NEW CLIENT INTAKE FORM
Confidential

BACKGROUND INFORMATION

Child's Name: _____

Date of Birth: _____ Current Age: _____ Boy _____ Girl _____

Father's Name: _____Occupation: _____

Mother's Name: _____Occupation: _____

Home Address: _____

Home Phone: _____

Mom Work/Cell: _____ Dad Work/Cell: _____

Email: _____

Siblings:

1. (Name)_____ (sex)_____(age) _____

2. (Name)_____ (sex)_____(age) _____

Diagnosis: _____

Diagnosed by: _____

Date of Diagnosis: _____ Age at Diagnosis: _____

Referred to RAE by: _____

PREVIOUS AND CURRENT INTERVENTIONS (Speech Therapy, Occupational Therapy, Behavioral Therapy, other services)

Intervention 1: _____

Provider: _____

Dates of Intervention (month/year-month/year): _____

Intervention 2: _____

Provider: _____

Dates of Intervention (month/year-month/year): _____

Intervention 3: _____

Provider: _____

Dates of Intervention (month/year-month/year): _____

MEDICAL HISTORY

Please list all medications **previously taken** including homeopathic, herbal or vitamin-based remedies).

1. Medication _____For treatment of _____

    Dates taken _____

2. Medication _____For treatment of _____

    Dates taken _____

3. Medication _____For treatment of _____

    Dates taken _____

Please list any and all **current** medications (including homeopathic, herbal or vitamin-based remedies).

1. Medication_____ For treatment of _____

   Start date: _____

2. Medication_____ For treatment of _____

   Start date: _____

3. Medication_____ For treatment of _____

   Start date: _____

DEVELOPMENTAL HISTORY

Describe pregnancy and delivery: _____

_____

Please list any childhood illnesses; list the child's age, the illness, and the treatment prescribed

_____

SELF-HELP SKILLS

Please describe your child's current level of functioning in the following areas:

Toileting: _____

_____

Feeding: _____

_____

Dressing: _____

_____

Grooming:_____

BEHAVIOR

Please describe any problematic behavior(s). Antecedents refer to causes or precipitating events, instructions or situations. Consequences refer to what you **or others** do or do not do in response to the behavior (e.g., ask your child to stop crying, tell him to go to his room, give him his favorite toy/snack, ignore the behavior).

Non-compliance: Yes/No

Please describe non-compliance: _____

_____

Frequency (daily, weekly, monthly): _____

Antecedents: _____

Consequences presented: _____

Tantrums: Yes/No

Please describe tantrums: _____

_____

Frequency (daily, weekly, monthly): _____

Antecedents: _____

Consequences presented: _____

Aggression: Yes/No

Please describe aggression: _____

Frequency (daily, weekly, monthly): _____

Antecedents: _____

Consequences presented: _____

Running away: Yes/No

Please describe: _____

Frequency (daily, weekly, monthly): _____

Antecedents: _____

Consequences presented: _____

Other behavior: Yes/No

Please describe Behavior 1: _____

Frequency (daily, weekly, monthly): _____

Antecedents: _____

Consequences presented: _____

Please describe Behavior 2: _____

Frequency (daily, weekly, monthly): _____

Antecedents: _____

Consequences presented: _____

SELF-STIMULATORY BEHAVIORS

Repetitive mannerisms: (such as hand flapping, finger flicking, gazing, lining up objects, hoarding objects, toe walking, running back and forth, repeating previously heard words out of context, etc.) _____

_____

_____

Difficulty with transitions or changes in routine: _____

_____

_____

Unusual preoccupations/obsessions: (anything he or she likes to do repeatedly) _____

_____

_____

SOCIAL BEHAVIOR

Does your child show you affection? _____How? _____

_____

Does your child play with other children? If so, describe how. _____

_____

Does your child play with toys? If so, describe how. _____

_____

Does your child have good eye contact? How often and with whom? _____

_____

Does your child respond to his or her name? Yes/No

Does your child come to you for comfort? Yes/No

Does your child respond better to any particular person? To whom? _____

_____

Does your child show interest in other people? How? _____

_____

LANGUAGE

RECEPTIVE (Understanding)

Does your child follow verbal directions when not given any visual cues? Yes/No

How much language do you think your child understands (what directions, words)? _____

_____

EXPRESSIVE (Speech or AAD)

Does your child say any words/phrases/sentences? If yes, give examples. _____

_____

Are these words/phrases/sentences used in context or out of context? _____

Does your child imitate words? If so, please list below. _____

_____

EDUCATIONAL BACKGROUND

Does your child attend school? Yes/No

Name of School: _____

Address: _____

What type of classroom does your child attend? _____

How long has your child been attending school? _____

Does your child have an aide or shadow while attending school? Yes/No

Full or part-time? _____

REQUEST FOR SERVICES

Are you looking for school-based services, home-based services, or both? _____

If you are requesting **school-based services**, please provide the following:
Days and Times of School Attendance: _____

What days and times work best for **home-based services**? Please provide a schedule of availability/time frames in which your family is available for home-based services:

Sundays: _____

Mondays: _____

Tuesdays: _____

Wednesdays: _____

Thursdays: _____

Fridays: _____

Saturdays: _____

GOALS AND OBJECTIVES

Please list several goals that you would like your son or daughter to achieve by participating in behavioral intervention services (e.g., eating a wider variety of foods, using words to make needs known, toileting independently, playing appropriately with toys, developing and/or maintaining friendships, etc.)

_____

_____

_____

_____

Parent Name

_____

Parent Signature

_____

Date

_____

Please mail or fax completed intake form to:

Resources in Autism Education, Inc.
1223 El Prado Avenue
Torrance, CA 90501
Attn: Intake
Fax: (310) 787-1768

Thank you for taking the time to provide this essential information. We will review the completed form and contact you within 2 business days.