CENTERS OF EXCELLENCE

Initial Intake Form

This form has been designed to learn more about your child and your family. It will provide useful information for your child's treatment report and assessment. While it may be time consuming and it may seem repetitive, please do your best to complete it fully and to the best of your ability. If you feel uncomfortable completing any section, please feel free to leave them blank.

Required Documents

Before beginning the authorization process, we require the following documents in full:

1. A copy of the diagnosis and assessment completed by a Developmental Pediatrician, Psychologist, Neurologist, or Psychiatrist.
2. A copy of the child's proof of insurance.

Please bring these documents as soon as possible. A copy will be made and the originals will be delivered back to you immediately. These documents are required by the insurance company to begin therapy.

Client Basic Information

Child's Name			
Date of Birth		Age	
Nationality		Gender	
Religion / Spirituality			
Weight		Height	
Dominant Hand			
Last 4 Digits of Social Security			
Full Address			
Who does the child live with?			
Diagnosis			
Date of Diagnosis			
Doctor who Diagnosed			
Names of siblings & ages			
Do any siblings have autism?			

Guardian(s) Basic Information

Mother Name	
Full Address	
Cell Phone #	
Work Phone #	
Email Address	
Occupation	

Father Name	
Full Address	
Cell Phone #	
Work Phone #	
Email Address	
Occupation	

What is the current state of the relationship of the biological parents? Please circle			
Married	Together	Separated	Divorced

If divorced or separated, please list step parents or significant others below.

Medical History

Does your child have a Primary Care Physician?	Yes No
Name of your child's pediatrician	
May we contact the Physician to collaborate?	Yes No
***Note**: If you responded yes to the above question, please sign the release form at the end of the document.*	
Doctor Address	
Doctor Phone #	

Please list any psychological or medical testing that your child has completed below.		
Test	**Date**	**Results**

***Note**: if your child received an ADOS evaluation, please attach a copy of the results.*

Please circle any medical diagnosis that apply:		
Autism Spectrum Disorder	Asperger Syndrome	Fragile X Syndrome
ADHD	Global Developmental Delay	ADD
Speech Delay	Cerebral Palsy	Down Syndrome

***Note**: if your child received any of these diagnoses, please attach a copy of the results.*

- Has your child experienced any of the following medical problems? Please circle the ones that have occurred:

Serious accident	Hospitalization	Surgery
Asthma	Head injury	High fever
Convulsions / seizures	Allergies	Hearing problems
Meningitis	Loss of consciousness	Other

Please elaborate on any of the above medical problems below:

- Does the child have his or her immunizations up to date? If he or she does not, please list which immunizations not up to date. *Please attach a copy of the child's immunization records or exemption waiver.*

- Did the mother of the child smoke tobacco or use any alcohol, drugs or medications during the pregnancy? If so, please list which substances were used:

- Were there any problems or complications during the pregnancy or during delivery? If so, please describe them:

- Is there a history of Autism in the immediate family (parents or siblings)? If so, please elaborate:

- Is there a history of chronic illness in your family? If so, please describe them:

- Did your child have any delays in reaching developmental milestones? Please estimate at which age your child gained the following skills:

Skill Area	**Skill Acquired (yes or no)**	**Age Skill Acquired**
Rolled over consistently		
Sat up unsupported		
Stood up		
Crawled		
Walked unassisted		
Said 1st intelligible words		
Said 2-3 word phrases		
Used sentences regularly		
Potty trained		
Dressed self independently		

Is your child taking any medication? If yes, what kind and what dosage?

Reason for medication, and if applicable, how long has your child been on medication?

Has your child ever been hospitalized for a physical illness or accident? Please Describe.

Has your child ever been hospitalized for a mental illness? Please describe.

Has your child had any major illnesses or surgeries? Please describe.

Does your child have hearing or vision problems? Please describe.

Does your child have an chronic or recurring conditions?

Has your child received ABA therapy before? If yes, where, how long and why was he or she discharged from care?

Is your child being seen by another behavioral health physician (psychiatrist, social worker, psychologist)? If so, please list his or her name and contact information below.

Do we have permission to contact the behavioral health physician? Yes No
***Note**: If yes, please sign the release form at the end of the document.*

Please list any medication, vitamins or supplements that your child is currently taking:

Medication Name	**Dosage**	**Length of time**

***Note**: If your child has been previously evaluated, please provide a copy of the report.*

Family History

Please list the full names of the child's biological parents:	
Mother	
Father	

Who has guardianship of your child?

Are the child's biological parents together or separated?

Is the family facing any legal issues?

Please list all the people currently living in the same household as your child:		
Name	**Age**	**Relationship to child**

Please list any significant people in your child's life who do not live with him or her:		
Name	**Age**	**Relationship to child**

Has anyone in your family ever been diagnosed with a mental health disorder or has experienced mental health challenges? If yes, what relation are they to your child and what was there identified mental health diagnosis?

