Therapies 4 Kids
Exceptional Care For Exceptional Children

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ABA THERAPY INITIAL INTAKE FORM

OFFICE USE

Date completed: ___ / ___ / _____ *(Mo./Day/Year)* Date revised: ___ / ___ / _____ *(Mo./Day/Year)*

PATIENT INFORMATION

All questions contained in this questionnaire are strictly confidential and will become part of your child's records at Therapies 4 Kids.

Child's Last Name: _____ **Parent**'s Last Name: _____

First Name: _____ M.I.: _____ First Name: _____ M.I.: _____

D.O.B: ___ / ___ / _____ *(Mo./Day/Year)* Gender: ☐ M ☐ F Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Street Address: _____

_____

City: _____ State: _____ Zip code: _____ Country: _____

Phone: _____ Cellphone: _____ E-mail: _____

Pediatrician: _____ Pediatrician's Phone: _____

Diagnosis: _____ Diagnosis Given by: _____

Referred by: _____ Date of last physical exam: ___ / ___ / _____ *(Mo./Day/Year)*

What services are you seeking from Therapies 4 Kids:

☐ ABA / Behaviour Therapy ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech / Language Therapy ☐ Medical

☐ Social Skills ☐ Academic/Tutoring ☐ Sibling Group ☐ Other _____ *(please specify)*

HEALTH AND DEVELOPMENTAL HISTORY

Length of Pregnancy: _____ *(in weeks)* Weight at Birth: _____ *(Lbs, Oz)*

Describe any difficulties during pregnancy and/or delivery: _____

_____

At what age did child sit up? ____ *year(s)* ____ *months*

At what age did child begin to walk? ____ *year(s)* ____ *months*

At what age did child begin to use single words? ____ *year(s)* ____ *months*

At what age did child begin self-feeding? ____ *year(s)* ____ *months*

At what age did child begin to crawl? ____ *year(s)* ____ *months*

At what age did child begin to babble? ____ *year(s)* ____ *months*

At what age did child begin to use sentences? ____ *year(s)* ____ *months*

Childhood Illnesses: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Please describe any major medical problems child has experienced: _____

_____

Please describe any major medical problems in the family: _____

_____

Is there a family history of mental illness? ☐ Yes ☐ No If yes, please describe: _____

List of medications your child is taking

NAME OF MEDICATION	DOSE	FREQUENCY TAKEN

ALLERGIES TO MEDICATION	ALLERGIES TO FOOD

CURRENT CONCERNS

Check all the concerns or problems that have brought you to the Therapies 4 Kids.

☐ Speech delay ☐ Motor delay ☐ Social delay ☐ Toileting ☐ Feeding ☐ Sleeping ☐ Behavior

How long has this been a concern or problem? ____ *year(s)* ____ *months* Age at which problem was noted: ____ *year(s)* ____ *months*

Does anyone else in your family have a similar problem? ☐ Yes ☐ No If yes, please describe: _____

What treatments has your child received for this concern or problem:

☐ Behaviour Therapy ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech / Language Therapy ☐ Medical ☐ None

☐ Other _____ *(please describe)*

Was this treatment effective at reducing problem? ☐ Yes ☐ No Please describe the duration of this treatment: ____ *year(s)* ____ *months*

EDUCATIONAL HISTORY

Attended/Participated in Early Intervention Program (before age 3)	☐ Yes	☐ No	☐ Currently	Name of program: _____
Attended pre-school?	☐ Yes	☐ No	☐ Currently	Name of school: _____
Attended kindergarten?	☐ Yes	☐ No	☐ Currently	Name of school: _____
Attended elementary?	☐ Yes	☐ No	☐ Currently	Name of school: _____
In any special class?	☐ Yes	☐ No	☐ Currently	Name of class: _____
Repeated grade?	☐ Yes	☐ No	☐ Currently	Grade held: _____
Ever suspended / expelled?	☐ Yes	☐ No	☐ Currently	Reason: _____
Ever had psychological testing at school?	☐ Yes	☐ No	☐ Currently	If Yes, please attach a copy.

