Intake Information Form

Please have the person most familiar with the child to help in the completion of this form.

Contact Information

Contact Person: _____ Occupation: _____

Relationship to Child: _____ Mobile Phone #: _____

e-mail Address: _____ Work Phone #: _____

Fax Phone #: _____

Basic Information

Child's Full Name: _____ Date of Birth: _____

Home Address: _____ Age: _____

_____ Gender: boy: ____ girl: ____

Home Phone #: _____ Height: _____

Languages spoken in the Home: _____ Weight: _____

Your Family's Information

Spouse's Name: _____ Occupation: _____

Relationship to Child: _____ Mobile Phone #: _____

e-mail Address: _____ Work Phone #: _____

Marital Status: _____ Fax Phone #: _____

Tell us about your family living situation including family circumstances, work schedules, or any custody issues that may impact treatment.

_____

_____

_____

_____

Your Family's Information (continued)

List the names of any other persons living at home with the child. If the person is a sibling, please provide any diagnosis they may have (e.g., Austistic Disorder, Attention-Deficit Hyperactiivty Disorder, Asperger's Syndrome).

Name(s):	Age(s):	Relationship:	Diagnosis:

Does your family have any pets? If so, please list the pets that reside at home.

Your Child's Medical History

Please list any psychological or medical diagnoses your child has received.

Diagnosis or Medical Condition:	When Was It Given?	By Whom?

Provide the most up-to-date information for the following:

Does your child have SEIZURES? yes ____ no ____

How often do seizures occur? _____ Are they Grand Mal? yes ____ no ____

Does your child have any ALLERGIES? yes ____ no ____

Was s/he tested for specific allergic reactions? yes ____ no ____

If Yes, what did s/he test allergic to? _____

_____

Your Child's Medical History (continued)

List the medications your child is receiving, the dosage, and the reason for its prescription.

Name of Medication:	Dosage:	Reason for Prescription:

Which vitamin(s) or supplement(s) is your child currently taking? Fill in any that are not already listed.

____ None ____ Vitamin C ____ Calcium Others: _____

____ Daily Multi ____ Vitamin D ____ Probiotics (Please List) _____

____ Vitamin A ____ Fish Oil ____ Digestive Enzymes _____

____ Vitamin B-6 ____ Magnesium _____

Has your child been diagnosed or identified as at risk for any of the following?

____ Malnutrition ____ High Cholesterol ____ Asthma ____ Acid Reflux ____ GI Problems

____ Obesity ____ High Blood Pressure ____ Diabetes ____ Ear Infections

Is your child up to date with all of his/her immunizations? yes ____ no ____

If no, what immunizations does s/he not have and why?

_____

_____

Does your child do at least 60 minutes of intensive physical activity each day? yes ____ no ____

Tell us about any other medical related issues we should know about your child.

_____

_____

_____

_____

Your Child's Information

Which statement best characterizes your child's food preferences (check only one)?

____ My child has some food preferences, but will MOSTLY eat what is served.

____ My child REFUSES to eat a FEW foods.

____ My child REFUSES to eat MOST foods.

____ My child consistently eats only these 1 or 2 foods: _____

Approximately how many foods will your child eat on his/her own? _____

Is your child on a Gluten-Free, Casein-Free (GF/CF) Diet? yes ____ no ____

Does your child only eat specific foods from specific places (e.g., Carl's Jr. nuggets)? yes ____ no ____

Does your child eat non-preferred foods only if you hand feed him/her? yes ____ no ____

My child has food sensitivities including:

specific food textures such as: _____

specific food smells such as: _____

specific food colors such as: _____

My child's favorite food is: _____

My child's favorite drink is: _____

My child cannot eat or drink these items: _____

My child INDEPEDENTLY eats using: ____ I need to hand feed my child ____ fork ____ knife

____ his or her fingers ____ spoon

Does your child eat too fast for his/her safety? yes ____ no ____

Does your child stuff his/her mouth with too much food? yes ____ no ____

Does your child constantly request or seek out food? yes ____ no ____

If yes, what food(s) or types of food(s)? _____

Does your child keep non-preferred foods in their mouth for long periods of time? yes ____ no ____

Does your child spit out unwanted foods? yes ____ no ____

Has your child made themselves throw up by crying and gagging on foods? yes ____ no ____

My child regularly drinks from a: _____

In the past month, my child has drank from a (check all that apply):

____ Bottle ____ Sippy Cup ____ Cup ____ Sports Bottle ____ Water Bottle ____ Through a Straw

Your Child's Information (continued)

Which statement best characterizes your child's clothing preferences (check only one)?

