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1 Personal Details

Child's Name: (First, Middle, Last)	Child's Date of Birth	Gender	
Address 1	City	State	Zip Code
Address 2	County	Country	
Client Name:		Today's Date:	
Date of birth:		Age (yr:mo)	
Address, City:		Phone Number:	
Primary Funding Source:	Secondary Funding Source:		
Referral source:			

Family Supports and Living Arrangements		
Name	Relationship to Client (Parent, Guardian, Grandparent, Sibling, etc.)	Full-time / Part – time %
Other family supports that do not live with client:		
Notes on supports and living arrangements:		
Notes on spiritual beliefs that may impact treatment:		
Notes on cultural beliefs that may impact treatment:		

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2 Medical Information

Name of Child's Primary Care Physician:	Physician Phone:	
Is your child taking any prescribed medications and/or supplements?	☐ Yes	☐ No
Medication:	Dosage:	Frequency:
Allergies:		

Dietary Restrictions		
☐ Gluten Free	☐ Soy Allergy	☐ Organic Only
☐ Casein Free	☐ Vegetarian	☐ Diabetic
☐ Metabolic Disorder	☐ Egg Allergy	☐ No Red Dye
☐ Lactose Intolerant	☐ No Sugar	☐ Peanut Allergy
☐ Other:		

Diagnostic History		
Provider of diagnosis	Date	Diagnosis/results

3 Medical History

Was pregnancy and delivery of child typical/healthy?	☐ Yes	☐ No
If no, describe medical challenges during these time periods:		
Vaginal or C-Section delivery:		
Child was born at 40 weeks gestation?	☐ Yes	☐ No
If no, describe number of weeks of gestation until birth and why early delivery occurred:		
Has there been anything significant in your child's medical history?	☐ Yes	☐ No

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If yes, summarize medical history:	
Does your child have any difficulty with sleep or eating?	☐ Yes ☐ No
If yes, describe problem areas:	
Did your child hit developmental milestones in a timely fashion (walking, talking, etc)?	☐ Yes ☐ No
If no, describe delays:	

Presenting Problems / Current Concerns / Priorities for Treatment (What are your main goals for therapy?)

4 Developmental History

Did your child reach milestones on time?	
Please describe your child's development and when/if they reached the following milestones:	
Rolling Over:	
Babbling:	
Crawling:	
Walking:	
Talking:	
Other:	
Medical Treatment History	
Please list any relevant historical and current medical treatments, providers, and your child's response to these:	

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Therapy History
Please list any relevant historical and current therapies, providers, and your child's response to these:

ABA Therapy History
Please list any relevant historical and current ABA therapies, providers, and your child's response to types of interventions:

5 Communication

How does your child communicate? (Please check all that apply)

☐ Aggression ☐ Crying ☐ Gestures ☐ Pictures ☐ Pushing/Pulling Away ☐ Sign ☐ Verbal

Does your child?		
Make spontaneous requests	☐ Yes	☐ No
Make spontaneous comments	☐ Yes	☐ No
Respond to questions	☐ Yes	☐ No
Respond to comments	☐ Yes	☐ No
Imitate/Echo	☐ Yes	☐ No
Request reinforcers	☐ Yes	☐ No
Ask for help	☐ Yes	☐ No
Ask for a break	☐ Yes	☐ No
Respond to "What do you want?"	☐ Yes	☐ No
Understand "wait"	☐ Yes	☐ No
Follow one-step instructions	☐ Yes	☐ No
Follow multi-step instructions	☐ Yes	☐ No
Follow a schedule	☐ Yes	☐ No

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Answer questions	☐ Yes	☐ No
Respond to "No"	☐ Yes	☐ No
Indicate yes/no	☐ Yes	☐ No

At home, we currently utilize the following augmentative communication tools:
☐ Electronic Talkers ☐ iPad ☐ PECS ☐ Picture Schedules ☐ Sign

6 Play and Social Interaction

Does your child play functionally?	☐ Yes	☐ No
Does your child show interest in peers?	☐ Yes	☐ No
Does your child play with peers?	☐ Yes	☐ No
Does your child verbally communicate with peers?	☐ Yes	☐ No
Does your child understand emotions?	☐ Yes	☐ No
Is your child able to take others' perspective?	☐ Yes	☐ No

7 Daily Living Skills

Do you currently have any safety concerns regarding your child?	☐ Yes	☐ No
Does your child engage in self-help skills?	☐ Yes	☐ No
Is your child toilet trained?	☐ Yes	☐ No

Describe any independent skills your child has:

8 Sensory Processing

General Indicators of Sensory Processing Difficulties: (Check all that apply)

☐ Hypersensitive to sensory input	☐ Upset by change
☐ Perseverative behaviors (can't let go of ideas)	☐ Overly aroused or overly passive
☐ Poor planning and organization of behavior	☐ Hyposensitive to sensory input (clumsy/doesn't seem to 'get it' or 'catch on')
☐ Low frustration tolerance/angered easily	

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9 Maladaptive Behaviors

Behavior		
I have observed the following behaviors from my child: (Please check all that apply)		
☐ Kicking ☐ Hitting ☐ Biting ☐ Mouthing ☐ Climbing ☐ Screaming ☐ Head Banging ☐ Skin Picking ☐ Other: _____	☐ Tantrums ☐ Repetitious/Compulsive ☐ Feces Smearing ☐ Hair Pulling ☐ Spitting ☐ Covers Ears ☐ Swearing ☐ Grinding Teeth	☐ Rectal Digging ☐ Eloping ☐ Property Destruction ☐ Scratching ☐ Pacing
Please list the triggers to behavior?		

Additional Important Information:

RESET PRINT