Current School Name: _____ Teacher's Name: _____

School Address: _____

City: _____ State: ____ Zip code: _____ Country: _____

Phone: _____ Fax: _____ E-mail: _____

HOUSEHOLD

Mother's Last Name: ______________________ First Name: ______________________ M.I.: ______

Faher's Last Name: ______________________ First Name: ______________________ M.I.: ______

Please list all individuals living in the same household with child:

NAME	AGE	GENDER	RELATIONSHIP TO CHILD
		☐ M ☐ F	☐ Parent ☐ Step-parent ☐ Sibling ☐ Grandparent ☐ Caretaker ☐ Other: ______
		☐ M ☐ F	☐ Parent ☐ Step-parent ☐ Sibling ☐ Grandparent ☐ Caretaker ☐ Other: ______
		☐ M ☐ F	☐ Parent ☐ Step-parent ☐ Sibling ☐ Grandparent ☐ Caretaker ☐ Other: ______
		☐ M ☐ F	☐ Parent ☐ Step-parent ☐ Sibling ☐ Grandparent ☐ Caretaker ☐ Other: ______
		☐ M ☐ F	☐ Parent ☐ Step-parent ☐ Sibling ☐ Grandparent ☐ Caretaker ☐ Other: ______
		☐ M ☐ F	☐ Parent ☐ Step-parent ☐ Sibling ☐ Grandparent ☐ Caretaker ☐ Other: ______
		☐ M ☐ F	☐ Parent ☐ Step-parent ☐ Sibling ☐ Grandparent ☐ Caretaker ☐ Other: ______

CHILD'S BEHAVIOR

Check all skills that most closely describe your child.

Learning Readiness:

Eye Contact: My child...

- ☐ Makes no eye contact
- ☐ Makes spontaneous eye contact when name is called
- ☐ Makes eye contact upon request

Appropriate Sitting (sits correctly in chair): My child...

- ☐ Does not sit appropriately
- ☐ Sits upon request but only for a limited amount of time
- ☐ Sits upon request

Simple Directions: My child responds consistently to...

- ☐ "Come here."
- ☐ "Hands down."
- ☐ "Stand up."
- ☐ "Get (object)."

Self-Care:

Toileting: My child...

- ☐ Is in diapers at all times
- ☐ Is in diapers but taken to bathroom
- ☐ Is urine-trained
- ☐ Is bowel-trained
- ☐ Is night-time trained

Dressing: My child...

- ☐ Needs to be dressed
- ☐ Attempts to help in dressing (puts up arms)
- ☐ Can put on some clothing independently
- ☐ Can dress independently

Bathing/Washing: My child...

- ☐ Needs to be bathed/washed
- ☐ Attempts to help with bathing/washing
- ☐ Will do some bathing/washing independently

Eating:

My child...

- ☐ Does not use utensils
- ☐ Uses utensils occasionally
- ☐ Uses utensils well
- ☐ Exhibits strong food preferences
- ☐ Exhibits strong food aversions
- ☐ Eats well balanced diet

Occupational/Fine Motor Skills:

My child is able to correctly do/use...

- ☐ Puzzles
- ☐ Manipulative toys (e.g., busy box)
- ☐ Stacking rings
- ☐ Crayons
- ☐ Is right handed
- ☐ Blocks
- ☐ Pegboard
- ☐ Dolls
- ☐ Is left handed
- ☐ Beads and strings
- ☐ Trucks/cars
- ☐ Nesting cups
- ☐ Is ambidextrous

Recreational Activities:

My child enjoys...

- ☐ Outdoors
- ☐ Gross motor equipment (swings, slides, etc.)
- ☐ Car rides
- ☐ Shopping trips
- ☐ Eating out
- ☐ Other _____ *(specify)*

Social Activities:

My child has exposure to other children through...

- ☐ Siblings
- ☐ Relatives
- ☐ Friends/neighbors
- ☐ Other _____ *(specify)*

Academic Skills:

My child is able to...

- ☐ Recognize colors, letters and/or numbers
- ☐ Count
- ☐ Read
- ☐ Write

Language Skills:

My child is able to...

- ☐ Speak in full sentences
- ☐ Speak in phrases
- ☐ Use single words
- ☐ Use manual signs
- ☐ Use gestures to communicate
- ☐ Use neither words nor signs

Behavior:

My child engages in...

- ☐ Self-stimulatory behavior:
  - ☐ Finger play
  - ☐ Sniffing/smelling objects
  - ☐ Rocking
  - ☐ Spinning
  - ☐ Vocalizations
- ☐ Self-injurious behavior:
  - ☐ Self-biting
  - ☐ Scratching
  - ☐ Head banging
  - ☐ Self-hitting
- ☐ Aggressive/highly disruptive behavior:
  - ☐ Tantrums
  - ☐ Pinching others
  - ☐ Biting others
  - ☐ Hitting others

Thank You for filling out this questionnaire!

The Therapies 4 Kids ABA Staff

Date: ___ / ___ / _____ *(Mo./Day/Year)*

Signature: _____ Relationship to child: _____