____ My child readily wears all types and articles of clothing.

____ My child tolerates most articles of clothing, but refuses to wear specific textures.

____ My child tolerates most textures of clothing, but refuses to wear specific clothing items.

____ My child refuses to wear most types and articles of clothing.

What specific articles of clothing does your child refuse to wear?

_____

What specific textures of clothing does your child refuse to wear?

_____

Does your child insist on wearing certain clothing (e.g., blue clothing, princess dress)? yes ____ no ____

If yes, what? _____

Does your child readily try on new items of clothing? yes ____ no ____

Does your child tolerate having his/her hair cut? yes ____ no ____

If yes, does s/he get it cut at a salon? yes ____ no ____

If not, do you need to do it when s/he is asleep? yes ____ no ____

Does your child tolerate having his/her hair brushed? yes ____ no ____

Does your child tolerate having his/her hair washed/shampooed? yes ____ no ____

Does your child tolerate a shower spray? yes ____ no ____

Does your child tolerate having his/her body washed? yes ____ no ____

Does your child tolerate having his/her nails cut? yes ____ no ____

If not, do you need to do it when s/he is asleep? yes ____ no ____

Does your child tolerate noises from household appliances (e.g., vacuums, blenders)? yes ____ no ____

If no, what appliances or types of noises does s/he react to?

_____

Does your child tolerate the end of shows or movies (i.e., rolling credits)? yes ____ no ____

Does your child notice when you or someone in your family leaves the house? yes ____ no ____

If yes, does s/he protests? yes ____ no ____

If yes, who does s/he protest for? _____

Your Child's Information (continued)

Which items below does your child dress themselves INDEPENDENTLY (not including buttoning or zipping):

____ Underwear ____ Shorts or Pants ____ Dresses ____ Shoes (slip-ons)

____ T-Shirts ____ Socks (ankle length) ____ Jackets ____ Shoes (with Velcro)

____ Shirts (Long-Sleeve) ____ Socks (knee high) ____ Sandles ____ Shoes (with Laces)

Does your child put on clothes BACKWARDS unless you orient it for him/her? yes ____ no ____

Does your child put on clothes INSIDE OUT unless you give it to them right-side out? yes ____ no ____

Does your child INDEPENDENTLY fasten buttons? yes ____ no ____

If yes, does your child consistently align buttons correctly on button-down shirts? yes ____ no ____

Does your child zip zippers? yes ____ no ____

If yes, does your child independently align the zipper ends together to zip them up? yes ____ no ____

Does your child undress INDEPENDENTLY? yes ____ no ____

If no, what articles of clothing does s/he need help with? _____

Does your child tolerate having his/her teeth brushed? yes ____ no ____

Does your child tolerate toothpaste? yes ____ no ____

Does your child rinse his/her mouth clean after brushing his/her teeth? yes ____ no ____

Does your child swallow toothpaste? yes ____ no ____

Which items below does your child do INDEPENDENTLY (without any assistance):

____ Wash Hands ____ Dry Hands ____ Comb or Brush Hair ____ Brush Teeth

Does your child resist touching any particular textures (i.e., Play Doh, hand paint)? yes ____ no ____

If yes, what textures? _____

Is your child sensitive to any particular smells? yes ____ no ____

If yes, what smells? _____

Does your child appear to be insensitive to pain? yes ____ no ____

Does your child chew gum? yes ____ no ____

If yes, does your child eat the gum? yes ____ no ____

Which of the following activities does your child enjoy (laugh during or request frequently)?

