New Client Intake

The information provided will be very helpful in treating your child as well as in the insurance authorization process. Please fill out completely or to the best of your knowledge.

Date:____________________
How did you hear about us?____________________

General Information

Your Name: ____________________________Relation to client _________________________________

Home Phone: _____________________________ Cell Phone: ___________________________________

Child's Legal Name (Last, First, Middle): ____

Child's DOB (MM/DD/YYYY): _________________ Gender: **Male Female**
Current Grade:____________

Child's Primary Residence (Street Name, Building and/or Apt. #, City, State, ZIP):

____

____

What is your child's ethnic/cultural background? ____

List any legal issues involving your child (divorce, custody issues, etc):

____

Primary Contact Information

Father's/Mother's/Guardian's Name (Last, First, Middle): ___________________________________

Living with Child? **Yes** **No**

Primary Residence (If Different from Student's Address):

____

Home Phone: __________________Work Phone: _______________Cell Phone: __________________
Email: __________________________

What is your preferred method of contact (email, phone):
____

Father's/Mother's/Guardian's Name (Last, First, Middle):_________________________________

Living with Child? **Yes** **No**

Primary Residence (If Different from Student's Address):
____

Home Phone: ________________Work Phone: _________________Cell Phone: _____________

Email: ______________________________

List Siblings (Brother/Sister, Name, Age):____

____

Who lives in child's main household?
____

Behavior

What behavior challenges is your child having?
____

____

How have these behaviors affected the child and family members?____

Has your child ever threatened/attempted to harm self or others? **Yes** **No**
Explain: ____

Does your child elope (run away)? **Yes** **No**

What do you do when your child misbehaves?
You: ____

Response to behavior:
____

Health History

Pediatrician: __________________________Phone number: _____________________________

Please list child's main diagnosis(es) ex. Autism:

Diagnosis	Date

Diagnosing physician and phone number: ______________________________

List any medications and/or supplements your child is on:

Medication/Dosage	Side Effects

List all therapies and/or treatments child is currently receiving:

Name	Contact Info	Date Started

List therapies/treatments child received in the **PAST**:

Name	Contact Info	Date(Beginning-End)

Are all immunizations up-to-date? **Yes** **No**

If "no", list which ones:

____

Does this child have an ongoing health concern? (Asthma, Diabetes, Etc.) **Yes** **No**

If "yes", please describe:

____

Does this child have any allergies (food, medication, etc)? : **Yes** **No**

If "yes", please list:

Has the allergy required emergency treatment? **Yes** **No**

If "yes", please explain:

Does your child present with a hearing loss? **Yes** **No**

Has your child ever had ear infections? **Yes** **No**

If your child has not been previously diagnosed with a hearing loss, do you suspect a hearing problem? **Yes** **No**

Circle all that apply:

Asthma or Lung Problems	**Fracture/Dislocation/Strain**	**Ulcers/Digestive**
Depression/Mental Health Issue	**Hearing Aid/Orthopedic Braces**	**Skin/Toes**
Diabetes/Hepatitis	**Head Injury**	**Surgery**
Ear/Nose/Throat	**Heart Problems**	**Other (ADHD,AIDS, etc.)**
Epilepsy/Seizures	**Kidney/Urinary Problems**	____________________

For each condition circled above, please indicate if it is past or present condition, the treating physician's name and phone number, and current medication requirements and purpose:

Is there a history of any hospitalizations, significant injuries or surgery? **Yes** **No**

If "yes", please describe:

Major Family events that could effect behavior:

Describe child's usual energy/activity level:

Developmental History

Were there any issues during pregnancy, labor and/or delivery for this child? **Yes** **No**

Describe child as an infant/toddler, up to 24 months (cheerful, fussy, cuddly, withdrawn, etc):

Age child first sat up: ________ Took steps: __________ Spoke words: _________

Age first spoke in sentences: ________ Age toilet-trained during day: ________ Night: ________
Problem now? ________ Age dressed self: ________ Tied shoe-laces: ________ Rode 2-wheel bike: _______

Speech and Language Development History

Child said first words between the ages of 12 and 18 months? **Yes** **No**
Child used two words together (i.e., "Mommy go," or "Want drink") by 24 moths? **Yes** **No**
During the first year, was your child unusually quiet and/or made few sounds other than crying? **Yes** **No**
How much does the child talk at home?_____ Average ______ None _____ A few words
Does the child use gestures with words? **Yes** **No**
Does the child mainly use gestures? **Yes** **No**
Are there languages other than English spoken in the home? **Yes** **No**
If yes, what language(s)? ____
Does the child speak or understand other languages? **Yes** **No**
If yes, what language(s)? ____
How well does the family understand the child's speech?
_____ Easily understood
_____ Understood if the listener knows the topic
_____ Words understood now and then
_____ Completely unintelligible
_____ Gestures understood
Did your child's speech/language learning ever seem to stop? **Yes** **No**
If yes, please explain:____

Does your child have difficulty understanding directions or conversations? **Yes** **No**

Does your child respond to the following?

His/Her Name	**Yes**	**No**
Verbal Instructions	**Yes**	**No**
Instructions with gestures	**Yes**	**No**
Gestures Alone	**Yes**	**No**
Soft Noises	**Yes**	**No**
Loud Noises	**Yes**	**No**

How do you communicate with your child?
____
____

How does your child make his/her needs known to you?
____
____

Please describe your main concerns regarding your child's speech and language?
____
____

School Information (if applicable)

School: ______________________________ Address: ____________________________________

Phone: ________________Teacher: _______________________ Counselor: _________________

List any known learning disabilities your child has:

____

Is your child receiving Special Education services at school? **Yes** **No**

If "yes", then please complete the following:

Circle all that apply:

Content Mastery/Resource Room **Occupational/Physical Therapy**
Counseling **Behavior Unit**
Structured learning classroom **Functional Life Skills**
Speech Therapy
Other:_____________

If "no", then please complete the following:

Has child ever received Special Education services? **Yes** **No**

If "yes", please specify school name and year:_________________________

Describe effort/attitude toward school:

____

Describe academic performance:

____

Describe behavior in school:

____

Will you need IEP review or ARD advocacy? **Yes** **No**

Please attach recent reports from other ABA providers, IEP, Diagnosis (diagnostic report) and prescription for ABA.