Phone: (850)860-4050
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Intake Questionnaire

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.

Background Information:

Client's Name:

Date of Birth:

Parent Name(s):

Phone:

Email:

Address:

Insurance Type:

Insured under/Sponsor's Name:

Policy Number/Sponsor ID:

Insured/Sponsors DOB:

Name and DOB for Caregiver completing Outcome Measures:

Please list everyone that the client lives with, including their age and relationship to the client

Name	Age	Relationship

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Medical Information:

PCM Referring Provider:

Date of Autism Assessment/Diagnosis:

Autism Diagnosing Provider:

Severity Level:

Please give us a short explanation explaining the client's early developmental history which led to an Autism Diagnosis

Please List all diagnoses the client has

Does the client have any allergies or medical conditions?

Does the client have any dietary restrictions?

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Please list any medication, length of time on medication, and reason for medication

Is the client currently receiving any other services (Speech, Occupational Therapy, Physical Therapy, Counseling, etc.). If so, please provide the therapy provided, the days of the week they attend, and the times of each session.

Has the client received ABA services before? If so, please describe how long your child has received services and why they discontinued

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Education History:

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

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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 to know

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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

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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 client's current social weaknesses.

Please provide any additional information about the client's social skills you would like for us to know

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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/snacks/drinks?

Does the client have any issues with mealtime or food variety? If so, please describe

Does the client tolerate activities such as haircuts, going to the doctor/dentist, etc.

Does the client have any difficulties in the community? (Stores, parks, etc.) If so, please describe.

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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.

Play Skills

Please list any items/activities that the client enjoys or is passionate about

How does the client play? Do they engage in creative/imaginary play? Do they invite others to play? Do they prefer to play alone or with peers/adults?

Are there certain toys/activities that the client is not allowed to have or is limited?

Please provide any additional information about the client's preferred items/play skills that you would like for us to know

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Problem Behaviors

What events typically trigger problem behaviors (some examples may be asking them to complete a task, telling them they cannot have a toy or activity, periods of low attention when they need to entertain themselves, etc.)?

What do the behaviors look like (some examples may be crying, laying on the floor, hitting, kicking, yelling, throwing item, head banging, etc.)

How long does each behavior typically last?

How many times per DAY does the client typically engage in each behavior?

How many times per WEEK does the client typically engage in each problem behavior?

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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

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Main Areas for ABA to Address

What are 3 goals that you would like for ABA to place a heavy emphasis 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

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