Beyond Expectations Eau Claire

2125 HEIGHTS DRIVE, STE 3-1
EAU CLAIRE, WI 54701
715-514-0790
INFO@BEYONDEXPECTATIONSEC.ORG

Clinical Intake Form

Child's Information

Child's Name:	D.O.B.:
Address:	City:
Emergency Contact 1	Emergency Contact 1 Phone #:
Emergency Contact 2	Emergency Contact 2 Phone #:
Emergency Contact 3	Emergency Contact 3 Phone #:
Allergies/Medical Concerns:	Preferred Hospital:
Child's Strengths:	

Parent 1 Information

Parent's Name:	Place of Employment:
Address:	City:
Primary Phone #:	Primary Email:
Work Phone #:	Is it ok to text: ☐ Yes ☐ No
Is it ok to leave a voicemail: ☐ Yes ☐ No	Is it ok to email: ☐ Yes ☐ No

Parent 2 Information

Parent's Name:	Place of Employment:
Address:	City:
Primary Phone #:	Primary Email:
Work Phone #:	Is it ok to text: ☐ Yes ☐ No

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Is it ok to leave a voicemail:	☐ Yes ☐ No	Is it ok to email:	☐ Yes ☐ No

Siblings

Sibling(s):	Ages:

Diagnostic Information

Diagnosis:		Evaluator:	
Age of Diagnosis:		Evaluation Clinic:	
Date of Completion:		Has a Release of Information been signed	☐ Yes ☐ No

Child Specific Interests

Toy Interests:

Outside Interests:

TV/YouTube/Music:

Social Interests:

Child Specific Areas for Growth and/or Concerns

Communication:

Social Interactions:

Toy Play:

Sensory Sensitivities:

Fears/Anxiety:

Toileting:

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Daily Living Skills:

Challenging Behaviors:

Current Interventionists/Specialists/Community Supports

Primary Care Doctor:	☐ Yes ☐ No	Location:	Phone
Birth to 3:	☐ Yes ☐ No	Location:	Phone
CLTS:	☐ Yes ☐ No	Social Worker Name:	Phone
CCS:	☐ Yes ☐ No	Social Worker Name:	Phone
Speech Therapy:	☐ Yes ☐ No	Location:	Phone
OT/PT	☐ Yes ☐ No	Location:	Phone
Counseling/Therapy	☐ Yes ☐ No	Location:	Phone
OTHER:	☐ Yes ☐ No	Location:	Phone

**Please sign a release for any current interventionists and supports to ensure collaboration between services.*

Previous Interventionists/Specialists/Community Supports

Primary Care Doctor:	☐ Yes ☐ No	Location:	Phone
Birth to 3:	☐ Yes ☐ No	Location:	Phone
CLTS:	☐ Yes ☐ No	Social Worker Name:	Phone
CCS:	☐ Yes ☐ No	Social Worker Name:	Phone
Speech Therapy:	☐ Yes ☐ No	Location:	Phone
OT/PT	☐ Yes ☐ No	Location:	Phone

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Counseling/Therapy	☐ Yes ☐ No	Location:	Phone/Email
OTHER:	☐ Yes ☐ No	Location:	Phone/Email

General Questions:

1. How does your child sleep at night? Do they have trouble falling asleep or staying asleep? Do they sleep alone or with another person?

2. Describe your child's bedtime routine.

3. Would you consider your child a picky eater?

4. What are you child's preferred foods?

5. What food does your child dislike?

6. Does your child follow directions?

7. Does your child stay with you or run from you in the community? When did this happen last?

8. Do you feel your child tantrums more than the average child? What do their tantrums look like?

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9. Are there any specific triggers or warning signs prior to a tantrum?

10. Does your child avoid crowds or loud noises? Explain:

11. Does your child avoid certain textures or clothing? Explain:

12. Does your child seek out specific textures or clothing? Explain:

13. Does your child struggle with constipation? If yes, what interventions have been tried?

14. Does your child have frequent earaches?

15. Is there anything else you would like us to know about your child?

Parent 1 Signature Date:

Parent 2 Signature Date: