Client Intake

Once completed this form will be placed in the client file

Child's Legal Name: _____ Date of Birth: _____ Sex: M F

Person Responding & Relationship: _____ Date Completed: _____

Primary Caretakers (Please list the family members, teachers, therapists, or other individuals who care for your child on a regular basis):

Name	Relationship

Address: _____ Home Phone: _____
State, Zip: _____
Apartment Complex Name: _____
Gate Code for Apt: _____ Bldg Number: _____
Mom's Cell: _____ Mom's Email: _____
Dad's Cell: _____ Dad's Email: _____
Best way to contact Mom?: _____Best way to contact Dad?_____
Mom's Driver's License (No. and State): _____
Dad's Driver's License (No. and State): _____

Please list all siblings and ages: _____
_____

Please make sure to send a copy or picture of both driver's licenses and the front and back of the child's insurance card.

Living Arrangement: Please describe your home and community:
_____
_____

Have pets in the home? Yes No
If "yes", please describe: _____

Programs and Services

Please list the educational or therapeutic programs (e.g., school, daycare, OT, PT, speech) in which your child is currently participating:

Educational Services:

Program/Service	Contact Person	Frequency (how often)

Therapeutic/Medical Services:

Program/Service	Physician/Provider	Frequency (how often)	Send a Coordination of Care Form?
			No or **Yes**
			No or **Yes**
			No or **Yes**

Have you received behavioral health services (ABA) in the past? **No** or **Yes**
If yes, what was the approximate range of dates you saw that provider for? _____
Who was the provider? _____
What were your child's responses to the treatment provided (i.e., what worked, and what didn't work?)
_____
_____

Broad Goals (i.e., what does the caregiver/individual see as their ultimate goals in life?)
_____
_____
_____

Medical Issues

What problems is your child having? _____

Describe how your child's problems affect you and other family members:
_____

Describe prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual, and academic).
_____
_____
_____
_____
_____

Please list any medical, psychological, psychiatric diagnoses that your child has received including any previous or current infectious diseases.
_____
_____

_____

_____

Pregnancy Complications? **Yes** **No**

If "yes", please describe: _____

Birth Complications? **Yes** **No**

If "yes", please describe: _____

Explain if mother/child separated after birth or any other parent/child separations:

_____

Please list out any diagnosis the child may have:
(*The following must be formal medical diagnosis not simply characteristics / Diagnosing physician*)
Axis 1: _____ (DX referred for; this could be multiple diagnosis, ex: autism, anxiety disorder) / Physician & Date: _____
Axis 2: _____ (intellectual disabilities and personality disorders) / Physician & Date: _____
Axis 3: _____ (general medical diagnosis) / Physician & Date: _____
Axis 4: _____ (environmental or psychosocial stressors; ex: death in family, divorce, new sibling born, moving, etc.) Physician & Date: _____
Axis 5: _____ (global assessment of functioning) / Physician & Date: _____

Please list any medications your child is taking that could impact his or her behavior.

Medication	Dose	Frequency	Reason	Impact	Prescribing Physician

Please describe any additional medical complications that could be affecting your child's behavior (e.g., asthma, skin conditions, stomach problems, diabetes, fractures, digestive issues, heart problems, seizures, substance abuse).

_____

_____

_____

Does he or she have a primary care physician? **No** **Yes**: _____
If Yes: Phone: _____ Address: _____

Are you currently receiving behavioral health services from another provider? **No** or **Yes**: _____
If Yes: Phone: _____ Address: _____

About how many hours of sleep does your child get each day (including naps)? _____
Does he or she sleep through the night? **Yes** **No**

Does your child have any eating habits or dietary restrictions that could affect his or her behavior? If so, please describe.

_____

_____

Please identify if child has had the following diseases by writing the age he/she had the disease on the line:
Chickenpox: _____Measles: _____Mumps: _____
Age Age Age

Are all immunizations up-to-date? **Yes No**
If "no", list which ones: _____

Does this child have any allergies (food, medication, etc)? : **Yes No**
If "yes", please list (describe if ingestion, contact, or airborne): _____

_____

Has the allergy required emergency treatment? **Yes No**
If "yes", please describe: _____

Does your child present with a hearing loss? **Yes No**
Has your child ever had ear infections? **Yes No**
If yes, how many ear infections and at what age? How were they treated?

_____

_____

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

Is there a history of any hospitalizations, significant injuries or surgery? **Yes No**
If "yes", please describe: _____

Describe child's usual energy/activity level: _____

Has your child ever threatened/attempted to harm self or others? **Yes No**
If "yes", please describe: _____

Is your child currently experience homicidal or suicidal ideations? **No** or **Yes**
(*If yes, then 1- refer for immediate evaluation by an appropriate psychiatric professional, or 2- call 911, depending on the level of risk*).

Has your child been a victim of abuse of any kind? **No** or **Yes**
Has your child been a perpetrator of abuse of any kind? **No** or **Yes**
If yes for either of the above, please describe: _____

_____

_____

12 years and older - If appropriate, please explain any sexual behavior history:

_____

_____

12 years and older - Are you aware of any past or current substance abuse your loved one may have engaged in including the use of nicotine and alcohol? Please describe.

_____

_____

Has any substance abuse screening occurred? **No** or **Yes**

If "yes", please describe: _____

_____

Pertinent Family History

Please describe any relevant medical family history (e.g., sibling/caregiver's psychological diagnoses, medical conditions, medications/treatments, substance abuse, etc.) that could affect your child's behavior, treatment implementation, and/or the participation of team members.

_____

_____

_____

Please describe any relevant behavioral family history (e.g., sibling/caregiver's behavioral diagnoses, criminal history, behavioral history, treatments, etc.) that could affect your child's behavior, treatment implementation, and/or the participation of team members.

_____

_____

_____

Please describe any relevant spiritual or cultural variables (e.g., family beliefs, perspectives, rituals, observations, traditions, etc.) that could affect your child's behavior, treatment implementation, and/or the participation of team members.

_____

_____

_____

Describe any legal or marital issues that may impact the implementation of services (ie., divorce, guardianship, custody issues, etc.).

_____

_____

_____

Developmental History

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: _____ Weaned: _____ Fed him/herself: _____
Age toilet-trained during day: _____ Night: _____ Problem now? _____
Age dressed self: _____ Tied shoe-laces: _____ Rode 2-wheel bike: _____
Age his voice changed (adolescent male): _____ Developed body hair: _____

Age 1st menstruation (adolescent female): _____ Breast development: _____

Speech and Language Development History

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

_____

_____

_____

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 describe: _____

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**
Vibrations **Yes No**

How do you communicate with your child?

_____

_____

How does your child communicate his or her needs (please check all that apply)?

	Words	Signs	Gestures	Other

Request attention				
Ask for assistance				
Request toy/object				
Initiate activity				
Avoid a situation				
Take a break/stop				
Say “no” to request				
Indicate discomfort				

School Information (if applicable)

School: _____ Address: _____

Phone: _____Teacher: _____ Counselor: _____

Last Grade Completed: ____

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
Counseling
Speech Therapy
Occupational/Physical Therapy
Behavior Adjustment Class
Other:_____

Has the child ever attended any other schools? **Yes No**

If “yes”, please list out names and years attended: _____

_____

Describe effort/attitude toward school:

_____

_____

Describe academic performance: _____

Describe behavior in school: _____

When did school performance/behavior change?

_____

_____

Why do you think it changed? _____

_____

Parent/Child Relationship

How do you and spouse/partner show affection to your child? How?

_____

List any of your child's responsibilities/rules: _____

_____

How does your child handle these? _____

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

What do you and your spouse/partner do the same thing when your child misbehaves? If not, what is different?
You: _____
Spouse/Partner: _____

Has family ever been involved with Protective Services: **Yes No**
If "yes", when and reason for: _____
_____
_____

Describe any behaviors of yourself, partner, or other adults in the home that may have affected your child:
_____
_____

Behavioral Profile

Child's Strengths: What are your child's greatest strengths (e.g., skills, interests)?

_____
_____
_____

Potential Reinforcers: What does your child like (i.e., if presented with a variety of options or given free time, what would your child choose)?

Attention (e.g., conversation, eye contact, touch)_____

Tangibles (e.g., activities, toys) _____

Sensations (e.g., smells, sights) _____

Problem Behaviors

Behaviors of Concern: What does your child say or do that concerns you most (e.g., aggression toward self or others, property destruction, tantrums, screaming, inappropriate interactions, resistance, off-task behavior, substance abuse, sexual behavior)? Estimate how often, long, and severe.

