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Intake Form

General Information

**Write name AND address as it appears on insurance card.*

Child's Name:_____DOB:_____Age:_____

SSN:_____

Physical Address: _____

Mailing Address (if different): _____

___Male Referred By:_____Diagnosing Dr: _____

___Female Primary Diagnosis:_____Secondary Diagnosis: _____

Date diagnosis was given: _____

Guardian Information

Guardian Name:_____Relationship:_____

Phone number:_____Address if different from above: _____

Email address: _____

Do you live with patient: y / n

Place of employment:_____Address:_____

Phone Number:_____Contact:_____

Guardian Name:_____Relationship:_____

Phone number:_____Address if different from above: _____

Email address: _____

Do you live with patient: y / n

Place of employment:_____Address: _____

Phone Number:_____Contact: _____

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Insurance Information

Primary:_____Insurance ID Number:_____.

Name of policy holder:_____

Policy holders DOB: _____

Secondary:_____Insurance ID Number:_____

Name of policy holder:_____

Emergency Contact

Other than guardians listed above

Name:_____Relationship:_____

Address:_____Phone Number: _____

Authorized to pick up: y / n

Name:_____Relationship:_____

Address:_____Phone Number: _____

Authorized to pick up: y / n

Name:_____Relationship:_____

Address:_____Phone Number: _____

Authorized to pick up: y/n

Authorized Pick-Up

List if not listed above

Name:_____Relationship: _____

Phone Number: _____

Name:_____Relationship: _____

Name:_____Relationship: _____

Phone Number: _____

Name:_____Relationship: _____

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Physicians

Primary Physician:_____Group: _____

Phone number:_____Permission to contact? y / n

Diagnosing Dr:_____Group: _____

Phone number:_____Permission to contact? y / n

Specialist:_____Group: _____

Phone number:_____Permission to contact? y / n

Specialist:_____Group: _____

Phone number:_____Permission to contact? y / n

Other Therapies/Services

Include how often, dates and if currently receiving

Speech: ___y ___ n

Name of Provider:_____Group: _____

Length of sessions:_____# days/week:_____Effective: ___y ___n

Begin date:_____- End date_____or Current ___y ___n

Occupational Therapy: ___y ___ n

Name of Provider:_____Group: _____

Length of sessions:_____# days/week:_____Effective: ___y ___n

Begin date:_____- End date_____or Current ___y ___n

Other: ___y ___ n
Name of Provider:_____Group: _____

Length of sessions:_____# days/week:_____Effective: ___y ___n

Begin date:_____- End date_____or Current ___y ___n

School Name: _____ Grade attended: _____ Currently enrolled: y / n

School Name: _____ Grade attended: _____ Currently enrolled: y / n

Other Services provided at school: _____

If other services are provided, who are they provided by? _____

Current IEP? ___ yes ___ no If yes, attach to intake.

Past ABA Services

Past ABA Received? ___ yes ___no If yes, received by:_____

Dates of services: Began_____End_____

Reason for discontinuing? (If more than 1 past provider- list them below with dates & name of providers)

Reason for seeking out Ready Set Grow/Ecole Pour Tout for services:

_____

_____

_____

_____

Allergies

List all allergies: _____

Treatment for allergies listed: _____

Diagnosing Dr: _____

_____

Current Medications

Medication: _____Dose: _____Frequency: _____ Effective: y / n

Medication: _____Dose: _____Frequency: _____ Effective: y / n

Medication: _____Dose: _____Frequency: _____ Effective: y / n

Medication: _____Dose: _____Frequency: _____ Effective: y / n

Medication: _____Dose: _____Frequency: _____ Effective: y / n

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Skills Assessment

Check the most appropriate that describes your child.

Skill	Always	Sometimes	Never
Does your child speak freely and easily?			
Does your child use sentences to get their needs or wants met?			
Does your child communicate with gestures, sign language, or communication device?			
Does your child ask for at least 5 items on a daily basis?			
Skill	Always	Sometimes	Never
Does your child say words or sounds you say after you say them (echo you)?			
Does your child answer questions correctly when asked (if the answer is known)?			
Does your child follow directions and routines?			
If you show your child how to do something, will they do it after you show them? (imitation)			
Does your child follow simple motor commands (ie. they are told to clap (without being shown) and they clap)?			
Does your child orient to speaker?			
Does your child respond to his/her name?			
Does your child engage in age appropriate activities?			
Does your child have a particular topic they could engage in all day if you would let them?			
Is your child free of urine accidents?			
Is your child free of bowel movement accidents?			
Does your child wear underwear?			
Does your child dress by themselves?			
Does your child have a sense of danger?			

Parent/Guardian Signature:_____Date: _____

Reviewed By (Staff Signature):_____Date: _____