



**INTAKE APPLICATION**

**Personal Information**

Child's Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Address (include zip code): \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Work # \_\_\_\_\_

Father's Name: \_\_\_\_\_ Work # \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Parents living together: Yes/No

**Medical**

Primary Diagnosis: \_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_

Age at Diagnosis: \_\_\_\_\_

Diagnosed by whom: \_\_\_\_\_

Current Medication:	Past Medication:
_____	_____
_____	_____
_____	_____





Allergies: \_\_\_\_\_

Special Diet: \_\_\_\_\_

Other Bio-Medical Interventions: \_\_\_\_\_

**Has an ABLLS or ABLLS-R (The Assessment of Basic Language and Learning Skills-R) been completed? By Whom:** \_\_\_\_\_

**When:** \_\_\_\_\_

VB-MAPP: \_\_\_\_\_ Who? \_\_\_\_\_ When?: \_\_\_\_\_

**Description of current educational/behavioral intervention programs:**

***In home program:***

Type of programming: \_\_\_\_\_

\_\_\_\_\_

Dates: \_\_\_\_\_

Past Consultant (s): \_\_\_\_\_

Current Consultant: \_\_\_\_\_

Overall Impression of program: \_\_\_\_\_

Hours a day of skills trainer currently: \_\_\_\_\_

Extended School Year in IEP?: How many hours/day? \_\_\_\_\_



*Pre School/School:*

Dates Attended: \_\_\_\_\_

Setting:

- Fully Self Contained (FSC) \_\_\_\_\_
- Inclusive (100% of day) \_\_\_\_\_
- Partial Inclusion (state % of day included with typically developing peers or name subjects) \_\_\_\_\_
- Home Schooled: \_\_\_\_\_
- Other (please describe): \_\_\_\_\_

If still attending, hours per week? \_\_\_\_\_

How much assistance in the classroom? \_\_\_\_\_

Describe any problem behaviors within a teaching setting and any plan for addressing them:

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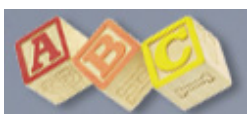
*Therapies*

Occupational Therapy: yes  no  Hours per week: \_\_\_\_\_

Goals: \_\_\_\_\_

Who provides service? \_\_\_\_\_

Physical Therapy: yes  no  Hours per week: \_\_\_\_\_



Goals: \_\_\_\_\_

Who provides service? \_\_\_\_\_

Speech and Language Therapist: yes  no  Hours per week: \_\_\_\_\_

Goals: \_\_\_\_\_

Who provides service? \_\_\_\_\_

Other therapies

Describe/hours per week/month: \_\_\_\_\_

Current Schedule

Number of hours in pre-school per week: \_\_\_\_\_

Number of hours at home with therapist per week: \_\_\_\_\_

NET (Natural Environment Teaching) hours per day: \_\_\_\_\_

ITT (Intensive Teaching) hours per day: \_\_\_\_\_

# Target Mands Per Day: \_\_\_\_\_

**General Information about your child:**

How does your child communicate with others? (*Vocalizations, words, sign language, PECS, etc.*) How many words?

\_\_\_\_\_

Does your child respond to smiles/tickles/eye contact/silly games? How?

\_\_\_\_\_

Describe how your child makes requests:

\_\_\_\_\_





If you clap your hands or wave will your child do the same motor movements (Imitation)?

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What instructions will your child follow when you tell them? (i.e. stand up, get the book, etc.)

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Does your child repeat a word you say (echo or imitate)?

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Does your child repeat adult phrases or phrases from videos spontaneously? (Give examples)

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Does your child name objects or pictures spontaneously? (Describe)

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Does your child talk about things that are not present? (i.e. talk about McDonalds, or the beach, or other event, or interest)

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Does your child initiate play with other peers? \_\_\_\_\_  
If yes, describe how (stands close to the peer, looks at the peer, vocal request, etc)

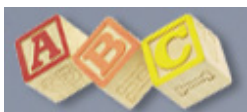
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Does your child comply with your requests to do what you ask?

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How long will your child sit at a table and participate in an activity with an adult?

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Does your child respond appropriately when you tell him/ her no? \_\_\_\_\_

If not, describe your child's behaviors when you say "no" :

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Can you take away reinforcers (preferred items) at home or in public places without behavioral problems? \_\_\_\_\_

If not, describe your child's behaviors when you take something away:

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Can your child wait appropriately?

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If not, describe your child's behaviors when required to wait:

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Are you able to take your child to public places?

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If not, describe your child's behaviors:

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## Other Issues

### *Potty Training*

Is your child potty trained? yes  no

Is your child schedule trained? yes  no

If not potty trained, describe the history: yes  no

Issues regarding potty training? yes  no



*Eating Issues*

Does your child have significant eating/feeding/food issues? yes  no

If yes, describe the issues:

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*Sleep Issues*

Does your child have significant sleep issues? yes  no

If yes, describe:

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**Primary Goals**

Please list your three major goals for your child over the next year:

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***Life Planning/Person Centered Planning***

1. *What are your dreams for your child?*
  - *Where do you see your child in 1 year? (skills, abilities, activities)*
  - *Where do you see your child in 5 years?*
  - *Where do you see your child in 10 years?*
  
2. *What are your nightmares for your child?*

***Please include copies of all IEPs/IFSPs, FBA, BIP/BSP, professional reports and evaluations (school or other professionals) you have for your child to assist in ensuring this program will be appropriate to address your child's unique needs. Please include within past 3 years, if appropriate.***

***A 30 minute video of your child in various environments would also be helpful. It would be useful to see him or her engaged in their favorite activities and in difficult situations where they are struggling to adapt to new or situations they do not enjoy. This does not have to be edited or beautifully presented – just give a sense of how your child reacts to different situations. Thank you.***

Return information via US Mail to the address below. Thank you. We will contact you to set up assessment and/or treatment for your child.

