**Intake Questionnaire Template**

**-CONFIDENTIAL-**

Please complete this intake questionnaire regarding your child. Feel free to add any additional information or attach additional reports that you think may helpful for us in getting to know your child. Spectrum Behavioral Services views all of the information that you provide us with as strictly confidential. This information is helpful for us in developing an initial understanding of your child’s needs and provides critical information for us to discuss with your insurance company to get authorization for services.

*Please TYPE your responses below.*

Today’s Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**GENERAL INFORMATION**

Name of Person Completing this Form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_\_\_\_ Sex:\_\_\_\_\_\_\_\_\_

Gender Identity/Pronouns \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_

Severity Level of Diagnosis if Any:\_\_\_\_\_\_\_\_\_ Age and date at first diagnosis:\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_

For Military Families Beneficiary or SSN number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear of our ABA agency? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT/GUARDIAN CONTACT INFORMATION**

Parent/Guardian 1 Name (First and Last Name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian 2 Name (First and Last Name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Home Telephone: (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_\_\_

Parent/Guardian 1 Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_

Parent/Guardian 1 Cell Phone: (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian 2 Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_

Parent/Guardian 2 Cell Phone: (\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL INFORMATION**

Name of Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Physician Phone Number: (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_\_

May we contact them?  Yes  No

Which hand does the patient show dominance?  Left  Right  No preference

Does the patient have any current health conditions, including infectious diseases?

Yes  No

\* If yes, please explain below.

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Please also provide the following:

|  |  |  |  |
| --- | --- | --- | --- |
| **Known Medical Conditions** | **Dates and Providers of Previous Treatment** | **Current Treating Clinicians** | **Current Therapeutic Interventions and Responses** |
|  |  |  |  |
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Does your child have any behavioral difficulties while seeing medical providers that impact the medical providers ability to provide care (i.e., does your child need to be sedated during dental procedures)

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List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other special conditions your child/adolescent has had.

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Does your child/adolescent have any vision problems?  Yes  No

\* If yes, please explain below and if there are any treatments currently being used for correction.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child/adolescent have any hearing problems?  Yes  No

\* If yes, please explain below and if there are any treatments currently being used for correction.

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Does your child/adolescent have a history of seizures?  Yes  No

\* If yes, please describe the types of seizures and current treatment as well as the seizure plan.

***\* Please provide us with copies of the seizure plan for the safety of your child/*adolescent*..***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Does your child/adolescent have chronic or recurring conditions?  Yes  No

\* If yes, please describe the condition and current treatment.

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Is your child/adolescent currently taking any medications?  Yes  No

\* If yes, please provide the following information:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Medication** | **Amount** | **How often is the medication taken?** | **When is the medication taken?** | **Please state any reactions or side effects your child/adolescent experiences from the medication.** |
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Does your child/adolescent have any allergies (seasonal, food, etc.)?  Yes No

\* If yes, please describe, including any adverse reactions and if any epi pen is needed:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Does your child/adolescent currently have any other diagnoses?  Yes  No

\* If yes, please provide the following information:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Diagnosis** | **Diagnosing Physician** | **Date Diagnosed** | **Diagnosis Code** | **Severity level** |
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***Please note that the diagnosis information is required for insurance coverage. By having this information, it assists us when speaking with your insurance company to get authorization for services and providing you with invoices for reimbursement through insurance.***

**CLIENT INFORMATION**

Please provide us with the following information to get to know your child/adolescent better.

List at least 3 strengths of your child /adolescent

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What is something that your child/adolescent loves doing?

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What is your child/adolescent’s favorite toys?

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What is your child/adolescent’s favorite tv shows?

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What is your child/adolescent’s favorite snack foods?

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Please list 3 goals that you would like to see addressed with your child/adolescent within the next 6 months

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Please list 3 goals that you would like to see addressed with your child/adolescent within the next year.

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Are there any spiritual/religious beliefs or values that you would like us to be aware of?

Yes  No \* If yes, please describe below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are there any routines or holidays specific to your family that you would like us to be aware of (e.g., prefer us to take off shoes in the home, celebration of Sinterklaas on December 5th and 6th etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are there any spiritual/religious beliefs or values that you think may impact how you provide discipline or behavioral supports to your child?

Yes  No \* If yes, please describe below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are there any cultural beliefs or values that you would like us to be aware of?

Yes  No \* If yes, please describe below.

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Are there any cultural beliefs or values that you think may impact how you provide discipline or behavioral supports to your child?

Yes  No \* If yes, please describe below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**CURRENT/PREVIOUS THERAPY PROVIDER INFORMATION**

Please provide us with information regarding the following types of current or previous therapy providers and copies of any recent evaluations that indicate dates of previous treatment and therapeutic interventions and responses.