____ being hugged ____ being tickled ____ being squeezed hard ____ being thrown in the air

Your Child's Information (continued)

With respect to toilet training, my child is:

____ Not Toilet-Trained (wears diapers)

____ Toilet-Trained for Urination (during the day) My child is on a schedule of every _____ hrs.

____ Toilet-Trained for Bowel Movements (during the day)

____ Toilet-Trained through the Night (does not wear diapers at night)

Answer the questions below if your child has at least 1 accident in a week.

How many urination accidents does your child have per week? _____

How many bowel movement accidents does your child have per week? _____

How often does your child wake up with a wet diaper per week? _____

Does your child have accidents more often when they are engaged in an activity? yes ____ no ____

Does your child attempt to hide his/her accident? yes ____ no ____

If yes, how? _____

Does your child completely remove his/her pants & underwear when using the toilet? yes ____ no ____

If your child is a boy, does he stand to urinate? yes ____ no ____

If your child is a girl, does she know how to wipe after urination? yes ____ no ____

If yes, does your child use the appropriate amount of toilet paper? yes ____ no ____

With respect to bowel movements, is your child fairly regular? yes ____ no ____

If no, is your child prone to diarrhea? yes ____ no ____

If no, is your child prone to constipation? yes ____ no ____

Approximately how often does your child have bowel movements? _____

Does your child independently wipe after a bowel movement? yes ____ no ____

If yes, does your child use the appropriate amount of toilet paper? yes ____ no ____

If no, does s/he use too much or too little? too much ____ too little ____

Where does your child usually sleep? _____

Does your child fall asleep alone? yes ____ no ____

If no, who does your child need to be with to fall asleep? _____

If your child wakes up at night, will s/he seek out your bed to sleep in? yes ____ no ____

Does your child have a difficult time waking up? yes ____ no ____

Your Child's Information (continued)

Does your child have trouble falling asleep? yes ____ no ____

If yes, how late do they usually stay up til? _____

Does your child have trouble staying asleep? yes ____ no ____

If yes, how often do they usually get up during the night? _____

If yes, when do they usually wake up at night? _____

If yes, how long do they usually stay up for after waking up? _____

Does your child lead you by the hand or pull you toward items s/he wants? yes ____ no ____

Does your child POINT (using his/her index finger) to items s/he wants? yes ____ no ____

Does your child ask for items s/he wants? yes ____ no ____

If yes, does s/he say it clearly (e.g., strangers understand him/her)? yes ____ no ____

If yes, how does s/he USUALLY ask for items (check only one):

____ 1 word requests (e.g., "cookie")

____ 1-2 word requests (e.g., "cookie please")

____ incomplete phrases (e.g., "want cookie")

____ full sentences (e.g., "I want cookie," "May I have a cookie?")

Does your child try to retrieve wanted items by themselves before asking for them? yes ____ no ____

Does your child try to retrieve wanted items after you've told them, "No"? yes ____ no ____

Does your child color? yes ____ no ____

Does your child color coloring pages by changing colors? yes ____ no ____

Does your child color coloring pages by (roughly) staying within the lines? yes ____ no ____

Does your child draw? yes ____ no ____

Does your child draw scenes from his/her environment? yes ____ no ____

Does your child draw people s/he knows as stick figures or block figures? stick ____ block ____

Can your child draw by copying someone else's drawing? yes ____ no ____

Does your child write any letters? yes ____ no ____

About how many letters can s/he write legibly? _____

Does your child use a tripod grip when holding a pen or pencil? yes ____ no ____

Does your child use a tripod grip when holding a crayon? yes ____ no ____

Your Child's Information (continued)

Does your child play with puzzles INDEPENDENTLY? yes ____ no ____

If yes, approximately how many puzzles does s/he play with? _____

If yes, what kind of puzzles does s/he play with? _____

If yes, does s/he play with the same puzzle repeatedly in the same sitting? yes ____ no ____

Does your child usually play with toys as they are INTENDED to be played with? yes ____ no ____

Does your child play close to other children with similar toys or activities? yes ____ no ____

If yes, does your child share toys or items appropriately? yes ____ no ____

If yes, does your child allow other kids to take the item they are playing with? yes ____ no ____

Does your child play with imagination with toys (i.e., making up stories or scenarios)? yes ____ no ____

Does your child play by pretending to be someone else (e.g., doctor, Spider-man)? yes ____ no ____

What does your child do when around other children (check all that apply):

____ s/he moves away from where most of the kids are

____ s/he stays on the perimeter of where a group of kids may be

____ s/he tries to interact with other children, but does so inappropriately (e.g., screaming, taking things)

____ s/he plays for short periods of time, but wanders away to play by him- or herself

____ s/he needs to be forced to interact with other children

____ s/he refuses to interact with other children

What types of devices do you have at home that your child has access to playing?

