	Relationship

Living Arrangement

Please describe your home and community:

Is there a family history of mental illness or substance abuse? By both sides of the family.

Programs and Services

Please list the educational or therapeutic programs (e.g., school, daycare, OT, PT, ST) in which your child is currently participating:

Service	Company	When Started	Frequency (How often and how long)

Previous Interventions

Please list strategies and interventions that you have tried to address your child's behavior, when they were used, and their impact.

Interventions Attempted (Including ABA)	Name of Company	Age Started	For How Long	Impact on Behavior

Educational History

	Yes	No	Currently	Name of Program/School
Attended Day-Care?				
Attended Pre-School?				
Attended Kindergarten?				
Attended Elementary?				
In any Special Classes?				
Repeated a Grade?				
Ever Suspended/Expelled?				
Ever had Psychological testing at school?				

*Ask parent to provide medical records of any psychological or psychiatric evaluation.

Is your child currently attending school? ☐ Yes ☐ No

If Yes, what is the school name? ______________________________

If Yes, at what time does he/she get out? ______________________________

Does the child have an individualized education plan (IEP)? ______________________

Educational Setting

Please describe the school setting, include grade level, classroom type, teacher ratio.

Health and Developmental History

LENGTH OF PREGNANCY: ____________ **Birth Weight:** ______________

Was your child in NICU? ☐ Yes ☐ No

If Yes, for how long? ____________________

Please describe any difficulties during pregnancy, delivery, or special services received at the hospital.

Developmental Milestones

Milestone	Years	Months
At what age did child babble?		
At what age did child begin to use single words?		
At what age did child begin to use single sentences?		
At what age did child begin to sit?		
At what age did child begin to crawl?		
At what age did child walk?		
At what age did child begin self-feeding?		
At what age was your child toilet-trained?		

Childhood Illness / Age:

☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Polio ☐ Rheumatic Fever

Surgeries: ____

Please describe any additional medical complications (e.g., asthma, allergies, skin conditions, stomach problems, seizures) that could be affecting your child's current behavior.

Please describe any major-medical problems in the family. By both sides of the family.

Current Medications

Please list any medications your child is currently taking that could impact behavior.

Medication	Dose	Frequency	Reason	Does it work?	When Started?

Who is the prescribing Physician for the medications listed above? ______________________________

Eating and Sleeping Patterns

About how many hours of sleep does your child get each day (including naps)? ____________________

Does he/she sleep through the night? ☐ Yes ☐ No

Does he/she take any sleeping medication? ☐ Yes ☐ No

Does your child have any eating habits or dietary restrictions that could affect his or her behavior? If so, please describe.

Behavioral and Skills Profile

Communication Skills

How does your child communicate his or her needs (please check all that apply)?

Function	Words	Signs/Gestures	Other
Request attention	☐ Words	☐ Signs/Gestures	☐ Other
Ask for assistance			
Request toy/object			
Initiate activity			
Avoid a situation			
Take a break/stop			
Say "no" to request			
Indicate discomfort			

Receptive Communication

How many times do you have to make requests and what is your child's response?

Behaviors imitated (does your child learn by imitation)? Be specific:

Does your child maintain eye contact with adults, other children, etc.? Please describe:

Other Skills

Describe your child's ability to perform the following type of skills.

Self-care (e.g., dressing, toileting, bathing, eating, brushing teeth): Does he/she need assistance? What level of assistance?

Social Skills (Does he/she interact with other children, share, initiate contact, etc.?)

Play/leisure (e.g., does he/she play with toys appropriately, is he/she independent? Imaginative play? Parallel play? Cooperative play?)

Daily living (e.g., household chores according to age). Is he/she cooperative, does he/she follow or comply with requests?

Safety Skills (e.g., obeying safety signs, staying away from hot stove, crossing the street, not running away from parent, not accessing dangerous situations).

Academics (e.g., writing, cutting, counting, coloring): Please be specific.

Problem Behaviors

What does your child say or do that concerns you the most? Estimate how often, long, and severe.

Problem/Target Behaviors Questionnaire

Instructions: Check the box(es) with the target/problem behaviors your child engages in.

Problem/Target Behavior	Definition/Topography
☐ Tantrum	Crying, screaming/yelling, throwing self on the floor, shaking head repeatedly, etc.
☐ Self-Injurious Behavior (SIB)	Hitting self with own body part (fist-to-head, etc.); head-banging against objects.
☐ Physical Aggression	Aggression directed at others: hitting, pushing, spitting, biting, throwing objects, hair-pulling, kicking, etc.
☐ Property Destruction	Damaging property (e.g., breaking objects; throwing objects but not at someone, ripping objects, etc.)
☐ Verbal Aggression	Cursing, using foul statements/language; making verbal threats, etc.
☐ Non-Compliance	Refusing to comply with instructions, requests, tasks, or chores; verbal protest.
☐ Inattention	Failure to attend to someone or something; needs several reminders to remain focused; easily distracted.
☐ Off-Task	Failure to remain on-task when engaging in an activity (starting a task or chore and not completing it).
☐ Self-Stimulatory Behavior	Repetitive behavior: hand-flapping; body-rocking, etc.
☐ Inappropriate Social Interactions	Invading personal space, taking/touching items without asking; hugging strangers, etc.
☐ Elopement	Running away from directed area; running away from adult supervision, etc.
☐ Incontinence	Day- or night-time bedwetting (e.g., not toilet-trained).
☐ Other	

Which, if any, of these behaviors occur together?

In what environments do these behaviors occur? ☐ Home ☐ School ☐ Community

Impact of Behavior

How are your child's behaviors affecting your child's development, or participation in activities or settings? What is the impact on your family? Be specific.

Possible Triggers

Do the following situations have an impact on your child's behaviors of concern?

Situation	More Likely	Less Likely	No Impact	Details
Asked to do a difficult task	☐	☐	☐	
Told "no" or stop activity	☐	☐	☐	
Attention is withdrawn	☐	☐	☐	
Change in routine/schedule	☐	☐	☐	
Loud or chaotic situations	☐	☐	☐	
Required to wait/delayed	☐	☐	☐	
Transitions	☐	☐	☐	

Broad Goals

What are your goals/wishes for your child? (Present and Future). Be specific and refer to each behavior.

Possible Barriers to Treatment

(E.g., People, language, schedule, medical issues)

Social Influence

With whom does your child behave BEST: ______________________________ **WORST:** ______________________________

Can your child follow a daily routine? ☐ Yes ☐ No

Provide details if necessary: ____

Potential Reinforcers

What does your child like (i.e., if presented with a variety of options or given free time, what would your child choose)?

☐ Edible/Snacks ☐ Toys/Other Tangibles ☐ Activities ☐ Music ☐ Electronics ☐ Sensory Items ☐ Social Reinforcement

Please list the most preferred items (#1 is the favorite and so forth...)

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

5. ______________________________

6. ______________________________

7. ______________________________

8. ______________________________

9. ______________________________