**Does your child/adolescent currently receive speech therapy services?**

Yes (Please provide information below.)

No

Have they ever received speech therapy services?

Yes (Please provide information below.)

No

Have they ever been diagnosed with apraxia or aphasia?

Yes (Please indicate which one.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

No

Do they use an augmentative communication device

Yes (Please indicate what is used.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

No

Name of **Speech Therapy Provider**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Phone Number: (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hours per week in therapy:\_\_\_\_\_\_\_\_\_

How long was speech therapy provided (months/years):\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for discharge from care:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we contact them?  Yes  No

**Does your child/adolescent receive occupational therapy services?**

Yes (Please provide information below.)

No

Have they ever received occupational therapy services?

Yes (Please provide information below.)

No

Name of **Occupational Therapy Provider**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Phone Number: (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hours per week in therapy:\_\_\_\_\_\_\_\_\_

How long was occupational therapy provided (months/years):\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for discharge from care:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we contact them?  Yes  No

**Does your child/adolescent currently receive physical therapy services?**

Yes (Please provide information below.)

No

Have they ever received physical therapy services?

Yes (Please provide information below.)

No

Name of **Physical Therapy Provider**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Phone Number: (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hours per week in therapy:\_\_\_\_\_\_\_\_\_

How long was physical therapy provided (months/years):\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for discharge from care:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we contact them?  Yes  No

**Does your child/adolescent currently receive psychiatric services?**

Yes (Please provide information below.)

No

Have they ever received psychiatric services?

Yes (Please provide information below.)

No

Name of **Psychiatric Provider**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Phone Number: (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hours per week in therapy:\_\_\_\_\_\_\_\_\_

How long was psychiatric therapy provided (months/years):\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for discharge from care:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we contact them?  Yes  No

**Did your child/adolescent receive ABA therapy?**

Yes (Please provide information below.)

No

Name of **ABA Therapy Provider**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Phone Number: (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hours per week in therapy:\_\_\_\_\_\_\_\_\_

How long was ABA therapy provided (months/years):\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for discharge from care:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we contact them?  Yes  No

**EDUCATIONAL HISTORY**

Please list all schools your child/adolescent has attended in order starting with the most current school.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of School** | **School System** | **Year(s)** | **Grade** | **Special Education Services** |
|  |  |  |  | Yes  No |
|  |  |  |  | Yes  No |
|  |  |  |  | Yes  No |
|  |  |  |  | Yes  No |

Does your child/adolescent have an IEP, 504 plan or IFSP? If yes which one.

Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Unsure

Is your child/adolescent currently classified for special education services or supports?  Yes  No

If you child is homeschooled or has a reduced schedule please provide the hours your child is in school

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\* Please provide us with copies of any reports from evaluations that you may have, as well as a copy of the current 504 plan or IEP.***

**FAMILY BACKGROUND**

Is there a history of trauma?

Yes  No. \* If yes, please describe below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please also provide the following:

|  |  |  |  |
| --- | --- | --- | --- |
| **Big Events In your Child’s Life** | **Current Event** | **Upcoming** | **Past Event** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Was the child in the foster care system?  Yes  No.

If yes please provide dates\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the child adopted?  Yes  No

If yes please provide dates\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the child know that they are adopted?  Yes  No

Was it an open or closed adoption? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the child have a relationship with their birth parents?  Yes  No

If yes please describe the relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Does either parent/guardian’s job require him/her to be away from home for long hours or extended periods of time that might prevent them from being involved in ABA services and parent training?  Yes  No

\* If yes, which parent/guardian and for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status:

Married  Separated

Civil Union  Widowed

Remarried  Single

Divorced  Cohabitants

\* If divorced, who has legal custody? \_\_\_\_\_\_\_\_Is it full or joint custody? \_\_\_\_\_\_\_\_

If joint custody what percentage does each parent have?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If joint custody where is the primary residence of the child?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide a copy of the custody documents for our records.

Are there siblings?  Yes  No

\*If yes, please provide the following information

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Name** | **Age** | **Relationship** | **Living in Home?** | **School** | **Grade** |
| 1. |  |  |  | Yes  No |  |  |
| 2. |  |  |  | Yes  No |  |  |
| 3. |  |  |  | Yes  No |  |  |
| 4. |  |  |  | Yes  No |  |  |
| 5. |  |  |  | Yes  No |  |  |
| 6. |  |  |  | Yes  No |  |  |

Please indicate and describe whether any of the siblings have any special needs, diagnoses, or concerns.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you also interested in seeking services for any of the siblings with special needs?