____ desktop computer ____ iPhone or equivalent ____ game console (Wii, Playstation, Xbox)

____ laptop computer ____ mp3 player ____ portable gaming unit (Nintendo DS, Sony PSP)

____ iPad or tablet ____ Tivo or DVR ____ learning toys (Leapster)

____ other: _____

Does your child play with age appropriate skill on those devices? yes ____ no ____

How many hours per day does your child spend playing on those devices in total? _____

Does your child watch tv shows or movies on television? yes ____ no ____

If yes, how many hours per day does your child spend watching tv? _____

Does your child structure his/her time productively in his/her freetime? yes ____ no ____

If not, about how long can your child stay engaged in an activity? _____

Your Child's Behaviors

How often does your child protest or tantrum each day? _____

If less than once a day, how many times in a week? _____

How long does your child usually protest or tantrum for? _____

In the past month, what was the longest protest or tantrum your child has had? _____

What was the longest protest or tantrum you remember ever having? _____

What usually sets a protest or tantrum off (check all that apply)?

____ When I ask him/her to DO or SAY something

____ When s/he want something they cannot have

____ When I take something away (e.g., my phone) s/he is engaged with

____ When I am are engaged in another activity (e.g., cooking, talking on the phone)

____ When there is any change to his/her schedule or routine

____ When there is any change to his/her environment (moved a toy or furniture)

What do you usually do when your child protests or tantrums at HOME (check all that apply)?

____ I try to ignore it until s/he stops crying, and I am usually successful

____ I usually end up giving him/her what s/he wanted

____ I try to explain the situation to them

____ I kiss, hug them, or hold them trying to provide comfort

____ I ask him/her what else s/he may want and/or try to give him/her something else s/he may want

____ I try to distract him/her with activities

____ I try to hide the item s/he wants

____ I send him/her to his/her room

____ I put him/her in time-out

What do you usually do when your child protests or tantrums in the COMMUNITY (check all that apply)?

____ I try to ignore it until s/he stops crying, and I am usually successful

____ I usually end up giving him/her what s/he wanted

____ I usually end up leaving the location eventually

____ I get my child and try to leave the area immediately

Your Child's Behaviors (continued)

Do you find yourself avoiding going to places for fear of your child's behaviors? yes ____ no ____

If yes, please indicate which places you tend to avoid:

____ Most places ____ Malls ____ Fast Food Restaurants ____ Friend's Homes

____ Grocery Stores ____ Stores ____ Sit Down Restaurants ____ Church or related

____ Specific areas of places (e.g., toy aisle at Target) such as _____

_____

If yes, also indicate the situations you tend to avoid whenever possible:

____ Driving or walking a specific route

____ Going out to run basic errands such as _____

____ Going to social gatherings such as _____

____ Going to an event with lots of people such as _____

____ Going to an event with lots of noise such as _____

____ Going to an OVERNIGHT event such as _____

____ Leaving him/her OVERNIGHT with a relative or babysitter

____ Leaving him/her with a babysitter because _____

What concerns do you have about going out with your child?

____ Tantrums ____ Rigidities such as _____

____ Aggression ____ Safety problems such as _____

____ Running Off ____ Sensory difficulties such as _____

Has your child ever gotten lost in the community? yes ____ no ____

Have you ever needed to call 911 or others to help locate your child? yes ____ no ____

Do you always hold your child's hand or put them in a cart or other restrictive device to keep them from walking off, running off, or wandering away? yes ____ no ____

Your Child's Behaviors (continued)

Review the behaviors listed below and check the box whether your child has done the behavior in the PAST MONTH, in the PAST YEAR, or EVER done that behavior.

