New Client Intake Form

Confidential

Please complete the following questions prior to your intake appointment. Information provided by you on this form is strictly confidential and will only be released in accordance with HIPAA guidelines and as mandated by law.

General Information:

Client Name: _____ Date of Birth: _____

Home Address: _____

Parent/Guardian #1 _____ Phone Number: _____

Parent/Guardian #2 _____ Phone Number: _____

Diagnosing Provider:

Name: _____ Diagnosis: _____

Address: _____ Date of Diagnosis_____

_____ Please provide a copy of the Diagnosis

Phone Number: _____ Report to your consultant.

Referring Physician Information:

Name: _____

Address: _____

_____

Phone: _____

School Information:

School Name: _____

School Number: _____

Grade: _____

Current Teacher(s): _____

Who may we thank for the referral to us? _____

Medical History

Your child's heath is: ☐ Excellent ☐ Good ☐ Fair ☐ Problematic

Are your child's immunizations up to date? **Y** **N** **Unsure**

Does your child have any medical problems for which he/she sees a doctor or takes medication? (Examples: asthma, anemia, diabetes, heart condition, migraines) **Y** **N**
If yes, what: _____

Does your child have allergies? **Y** **N** **Unsure**
If yes, please list:_____
How serious?

- ☐ Potentially life-threatening
- ☐ Minor, ongoing problems (dust, cats)
- ☐ Occasional problem (hay fever)

Check any of child's reactions to foods, drugs, pollen, grass, animals, chemicals, etc.

- ☐ Behavior changes
- ☐ Rashes, eczema
- ☐ Wheezing
- ☐ Loose bowel movements
- ☐ Dark circles under his/her eyes
- ☐ Runny nose, congested

Other:_____

Does your child have any hearing or vision problems? _____
Please list last hearing/vision test and who performed (doctor, optometrist, audiologist, school)
_____

Developmental History

Describe child as a baby (<2 years old):

	Never	Sometimes	Often	Always
Liked to point to things				
Liked to show toys to people				
Enjoyed being held				
Good eye contact, smiling				
"Talking" with you				
Playing baby games				

Describe child as a toddler:
Select a number (1-5) to describe where your child falls

Happy and playful	1	2	3	4	5	Irritable, tantrum prone
Confident, made friends easily	1	2	3	4	5	Shy and cautious
Easy to satisfy	1	2	3	4	5	Demanding and fussy
Adaptable, take him/her anywhere	1	2	3	4	5	Upset by change/transition
Always showed feelings intensely	1	2	3	4	5	Hard to know how feeling

When did you first have concerns about your child's development? _____

Family Information

Who currently lives in the household? _____
Are parents: Married?_____ Separated?_____ Divorced?_____

Father's Occupation:_____
Mother's Occupation:_____

Does anyone else care for the child on a regular basis (nanny, daycare provider, etc)?
_____

Sibling Information

Name	Age	Living in the Home?	Diagnosis (if applicable)

Do any family members have medical/psychiatric diagnoses (ADHD, Fragile X, Bipolar Disorder, Schizophrenia, etc)?

Family Member	Diagnosis

Are there any religious or cultural beliefs that you would like to make us aware of so that we may take those into account when designing a program for your child?

Behavior Information

Do you have concerns about your child's behavior?
Does your child engage in behaviors that are harmful to him/herself or others? If yes, please explain.
What is your primary concern regarding your child's future?
What prompted you to seek ABA therapy?

Questions Regarding Past ABA Services

Has your child received ABA services in the past? _____

Start date of previous services? _____

Stop date of previous services? _____

Who provided the services? _____

*Please provide a copy of any previous behavior plans or plan updates to your consultant.

Questions Regarding Other Services

Please circle the following services if your child is currently receiving or has received the service in the past: SLP OT PT Other:_____

Please list the services your child is currently receiving:

Service:	Service Provider:	Days/Time of Service:
_____	_____	_____
_____	_____	_____

*Please provide a copy of any treatment plans or evaluations to your consultant.

Please indicate if your child is experiencing any of the following:

Your consultant will get more information from you about each "yes" response during your intake appointment.

Problems with eating	Yes	No
Problems making friends	Yes	No
Problems sleeping	Yes	No
Problems controlling temper	Yes	No
Fatigue/tiredness during the day	Yes	No
Problems with potty training	Yes	No
Problems with authority	Yes	No
Problems with changes in routine	Yes	No
Anxiety	Yes	No
Unmotivated	Yes	No
Stress from conflict between parents	Yes	No
Legal situation (anyone in the family)	Yes	No
History of abuse	Yes	No
Alcohol/drug use/abuse	Yes	No
School concentration difficulties	Yes	No
Sadness or depression	Yes	No

Discipline Information

Parents may use a wide variety of discipline strategies with their children. Listed below are several examples. Please state whether or not you use each strategy. For yes answers, let us know whether or not the strategy is usually effective.

Intervention			Effective?
Let situation go	Yes	No	
Take away a privilege (ex, no TV)	Yes	No	
Assign an additional chore	Yes	No	
Take away something material	Yes	No	
Send to room	Yes	No	
Physical punishment	Yes	No	
Reason with child	Yes	No	
Ground child	Yes	No	
Yell at child	Yes	No	
Send to time out	Yes	No	
List anything else you may do:			

Go back and rate the 3 most effective strategies. That is, place a 1 by the most effective, a 2 by the next most effective, and a 3 by the third most effective. Please circle the LEAST effective. Please rate what percentage of discipline is handled by each of the following:

Father: _____% Mother: _____% Other: _____% (Please specify): _____

General Information

Please list the 5 things you would like for your child to do more of and less of in order of priority to you. For example, instead of saying, "I want my child to be more responsible", translate that into actual behaviors such as "I want my child to do household chores" etc.

Like Child To Do More Often	Like Child To Do Less Often

Please list items/activities your child enjoys.
Please list items/activities that frighten your child or that your child does not like.
Please list 3 traits your child possesses for which you are most proud! 1. 2. 3.
Is there anything else you would like us to know about your child or family?

Name of person filling out form _____

Signature _____ Date _____