Yes  No  Not applicable

\*If yes, you will need to complete a new intake packet for that child.

Are there any other individuals residing in the house or that play a significant role on how your child/adolescent is raised?

Yes  No

\* If yes, please identify who else resides in the home or is involved in raising the child and their relationship to the patient.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are there any other significant people in your child/adolescent’s life who do not live with him/her?

Yes  No

\* If yes, please identify other significant people and their relationship to the patient.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Are there pets or other animals in the house?**

Yes (Please provide information below)

No

Please identify all animals in the house.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How does your child/adolescent interact with the animal?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**MEDICAL/PSYCHOLOGICAL HISTORY**

Please indicate below whether or not there is a history of the following in your immediate family or in either biological parent’s extended family.

**Yes** **No**

Autism Spectrum Disorders

Learning Problems/Disabilities

Speech Delay

Down Syndrome

Fragile X Syndrome

Cerebral Palsy

Epilepsy

ADD/ADHD-Attention Problems

Clinical Depression

Bipolar Disorder

Behavior Problems in School

Anxiety Disorders (e.g., OCD, etc.)

Intellectual Disability

Psychosis/Schizophrenia

Substance Abuse/Dependence

Addiction (Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Suicide Ideation or attempt

Other Mental Health Concerns (Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Other Medical Health Concerns (Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

If yes, please indicate who in the family currently has or has had these diagnoses:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has your child/adolescent had an outside psychological or psychiatric evaluation?  Yes  No

Has your child/adolescent ever been hospitalized for a psychiatric condition?  Yes  No

Please provide us with any other information on the psychological history that you feel would be helpful to us in understanding your child/adolescent.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**BIRTH AND DEVELOPMENTAL HISTORY**

Did the birth mother receive regular prenatal care?  Yes  No  Unknown

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Were there any complications with the pregnancy?  Yes  No  Unknown

\* If yes, please describe the complications below and treatment details.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Was birth at full term?  Yes  No.  Unknown

\* If no, please provide details.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What was the type of delivery?  Spontaneous  Induced.  Vaginal  C-Section  Unknown

Were there any complications during delivery?  Yes  No  Unknown

\* If yes, please describe the complications below and treatment details.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Were there any concerns at birth?  Yes  No  Unknown

\* If yes, please describe the concerns and treatment details.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were there any developmental milestones that your child was delayed in or did not achieve?

Yes  No  Unknown

\* If yes, please identify those milestones below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_­­­\_\_\_\_\_

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**Current Behavioral Concerns**

Please indicate if your child/adolescent engages in any of the following behaviors (check all that apply)

Aggression

Hitting (e.g., punch, slap, etc.)

Kicking

Biting

Pinching

Pulling hair

Head butting

Scratching

Spitting

Other (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Self-Injurious Behavior (specify below)

Hitting self with hands or fists

Where on body?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kicking self

Where on body?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Head-butting, walls windows, etc.

Pulling teeth

Pulling hair

Scratching skin

Picking scabs

Cutting/burning

Other (Please Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Property Destruction (Describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eloping (i.e., running out of a building, room, vehicle etc.)

Sensory issues (Describe)­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexualized behaviors (Describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Self-urinating/defecating

Fecal smearing

Rectal digging

Tantrums

Screaming/yelling

Repetitive behaviors

Other (Please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additionally, please indicate if your child/adolescent is experiencing any of the following (check all that apply)

Isolated socially from peers

Difficulty making friends

Problem keeping friends

Selective Mutism

Non verbal/vocal

Suspension or Expulsion from School

Difficulty with toileting

Problems with eating (Describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Problems with sleeping (Describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bedwetting

Fire Setting

Anxiety

Sadness or Depression

Hallucinations

Delusions

Suicidal Ideation/attempts

Feeling helpless

History of physical abuse

History of sexual abuse

Alcohol use/abuse

Drug use/abuse including nicotine and/or illegal drugs (list drugs)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Difficulty concentrating/maintaining attention

Difficulty waiting (to take turns, talk to other, etc.)

Are there any current or past legal issues pending with your child/adolescent or with your family?

Yes  No \* If yes, please describe below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**DISCIPLINE INFORMATION**

Please rate what percentage of discipline is handled by each of the following:

Parent/Guardian 1: \_\_\_% Relationship to Child/Adolescent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian 2: \_\_\_% Relationship to Child/Adolescent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is typically used for disciplining your child/adolescent (e.g., verbal reprimands, timeout, assigning chores, physical/corporal punishment, etc.)? Please list all forms of discipline that you use and if they are working for you.

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