

**Background Information:** 

Client's Name:

Phone: (850)860-4050 Fax: (850)739-7615 admin@flabatherapy.com

## **Intake Questionnaire**

Insurance Type:

This form is designed to ask questions about the client's history and current symptoms which will provide useful information for their assessment and treatment. While it may be time consuming, please do you best to complete it fully. If you feel uncomfortable completing any sections, feel free to leave them blank.

Date of Birth:	Insured under	:/Sponsor's Name:		
Parent Name(s):	Policy Numbe	r/Sponsor ID:		
Phone:	Insured/Spons	sors DOB:		
Email:	Name and DC Outcome Mea	OB for Caregiver completing asures:		
Address:				
Please list everyone that the client lives with, including their age and relationship to the client				
Name	Age	Relationship		

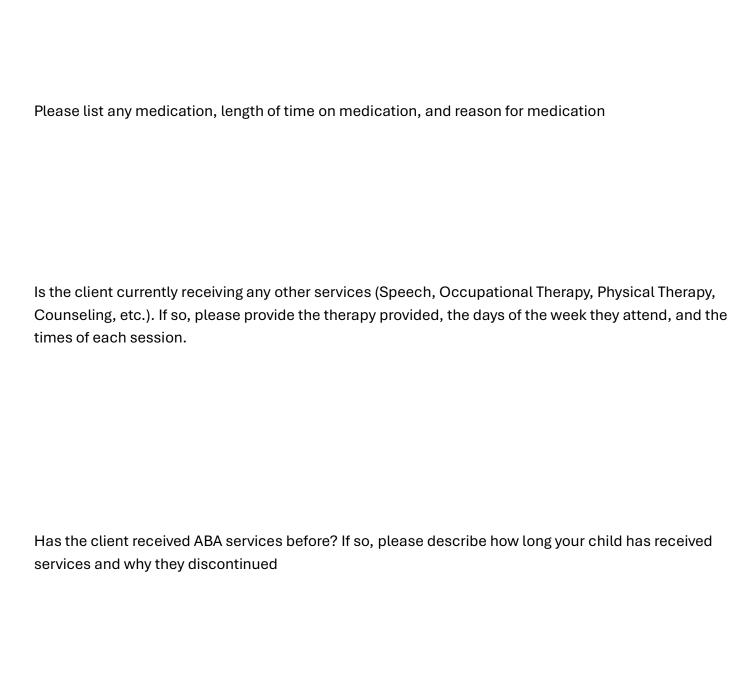


Medical Information:		
PCM Referring Provider:	Date of Autism	n Assessment/Diagnosis:
Autism Diagnosing Provider:	Severity Level:	
Please give us a short explanation e Autism Diagnosis	explaining the client's early developr	mental history which led to an
Please List all diagnoses the client I	nas	
Does the client have any allergies o	r medical conditions?	

Does the client have any dietary restrictions?









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Education His	LUIV.

Is the client attending school? What grade is the client in?

What school does the client attend? Does the client have an IEP/504?

What type of class is the client in?

Has the client experienced any of the following problems at school?

Fighting Suspension Gang Influence

Drug/Alcohol Use Learning Disabilities Incomplete Homework

Detention Poor Attendance Behavior Problems

Few Friends Poor Grades Bullying

Is the client currently receiving services during school? (Speech, Occupational Therapy, Physical Therapy, Counseling, etc.). If so, please provide the number of days he receives it and for how long.

Please provide any additional information about school you would like for us to know



Psychological History:
Has the client ever had difficulty with the following? (If so, please specify when).
Depressed mood, feelings of helplessness or worthlessness, or decreased motivation.
Stress, anxiety, or tension that was beyond what would be expected for a given event
Distressing physical sensations such as shortness of breath, racing heart, dizziness, etc.
Obsessive thought or images that they could not ignore
Repetitive behaviors or ritual that they felt compelled to complete
Has the client ever been hospitalized or received inpatient care for mental health? If so, please describe
Please provide any additional information about the client's psychological history you would like for us t know



Current Skill Level
Communication Skills
What is the client's main form of communication? (Vocal words, gestures, sign language, communication device, etc.) Please describe
How many words does the client typically use to request? Please describe how the client tells you what they want.
Does the client have 100 or more words they are able to use? Please provide any additional information about their use of words.
Does the client talk about items that are not present? (Such as saying, "I played on the swings" or "Can I have a lollipop?" while the swings and lollipop are not in sight.)
Please provide any additional information about the client's communication you would like for us to know



Social Skills
Does the client independently interact with peers? (Will they approach peers, will they share with peers
will they respond to peers, etc. all without requiring help from an adult).
Describe the client's current social strengths.
Describe the chefit's current social strengths.
Describe the client's current social weaknesses.
Please provide any additional information about the client's social skills you would like for us to know



