Behavioral Transformations
Strategies For Lasting Change

Intake Questionnaire

Please include a copy of your insurance card as well as copies of any assessments that have been done

<u>Demographic Information:</u>
Client's Name:
Date of Birth:
Parents' Names
    Mother's Name:
    Father's Name:
    Legal Guardian (if appropriate):

Best phone number to reach you:
Best email to reach you:
Do you prefer to be contact by phone or email?
Address
    Street Number and Street:
    Apt./Unit:
    City/Town, State and Zip Code:

Insurance Type:
Insured/Subscriber's Name:
Policy number/Subscriber's ID:
Subscriber's Date of Birth:

Medical Information:

Does your child have an Autism diagnosis? If so, please complete the information below and submit diagnostic report with this form. (We cannot move forward with enrollment until the diagnosis report is received)

Diagnosing provider:
Date of diagnosis:
Age of diagnosis:
Report attached? Yes No

Primary Care Practice:
Primary Care Physician:
Does your child have any allergies or medical conditions: Yes No
Please list all current diagnoses:
1.
2.
3.

Does your child have any dietary restrictions:

Please list any medications, length of time on medication, reason for medication:

Please give us a brief description of your child's birth and early developmental history, noting any significant health events or hospitalizations:

Please describe any notable events during pregnancy:

Is your child currently receiving any other services (Speech, Occupational Therapy). If so, for how long and how often?
Speech Therapy:
Name of Provider/Practice:
Contact information:
Frequency seen:

Occupational Therapy:
Name of Provider/Practice:
Contact information:
Frequency seen:

Other service provider:
Name of Provider/Practice:
Contact information:
Frequency seen:

Other service provider:
Name of Provider/Practice:
Contact information:
Frequency seen:

Grade and type of classroom is your child attending:

School attended:

Have you ever received ABA services before and if so, please describe how long your child has received services.

Family History

Language(s) spoken in the home environment:

Cultural or spiritual preferences that the team should be aware of?

Does the child's mother have any history of the following:
Diabetes
Heart disease
Medication for a mental health diagnosis
Intensive intervention for psychiatriatric condition
Neurological condition
Cancer diagnosis

Pregnancy history (include sibling information if appropriate):

Does the child's father have any history of the following:
Diabetes
Heart disease
Medication for a mental health diagnosis

Intensive intervention for psychiatriatric condition
Neurological condition
Cancer diagnosis

Current Skill Level

Communication

Is your child's main form of communication gestures, words, sign language, or augmentative communication device?

How many words does your child typically use to request?

Does your child have 100 or more words they are able to use?

Does your child talk about items that are not present?

Please provide any other information you would like us to know about your child's communication.

Social skills:

How does your child interact with peers in a community enviroment?

How does your child interact with siblings or close family members similar in age (i.e. cousins, etc.)

Describe your child's current strengths socially.

Describe your child's current weakness socially.

Please provide any other information you would like us to know about your child's social skills.

Self-Help Skills:

Is your child able to dress him or her self without help?

Is your child able to bath or shower independently?

Does your child have any issues with sleep?

Does your child have any issues with meal time or food variety?

Please provide any other information you would like us to know about your child's self-help skills.

Is your child toilet trained?

History of Behaviors:

Does your child demonstrate behaviors that present a risk of harm to themselves or others? Yes No

If yes, please list behaviors observed:

Does your child demonstrate a lack of awareness of safety considerations such as climbing on tall objects with no fear, running from a guardian in a crowded area, leaving home independently, etc? Yes No

If yes, please describe the behaviors observed:

Have first responders ever been notified or called to respond to a behavioral event?

If your child was to become separated from a caregiver, could they identify themselves and any other pertinent information to identify themselves to the first responders? Yes No

How many times per day or per week does your child typically engage in difficult behaviors?

On a scale of 1 to 10 (1 being not likely at all), if you ask your child to follow a familiar direction, how likely are they to comply with the request?

Preferred items/Reinforcers:

Please list any items that your child enjoys or is passionate about.

What skills or behaviors are most important to you and your family to target during services?

1.

2.

3.

Availability:

What is your child's availability for services?
Monday:
Tuesday:
Wednesday:
Thursday:
Friday:
Saturday:
Sunday:

Please make a note and include the location if you prefer services to occur somewhere other than at home (i.e., school, daycare, etc). Please include specific times so we can check availability of staff.

When are you looking to begin services?

This form has been completed by __________________________ on (date) ________________

I attest to completing this form with the most accurate and comprehensive information available to me.

Signed: ___________________________________ Date: ______________________________