Behavior	Description	Frequency	Duration	Severity

1.		□ hourly ___ □ daily ___ □ weekly ___ □ other:	___ seconds ___ minutes ___ hours	□ high □ medium □ low
2.		□ hourly ___ □ daily ___ □ weekly ___ □ other:	___ seconds ___ minutes ___ hours	□ high □ medium □ low
3.		□ hourly ___ □ daily ___ □ weekly ___ □ other:	___ seconds ___ minutes ___ hours	□ high □ medium □ low
4.		□ hourly ___ □ daily ___ □ weekly ___ □ other:	___ seconds ___ minutes ___ hours	□ high □ medium □ low
5.		□ hourly ___ □ daily ___ □ weekly ___ □ other:	___ seconds ___ minutes ___ hours	□ high □ medium □ low

Which, if any, of these behaviors occur together? _____

In what environments do these behaviors occur? □ Home □ School □ Community

Impact of Behavior: How are your child's behaviors affecting your child's development, or participation in activities or settings? What is the impact on your family?

_____
_____
_____

Previous Interventions: Please list strategies and interventions you have tried to address your child's behavior, when they were used, and their impact (i.e., how they worked).

Intervention Attempted	When	Impact on Behavior

Setting Events: List activities in which your child is most successful and those in which your child has the greatest difficulty.

Most Successful

_____
_____
_____
_____

Most Problematic

_____
_____
_____
_____

Predictability of Events

Is your child's daily schedule consistent (i.e., Do meals, bedtimes, and other daily events occur at the same time and in the same order)? **Yes No**

Do you feel that your child generally knows what is going to happen (e.g., where the child will be going, when, and with whom)? **Yes No**

Opportunities for Choice: Please describe the different types of choices your child has the opportunity to make on a regular basis (e.g., what to wear, with whom to play, what activities to do):

_____
_____

Social Influence: With whom is your child's behavior of concern…

Most Likely: _____

Least Likely: _____

Possible Triggers: What impact would you expect the following situations to have on your child's behaviors of concern?

Situation	More Likely	No Impact	Less Likely	Notes
Asked to do a difficult task				
Told no or to stop activity				
Attention is withdrawn				
Change in routine/schedule				
Loud or chaotic situations				
Required to wait/delayed				
Other situations that are particularly difficult:				

Possible Functions: What are the most common outcomes of your child's behaviors of concern (e.g., does your child get attention or items, avoid demands or situations)?

Behavior	What does your child get?	What does your child avoid?
1.		

2.		
3.		
4.		
5.		

Other Skills: Describe your child's ability to perform the following types of skills.

Self-care (e.g., dressing, toileting): _____
_____

Daily living (e.g., household chores): _____
_____

Play/leisure (e.g., using toys, games): _____
_____

Academics (e.g., writing, cutting): _____
_____

Other: _____

Please review the following list and circle the numbers that you feel fit your child. Then write those numbers below and briefly explain:

1. Speech difficulties
2. Nervous habits/behavior
3. Frequent headaches
4. Frequent stomachaches
5. Difficulty sleeping
6. Lacks guild/remorse
7. Difficulty making friends
8. Difficulty keeping friends
9. Little interest in friends
10. Little interest in activities
11. Disrespectful/argumentative
12. Doesn't complete schoolwork
13. Acts before thinking
14. Short attention-span
15. Unable to sit still
16. Overactive
17. Underactive
18. Sucks thumb
19. Bangs head
20. Grinds teeth
21. Nightmares
22. Seems angry
23. Hurts animals
24. Sets fires
25. Steals
26. Lies frequently
27. Too serious
28. Fights a lot
29. Clowns a lot
30. Acts spoiled
31. Tempter tantrums
32. In own world
33. Afraid/fearful
34. Accident-prone
35. Insecure
36. Sad/depressed
37. Worries a lot
38. Cries frequently
39. Defies authority
40. Interested in sex
41. Ignores rules
42. Separation anxiety
43. Imaginary friends

#____ Explain: _____

#____ Explain: _____

#____ Explain: _____

#____ Explain: _____

#____ Explain: _____

#____ Explain: _____

#____ Explain: _____

#____ Explain: _____

Other Issues: Please feel free to describe other issues you feel could be influencing your child's behavior.

Attach additional notes or copies of reports as needed.