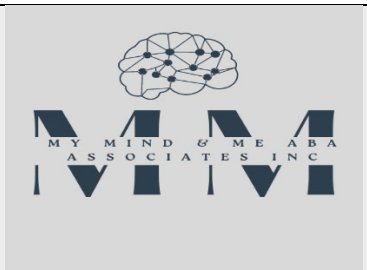

PRIMARY INFORMATION			
Client Name		DOB	Today's Date
Age	Sex M F	Demographic Information	
Your Name	Relation to Client	Phone	Email:

MEDICAL HISTORY			
Diagnosis	Nat-C-section-Prem-Ind.	Problems during pregnancy?	Gestation period
Any Surgeries		Allergies or other medical problems that we should know about?	
Medical Insurance Name	Group Number	Member ID	Phone Number
Diagnosing physician's name and specialty	Phone	Address	
Primary Care Physician (PCP)	Phone	Address	
Other Doctor's attending this child	Phone	Address	

List all medications taken by the client at this time. If none skip to the next section

Medication Name(s)	Dosage(s)	Reason for prescription

Is this the first-time receiving ABA services? Y/N	If yes? List the name of the previous provider. If not? skip	Is the client currently receiving other therapies that we should know about. If yes, please list the name of the therapy/intervention and the name of the provider facility(ies)

FAMILY BACKGROUND INFORMATION		
Provide household members information, ages, and dynamic with client.		
1	Mom Dad Sister Brother Grandfather	Grandmother Aunt Uncle Stepparent Other(s):
2	Describe household members relationships with the client?	
3	Describe how does the client get along with others?	
4	Are there any family routines or traditions that may impact the child's daily life?	
5	Is the client likely to respond more to a specific member of the family than to others? If yes, to whom?	
6	Do caregivers share equally responsibilities related to the client?	
7	How many hours per day are caregivers in contact with the client?	
8	To what extent can caregivers control or try to control the factors that influence the behaviors of concern?	
9	Have the caregivers tried strategies to reduce the behaviors of concern? If yes, have these been effective or not?	
10	Are there any extended family members/friends who play a significant role in the child's life and support network?	
11	Have the caregivers had pass experience with ABA or other disciplines? If yes, describe of successful or any problems with previous approaches if any?	
12	Are there any specific strategies or therapies that have been particularly effective for the child to help with social interactions or sensory challenges?	
13	How does the family communicate with the child (e.g., verbal, non-verbal, visual supports)?	
14	Are there any communication tools or assistive devices used to facilitate interaction?	
15	Can you walk me through a typical day in the life of the child, from morning to bedtime?	
16	Can you walk me through a typical day in the caregivers life?	
17	Have you established a support system. If yes, please explain	

18	Are there any sources of stress in the family related to health, finances, or legal problems?
19	Are there any barriers that would hinder the caregivers or technicians assessment of the target behavior, or that would not allow them to carry out the intervention as planned? Please advise.

HOME/COMMUNITY

1	Can you describe the child's living environment? House has ___ bedrooms//___bathrooms//kitchen//family room//dining room//Other: _____
2	Does the child have his own room_____//Child shares his room with: _____ Has his own closet//drawer-space//doesn't have personal space for belongings//privacy//lacks of privacy

ACADEMIC STATUS

School Name	Phone	Address
Teacher's Name	Phone	Grade level

What type of class does the client attend? (*Circle one***)**
Special Education Center Regular Education Other

Does the child have access to an IEP? If yes, provide documentation	Do you have access to report cards? Y/N	Have you reviewed other academic documents? Y/N

Mark areas of learning that the client is behind compared to other children his age (*mark all that apply*)

Counts to ___	Reads at ___ grade level	Writes at ___ grade level	Copies: Letters __ Words__ Numbers ___	Writes: Name __ Last name __ Single words__ Small phrases __ Sentences__

Has the client failed any grades? If yes list grade failed	Present grade average *(circle one)* A B C D E F

SKILLS ASSESSMENT

SAFETY

Emergency Contact Information : Can the client state the following *(Circle Y -Yes or N-No)*

Say full Name Y/N Address Y/N Phone Y/N Caregiver's name Y/N Caregiver's phone Y/N
Request for help Y/N Dial 911 Y/N

