Intentional Interventions, LLC

Progress with a Purpose!

Client Information			
Last Name:	First Name:		Middle Initial:
Address:	City:	State:	Zip Code:
Phone:	DOB:		Gender:
Diagnosis and Date :	Diagnosing Physician:		email:

Parental Information	
Marital Status (Circle One): Married Re-Married Divorced Widowed Single Cohabitants	
Parent 1: Name and DOB Relationship	Parent 2: Name and DOB Relationship
Parent 3: Name and DOB Relationship	Parent 4: Name and DOB Relationship
If divorced, who has physical custody?	Is it full or joint?
If divorced, who has legal custody?	Is it full or joint?
If divorced, please provide a copy of the custody agreement.	
Does either parent's job require him/her to be away from home long hours extended periods of time? If yes, please describe below:	
Are there any other people who have a significant role on how your child is raised?	

Sibling Information		
Name	Age	Living in Home?
1. _____	_____	Y/N
2. _____	_____	Y/N
3. _____	_____	Y/N
4. _____	_____	Y/N

Please indicate any special needs or concerns regarding other children living in your home:

Please indicate any concerns you have regarding the child for whom you are seeking services and these sibling relationship(s):

Cultural/Spiritual Assessment
What language(s) is/ are spoken predominantly in the home?
What is your ethnicity?
What aspects of your culture are most important to you?
What cultural traditions do you uphold?
What are your spiritual values?

Psychological History:

Is there a history of the following in your family:

Yes	No		Who:
_____	_____	Autism Spectrum Disorder	_____
_____	_____	Learning Problems/Disabilities	_____
_____	_____	ADHD/ADD – Attention Problems	_____
_____	_____	Depression/Manic-Depression	_____

_____	_____	Behavior Problems in School	_____
_____	_____	Anxiety Disorders (OCD, Phobias, etc.)	_____
_____	_____	Intellectual Disabilities	_____
_____	_____	Psychosis/Schizophrenia	_____
_____	_____	Substance Abuse/Dependence	_____
_____	_____	Other Mental Health Concern (Please List)	_____

Has your child been evaluated in the past? If yes, please describe below:

Please provide any other information on psychological history that you feel would be helpful for us in understanding your child?

Prenatal and Delivery History	
Did the birth mother receive regular prenatal care? (Circle one)	Yes or No
Were there any complications with the pregnancy? (Circle one)	Yes or No
If yes, please describe:	
Was your child considered Full Term? (Circle one)	Yes or No
Type of Delivery (Circle all that apply):	
Spontaneous Vaginal	Induced C-Section
Complications: Yes or No	
If yes, please describe:	
Were there any concerns at birth? (Circle one)	Yes or No
If yes, please describe:	

Developmental History

Please indicate the age at which your child did the following:

Rolled over consistently _____ Sat up unsupported _____

Stood _____ Crawled _____

Walked unassisted _____ Said 1st Word _____

Said 2-3 word phrases _____ Used sentences regularly _____

Toilet trained _____ Dressed self _____

Medical History

Does your child have any medical conditions? (Circle one) Yes or No

If yes, please describe:

Does your child have any allergies? (Circle one) Yes or No

If yes, please describe:

List any operations, serious illnesses, injuries, hospitalizations, or other special conditions your child has had in the past:

List all of your child's current medications below:

Medication	Dosage/Times	Purpose

Does your child have any vision problems? (Circle one) Yes or No

If yes, please describe:

Please list date of last vision test and who performed it (i.e., pediatrician, optometrist, school):

Please indicate if your child is experiencing any of the following (Check all that apply):

Problems with eating	_____	Isolated socially from peers	_____
Problems making friends	_____	Problems keeping friends	_____
Problems controlling anger	_____	Soiling self	_____
Problems with authority	_____	Anxiety	_____
Unmotivated	_____	History of Abuse	_____
Stress from conflict b/w parents	_____	Legal Situation	_____
Alcohol/Drug Use/Abuse	_____	Difficulties in school	_____
Inattention	_____	Hyperactivity	_____
Sadness/Depression	_____	Nightmares	_____
Fatigue/Tiredness during the day	_____	Bedwetting	_____
Problems getting to sleep	_____	Trouble waking up	_____
Problems sleeping through the night	_____	Deficits in social skills	_____
Restricted interests	_____	Compliance issues	_____

Does your child have any hearing problems? (Circle one) Yes or No

If yes, please describe:

Please list date of last hearing test and who performed it (i.e., pediatrician, audiologist, school):

Primary Physician: Date of last physical:

Outcome:

Dentist Name: Date of last dental appointment:

Outcome:

Educational History

List in chronological order all the schools your child has attended:

Name	Year(s)	Grade	Special Education?

Name of current teacher:

What is your child's favorite subject/class (if applicable):

Has your child ever repeated a grade? (Circle one) Yes or No

If yes, what grade?

If your child has been in Special Education, which of the following did they have? (Check all that apply):

- ☐ 504 Plan
- ☐ IEP
- ☐ Psychological Evaluation
- ☐ Speech Evaluation
- ☐ Behavior Intervention Plan
- ☐ Occupational Therapy Evaluation
- ☐ Physical Therapy Evaluation
- ☐ Adaptive Technology Evaluation
- ☐ Other (Please describe): _____

Does your child receive Speech Therapy in school? (Circle one) Yes or No

If yes, how many hours and days per week?

