



INTAKE APPLICATION

Personal

Child's Name: _____

DOB: _____

Address (include postal code): _____

Mother's Name: _____ Work # _____

Father's Name: _____ Work # _____

Home Telephone: _____ Cell: _____ Fax: _____

Email: _____

Medical

Primary Diagnosis: _____

Secondary Diagnosis: _____

Age at Diagnosis: _____

Diagnosed by whom: _____

Current Medication:

Past Medication:

Allergies: _____

Special Diet: _____

Other Biological Interventions: _____



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Has an ABLLS (The Assessment of Basic Language and Learning Skills) been completed? _____

Description of current intervention programs:

In home program:

Type of programming: _____

Dates: _____

Past Consultant (s): _____

Current Consultant: _____

Overall Impression of program: _____

Pre School:

Dates Attended: _____ Setting: _____

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:



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: _____

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: _____



General Information about your child:

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

Describe how your child makes requests:

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

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

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

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

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

Does your child talk about things that are not present? (i.e. talk about McDonalds)

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



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

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

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

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

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

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

Can your child wait appropriately?

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

Are you able to take your child to public places?

If not, describe your child's behaviours:



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 issues? yes no

If yes, describe the issues:

Sleep Issues

Does your child have significant sleep issues? yes no

If yes, describe:



Primary Goals

please list your three major goals for your child over the next year

Please include copies of all professional reports and evaluations you have for your child to assist in ensuring this program will be appropriate to address your child's unique needs.

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.