Identifying Safe v. Unsafe Situations *(Circle Y -Yes or N-No)*

Crossing the street when red Y/N Green traffic signal Y/N Touching hot stove Y/N OR Electric outlet Y/N Understands concept of danger Y/N	Identifying fire-hazards Y/N Identifying heights Y/N Identify strangers Y/N Identify candy v. pills Y/N CAN Identifying sharp objects or poison liquids Y/N
FINE MOTOR SKILLS	**GROSS MOTOR SKILLS**
Picks very small items ___ Has eye-hand coordination ___ Can manipulate objects with hands ___ Has a deficiency in eye-hand coordination ____ Explain deficiencies:_____	Normal movement of legs ____ Strength of Legs ____ Can stand on right foot ____ Can stand on left foot___ Normal strength of legs ____ Runs ___ Walks up/down- stairs ____ Holding rail or w/o ___ Walks independently ____ Can hop/jump up ___ Normal arm movement ____ Strength in arms ___ Can throw a ball ____ Explain deficiencies:_____
DAILY LIVING SKILLS	
Understands the concept of time: *(Check what applies)* Today □ Tomorrow □ Yesterday □ Now □ Days □ Weeks □ Later □ Soon □ Years □ Months □ Minutes □ **Can tell time :** Digital clock □ Analog clock □	**Understands the concept of money**: *(Check what applies)* Uses money independently □ Makes correct exchange □ Knows it exchanges for goods and services □ Has no understanding of money or its use □
Hygiene Skills: *(Check what applies)* Toilets □ combs hair □ brush hair □ showers/bathes □ Washes hair □ feminine hygiene brushes teeth □ Shaves □ cuts nails □ wears deodorant or perfume □	**Domestic Skills:** *(Check what applies)* Sets table □ dust □ wash & dry clothes □ make bed □ Vacuum □ iron □ fold & hang clothes □ sweep □ Mop s □ Wash dishes □ Loads dishwasher □ organize toys/personal belongings □
Operates multiple devices: *(Check what applies)* TV □ Radio □ Microwave □ Oven □ Stove □ Phone □ Toaster □ Dishwasher □ Dryer □ Washer □	**Travels Community:** *(Check what applies)* On foot □ Bike □ Public transport □ Accompanied □

Specify the skill level : *(Whereas 0-Does not do 1-needs physical assistance 2-verbal prompts 3-independently)*

Dressing/undressing: Can put on/take off *(mark box)*

	ON	OFF		ON	OFF
Underwear	□ __	□ __	Shoes	□ __	□ __
Bra	□ __	□ __	Socks	□ __	□ __
Pans	□ __	□ __	Button- shirts	□ __	□ __
Skirt	□ __	□ __	Button-pants	□ __	□ __
Dress	□ __	□ __	Pull-over shirt	□ __	□ __
Fasten snaps	□ __	□ __	Zips	□ __	□ __
Hooks	□ __	□ __	Laces	□ __	□ __
Buttons	□ __	□ __	Velcro	□ __	□ __
Shorts	□ __	□ __			

Eating Skills:

CAN USE:

Hands ____ spoon ___ fork ___ knife ___ glass ___
cup ___ plate ___ bowl ___

Spills too much ___ Difficulty chewing ___
Eats fast ___ eats slow ___ Difficulty swallowing ___

SOCIAL SKILLS
(Circle Y -Yes or N-No)

Makes eye contact Y/N Is affectionate Y/N
Responds to authority figures Y/N Smiles Y/N
Responds w/ called by name Y/N Reply to others Y/N

Comments:_____

Shakes hands Y/N Greets others Y/N
Keeps social distance Y/N Initiate interactions Y/N
Gets along with adults Y/N Peers of age Y/N

Comments:_____

LEISURE SKILLS
(List all activity that child engages in each category)

Solitary Activities child engages
_____
_____
_____

Frequency Duration
_____
_____

Interactive Activities child engages.
_____
_____
_____

Frequency
Duration
_____
_____

Community Activities child engages
_____
_____
_____

Frequency Duration
_____
_____

List other activities the child engages or would like to engage in, but has not had the opportunity to do so:
_____
_____
_____

VERBAL/ COMMUNICATION SKILLS
(Circle Y -Yes or N-No)

Follows 1-step command Y/N
Follows 2-step command Y/N
Follows 3-step/+ command Y/N
Receptively Identifies objects Y/N
Has RFF repertoire Y/N

If you responded No to any of the above explain:_____
_____
_____

Echoic Y/N
Mands Y/N
Tact's Y/N
Intraverbals Y/N

If you responded No to any of the above explain:_____
_____
_____