Education and Service History

Does your child attend school?	Yes No
Name of school	
Address	
Phone number	
Teacher(s), Grade	
How many days per week?	
Does your child have and IEP or 504 plan?	Yes No

***Note**: If yes, please provide a copy of your child's most recent IEP or 504 Plan*

Has your child experienced any of the following problems at school? Please circle.		
Fighting	Few friends	Suspension / expulsion
Poor attendance	Poor grades	Incomplete work
Problem behaviors	Exclusion from activities	

Does your child receive any other services?		Yes No	
Please circle the services received below:			
Speech	Occupational	Physical Therapy	APE
Where, when and with whom does the child receive services? Please explain below.			

Psychological History

Has your child had difficulty with the following, and if so, please specify when below:		
Depressed mood	Feeling helpless	Decreased motivation
Stress	Anxiety	Shortness of breath
Racing heart	Dizziness	Obsessive thoughts

Has your child experienced any of the following, and if so please explain and describe below:	
Repetitive behaviors	
Repetitive vocalizations	

Obsessive behaviors	
Self injurious behaviors	

- Please answer the questions below using the option on the right that best describes what you may have noticed in your child over the past six months.

	Never	Rarely	Sometimes	Often	Always
How often does she or he have difficulty staying organized?					
How often does she or he have problems remembering things?					
	Never	Rarely	Sometimes	Often	Always
How often does she or he fidget or squirm when required to stay seated?					
How often does she or he make careless mistakes?					
How often does she or he have difficulty paying attention during boring or repetitive tasks?					
How often does she or he misplace items?					
How often is she or he distracted?					
How often does she or he interrupt others who are talking?					
How often does she or he have trouble unwinding after an activity or day?					
How often does she or he have trouble waiting his/her turn?					
How often does she or he appear to “space out”?					

Note: *Please continue on to the next page.*

Open-Ended Functional Assessment Questionnaire

Please describe your child's language abilities below.

Please describe your child's leisure activities (including toys, videos, activities)

What are your child's most common problem behaviors? (i.e. hitting, biting, screaming)

Which behavior is your single **most** concern?

Please describe the range of intensity of your child's behaviors?

Does your child's behavior occur continuously or in bursts or randomly?

Which antecedents are most likely to cause behavior for your child? Circle all that apply.		
Interrupted activities	Demands	Transitions
Alone (automatic / sensory)	Told No	Can't communicate a need

What expectations and goals do you have for your child while enrolled in this program?

What do you consider your child's strengths?

Do you have any worries moving forward with ABA therapy?

Is there any other information concerning your child that we may find helpful during assessment or therapy?

Skill Assessment

Question	Response	Notes
Responds to name	Y N	At least 75% of the time
Attends to adults voices	Y N	Looks at adults talking
Performs 4 different motor actions on command	Y N	Ex. Jump John! Show me clapping.
Selects 4 named items or pictures	Y N	Ex. Point to the rabbit, Sally
Holds items with thumb and index finger	Y N	
Places items into a container, rings on a peg	Y N	
Matches 10 identical pictures or objects	Y N	
Manipulates toys for at least 1 consecutive minute	Y N	Ex. Rolls car on the ground
Indicates that he/she wants to be held	Y N	
Makes eye contact with children	Y N	
Engages in parallel play with peers	Y N	Plays near other kids
Imitates 2 gross motor movements	Y N	
Imitates 4 gross motor movements	Y N	
Imitates others behavior spontaneously	Y N	
Looks at books	Y N	
Plays with at least 5 toys	Y N	Appropriately
Makes eye contact when asking for something	Y N	
Plays with cause and effect toys	Y N	Ex. Jack in the box
Imaginative play	Y N	
Play games with rules	Y N	
Kicks ball	Y N	
Throws ball	Y N	
Sleeps through the night	Y N	
Drinks from a cup	Y N	

Eats with utensils	Y N	
Identifies shapes	Y N	
Identifies colors	Y N	
Identifies letters	Y N	
Identifies numbers	Y N	
Writes name	Y N	
Traces letters / numbers	Y N	
Writes letters / numbers	Y N	
Rote counts to 10	Y N	
Rote counts to 25	Y N	

Preference Assessment

Please list any food / snack items that your child likes:

Please list any toys / activities that your child likes:

Please list any community outings that your child likes (i.e. bowling, put-put, movies, etc…)

I understand that it is important to provide accurate information in order for treatment to be tailored to meet my child's needs. This information may be used as secondary information for the assessment report. This information is correct as I have described it.

_____ _____

Caregiver Signature Date

_____

Printed Name