	Past Month	Past Year	Ever
ignored instructions or demands			
cried without tears			
cried with tears			
screamed			
used profanity			
yelled or shouted			
dropped to the ground in protest			
flailed or waved arms around			
flailed or kicked legs around			
ran away from you or tried to			
pushed others away			
pushed items away			
grabbed other's hands or arms			
grabbed other's clothing			
pulled other's hair			
ripped or destroyed other's clothing			
kicked others			
pinched or scratched others			
pinched or scratched themselves			
swiped items off tables			
thrown items at the ground			
thrown items across the room			
thrown items at others			

	Past Month	Past Year	Ever
hit others			
hit themselves on their bodies			
hit themsevles on their head			
bit others			
bit themselves			
banged their heads on objects			
spat at others			
spat or drooled onto objects			
played with saliva			
dripped saliva out & sucked it back			
put items into his/her mouth			
put hands or fingers inside mouth			
flapped hands			
rocked body back and forth			
spun toys or objects			
lined up toys or objects			
stared at items from odd angles			
ran in circles			
repeated heard words or phrases			
watched same video clips repeatedly			
made repetitive sounds or noises			
scripts lines from shows or movies			
walked on toes			

Your Child's Behaviors (continued)

Review the behaviors listed below and check the box whether your child has done the behavior in the PAST MONTH, in the PAST YEAR, or EVER done that behavior.

	Past Month	Past Year	Ever
ran into or across the street			
ran across a parking lot			
left the house without notifying anyone			
jumped on furniture			
climbed on items (counters, shelves)			
ate (or tried to eat) non-food items			
put too much food in his/her mouth			
eaten too fast (not chewing enough)			
eaten food from other's plates			
eaten other's foods			
eaten messy (food gets everywhere)			
did not wipe mouth when dirty			
drank from other 's cups			
destroyed items inadventently			
unfastened seat belt in moving car			
opened door in moving car			
thrown items out of car windows			
gotten naked at home without consent			
gotten naked in neighborhood			
gotten naked in community (stores, malls)			
taken socks &/or shoes off in stores			
protested when different foods touched			
gotten into people's pockets or purses			

	Past Month	Past Year	Ever
looked disheveled (shirt partly tucked in)			
talked or stood too close to others			
talked too loud for situation			
talked too quietly for situation			
touched others private areas			
touched or played with own genitals			
repeatedly played with water in the sink			
flush toilet repeatedly			
shared too much private information			
obsessed about particular topics			
unfurled lots of toilet paper			
thrown non-flushables in toilet			
urinated in public places			
played with feces			
emptied full bottles (e.g., shampoo)			
referred to themselves by his/her name			
put his/her hands next to face oddly			
appeared not to hear things			
walked on top of items			
walked into items or furniture			
bumped into doors or walls			
avoided physical contact			
avoided eye contact			

Current Services

Does your child have medical insurance? yes ____ no ____

Who is his/her insurance carrier? _____ Member ID: _____

Additional Information

Tell us about any other information that may be relevant that we missed from above:

_____

_____

_____

_____

Applied Behavior Analysis (ABA) Services

Has your child ever received ABA services? yes ____ no ____

If yes, from whom? _____

What problems (if any) did you have with any of your previous providers?

____ unable to fill hours ____ inadequate supervision ____ child did not make much progress

____ poorly trained staff ____ disorganized ____ behaviors getting worse

____ other: _____

Acknowledgment

I acknowledge that I am the parent/guardian of the child requesting services from ABA BEARS. I authorize the use of this document in the assessment of our family for appropriateness of said services. The information contained in this document is, to the best of my knowledge, true and accurate. I acknowledge and affirm that typing my signature below shall have the same legal effect as signing the form in person.

_____ _____

signature date

Instructions on Submissions

ABA BEARS prefers that completed digital copies of this intake assessment form be sent to info@ababears.com. If filling the form by hand, please print the pdf version, complete it, and 1) scan and email the entire document to info@ababears.com OR 2) fax the entire document to 909.918.BEAR (2327).