Does your child receive Physical Therapy in school? (Circle one) Yes or No

If yes, how many hours and days per week?

Does your child receive Occupational Therapy in school? (Circle one) Yes or No

If yes, how many hours and days per week?

If your child is or has been in Special Education, how were they served?

- ☐ Consultation
- ☐ Resource Classroom

☐ Pull-out	☐ Self-Contained Classroom
☐ Special Program	☐ ABA Classroom
☐ Mainstreamed	☐ Other: _____

Does your child engage in any extracurricular activities, including sports, clubs, hobbies, lessons, etc.? (Circle one) Yes or No

If yes, please describe:

List any special abilities, skills, and/or strengths your child has:

Expressive Language Skills		
How does your child communicate with you (i.e., verbally, gestures, PECs, etc.)? (Please describe):		
Can your child indicate wants, needs, and/or preferences? (Please describe):		
Does your child engage in spontaneous language? (Please describe):		
Can your child imitate vocal sounds, words, or phrases?	(Circle one)	Yes or No
Can your child label items, events, and actions?	(Circle one)	Yes or No

Receptive Language Skills		
Does your child follow directions and routines?	(Circle one)	Yes or No
Please describe:		
Does your child follow directions in a community setting?	(Circle one)	Yes or No
Please describe:		
Can your child answer simple Wh questions?	(Circle one)	Yes or No

Motor Skills		
Can your child imitate simple motor movements?	(Circle one)	Yes or No
Can your child imitate actions with objects?	(Circle one)	Yes or No
Can your child imitate gross motor movements?	(Circle one)	Yes or No
Can your child imitate fine motor movements	(Circle one)	Yes or No

Daily Living Skills		
Can your child feed self? If no, please describe:	(Circle one)	Yes or No
Can your child wash and dry hands independently? If no, please describe:	(Circle one)	Yes or No
Can your child brush teeth independently? If no, please describe:	(Circle one)	Yes or No

Can your child dress independently? If no, please describe:	(Circle one)	Yes or No
Does your child toilet independently? If no, please describe:	(Circle one)	Yes or No
Can your child bathe independently? If no, please describe:	(Circle one)	Yes or No

Social/Play/Leisure Skills		
Does your child make eye contact with others?	(Circle one)	Yes or No
Does your child respond to his/her name when called?	(Circle one)	Yes or No
Does your child show interest in other children/peers?	(Circle one)	Yes or No
Does your child take turns when playing with others?	(Circle one)	Yes or No
Does your child have activities that he/she can do independently? Please describe:	(Circle one)	Yes or No
Can your child play with peers/other children?	(Circle one)	Yes or No
Does your engage in imaginative/pretend play?	(Circle one)	Yes or No

Problem Behavior		
Can your child wait without engaging in problem behaviors? If no, please describe:	(Circle one)	Yes or No
If your child is interrupted while playing with an enjoyable activity, will he/she engage in problem behaviors? If yes, please describe:	(Circle one)	Yes or No

If you deny your child something he/she wants, will he/she engage in problem behaviors? (Circle one) Yes or No

If yes, please describe:

Will your child engage in problem behaviors if he/she wants something? (Circle one) Yes or No

If yes, please describe:

Will your child engage in problem behaviors when he/she is left alone? (Circle one) Yes or No

If yes, please describe:

If you place a demand on your child, will he/she engage in problem behaviors? (Circle one) Yes or No

If yes, please describe:

Does your family have to modify activities, the environment, events, or other things because of your child's problem behaviors? (Circle one) Yes or No

If yes, please describe:

Has your child or anyone else required medical care as a result of the child's problem behavior? (Circle one) Yes or No

If yes, please describe:

Where does the problem behavior occur? (Circle one)
Home School Community Other

What is the frequency of behavior (Circle one):
Less than once per week 1-5 episodes per week 1-5 episodes per day More often

Describe the following as they pertain to your child; specifically, if your child engages in one of these behaviors, what does it look like?

Repetitive Behavior:

Physical Aggression:

Property Destruction:

Self-Stimulatory Behavior:

Self-Injurious Behavior:

Elopement:

Unsafe/Dangerous Behavior:

PICA:

Tantrums:

Refusal Behavior:

Other:

Safety
Does your child recognize dangers in the home? (i.e., stove/fire, avoiding harmful substances, leaving the house, etc.) (Circle one) Yes or No Please describe:
Does your child recognize dangers in the community? (i.e., strangers, elopement, crossing the street, etc.) (Circle one) Yes or No Please describe:

Reinforcers/Preferences
What activities and items does your child enjoy/like? (Please describe):
Please identify typical reinforcers (food, toys, praise, physical, music, etc.) (Please describe):

Goals of Treatment
What are your main goals of ABA Therapy for your child? (Please describe):
What are the clients goals (if able to communicate these)?

Proposed Schedule/Client Availability	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

Community Resources
Are you currently receiving support from and local groups, social services agencies, school-based associations or other social groups?

Additional Comments/Concerns/Notes