# **Self-Help/Daily Living Skills**

Circle the activities that the client can complete without requiring help

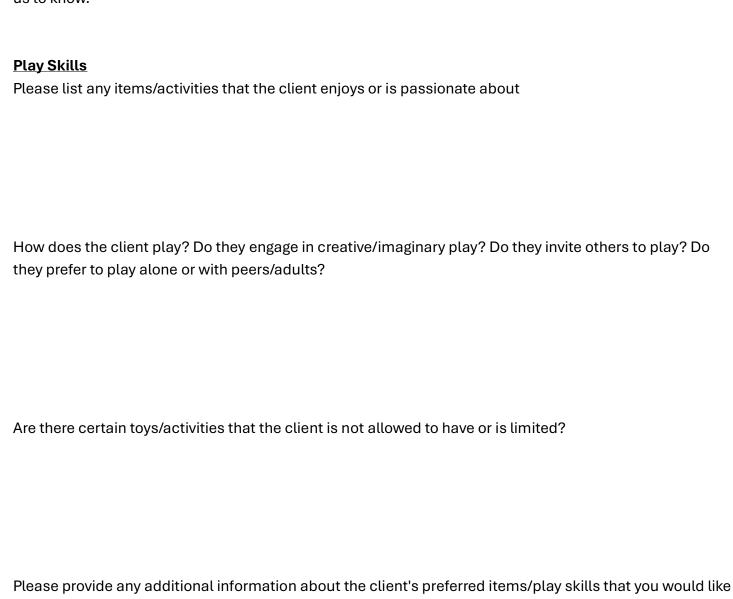
Dress themselves	Use the toilet	Write
Undress themselves	Use utensils when eating	Read
Take a bath/shower	Brush/Comb hair	Wipe efficiently after using
Brush their teeth	Trim Nails	the toilet
Does the client have any issues with	sleep? If so, please describe.	
What are the client's favorite foods/s	nacks/drinks?	
Does the client have any issues with	mealtime or food variety? If so, please	e describe
Does the client tolerate activities suc	ch as haircuts, going to the doctor/den	tist, etc.
Does the client have any difficulties i	n the community? (Stores, parks, etc.	) If so, please describe.



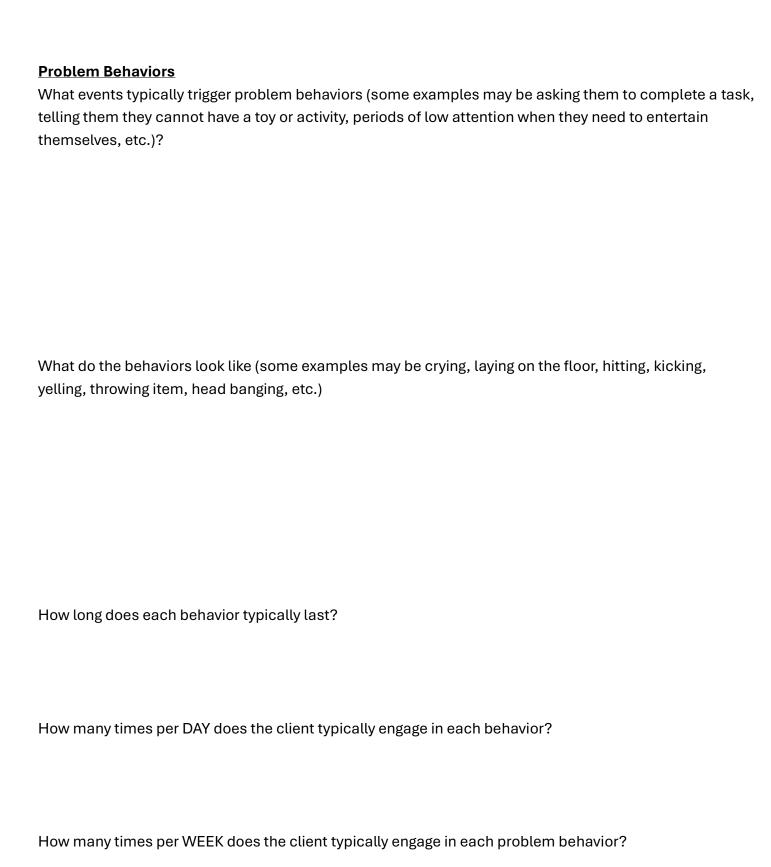
for us to know

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Please provide any additional information about the client's self-help/daily living skills you would like for us to know.









Has the client ever been hospitalized or received inpatient care for challenging behavior? If so, please describe
How long has the client been engaging in each behavior (For example, kicking: one month, hitting: 2 years)?
Does the client engage in any self-injurious behavior? If so, please describe.
Does the client engage in any physically aggressive behavior? If so, please describe.
Does the client engage in property destruction (For example, pushing over furniture, punching walls, breaking items, throwing items)? If so, please describe.
Please provide any additional information about the client's problem behaviors that you would like for us to know



### Main Areas for ABA to Address

What are 3 goa	als that you would	d like for ABA to p	lace a heavy emp	ohasis on over the	next 6 months?
1.					
2.					

3.

## **Parent Training**

We provide parent training to help parents do the same techniques that we implement in the clinic. We can also help with daily-living activities during parent training since we cannot do this during direct therapy. Parent Training is required once a month by Tricare, however, the amount of parent training that is clinically necessary will be recommended after the intake assessment, which could possibly be more than once a month. Parent Trainings typically last 1 hour but can go up to 2 hours. Please provide the days/times that you are available for parent training.

Monday	Tuesday	Wednesday	Thursday	Friday	

