Intake
Questionnaire

GENERAL INFORMATION:

Date:_____

Welcome to Providence Community!

Please take a moment to complete the Intake Questionnaire. Once complete, please also provide a copy of your primary insurance card (front and back). If you have secondary insurance a copy of the card will be needed as well. In addition to the completed Intake Questionnaire, and Insurance Card we will need a copy of your Diagnosis Report.

Parent/ Guardian Names:_____

Street Address:_____ Apt_____

City:_____ State:_____ Zip:_____

Phone #: Home:( )_____ Work:( )_____ Cell:( )_____

Fax: ( )_____ E-Mail:_____

Emergency contact's Name: _____ Cell: ( )_____

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

Diagnosis:_____ Child's Age at Diagnosis: _____

Diagnosis Date: _____ Diagnostician's Name/Title: _____

Referring Provider: _____

Please provide a full diagnosis report on the assessment appointment day.

_____

SIBLINGS- NAMES & AGES:_____

Are siblings also diagnosed with ASD or other similar DX?_____

1. When did you realize that there was a problem with your child? Describe your concerns at that time: _____

_____

_____

_____

Insurance Information

Subscriber's Name: _____

Subscriber's DOB: _____

Subscriber's Social Security Number: _____

Client's Social Security Number: _____

Was there any significant medical event before onset?_____If yes, explain:

_____

_____

Was birth history normal?_____If no, explain:_____

2. Did your child have speech and lose it? _____If yes, please note the age when speech was. lost_____and approximate # of words/ phrases your child had:_____

_____

Did your child have any other skills that he/she lost?_____

Describe:_____

_____

_____

3. Has or does your child receive/attend any of the following? Check any that apply:

Private Speech Therapy _____Diet/Nutrition/Feeding Therapy _____Physical Therapy _____

Visual Therapy _____Occupational Therapy _____Auditory Integration Therapy _____

_____

_____

Was birth history normal?_____If no, explain: _____

4. Did your child have speech and lose it? _____If yes, please note the age when speech was. lost_____and approximate # of words/ phrases your child had:_____

_____

Did your child have any other skills that he/she lost?_____

Describe:_____

_____

_____

5. Has or does your child receive/attend any of the following? Check any that apply:

Private Speech Therapy _____Diet/Nutrition/Feeding Therapy _____Physical Therapy _____

Visual Therapy _____Occupational Therapy _____Auditory Integration Therapy _____

Allergy Therapy ____Other_____

Public/ Private School (please describe):_____
Is the client in school Monday through Friday?: _____
Does the client receives any special education such as, Speech therephy, OT …..etc please indicate below

_____
Home Programming ABA Therapy: (please describe):

_____
_____
_____

6. Please describe your child's abilities/ traits in the following areas:

a. Speech/ communication: _____
_____

_____

b. Following verbal directions: _____

_____

_____

c. Compliance during adult or teacher directed activities: _____

_____

_____

d. Fine motor and gross motor skills: _____

_____

_____

e. Self-stimulatory activities: _____

_____

_____

f. General compliance at home: _____

_____

7. Please list any other information you feel would be helpful at intake.

_____
_____
_____
_____
_____
_____

****

PLEASE ALSO COMPLETE THE ATTACHED PAGES OUTLINING CURRENT SKILL LEVEL AND MEDICAL/BEHAVIORAL HEALTH HISTORY

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Provide original completed form, including the following pages (detailing current skill level and medical/behavioral health history) with a recent photo attached and ***a copy of the original diagnostic report from your child's medical provider*** to:

PROVIDENCE COMMUNITY ABA

623 Garrisonville Rd, Stafford, VA 22554

Phone: 540-645-4777 Fax: (540)2423216 Email: info@aba-providencecommunity.com
Website: ABA (aba-providencecommunity.com)

Retain a copy for your files. 2021

PLEASE GIVE US AN EXAMPLE OF YOUR CHILD'S CURRENT SKILL LEVEL:

RELEVANT MEDICAL ISSUES:

Do you feel there is a medical issue that needs to be considered?_____If so, please give details.

_____

LANGUAGE:

How would you describe your child's current language skills? ____Non-Verbal

_____Spontaneous Conversation _____Uses some words/ phrases appropriately.

_____Echolalic _____Speaks in short sentences _____Language just emerging

ACADEMICS:

_____demonstrates skills mostly at pre-school level.

_____demonstrates skills mostly at early primary level (grades K-1)

_____demonstrates skills mostly at mid primary level (grades 2-4)

_____demonstrates skills mostly at upper primary level (grades 5-6)

Indicate strongest academic area_____

Indicate weakest academic area _____

Please indicate any area of concern. _____

GROSS MOTOR/ FINE MOTOR SKILLS:

At what level (based on chronological age) would you estimate your child:

(Current Age: _____)

Gross Motor: _____below age level _____at age level _____above age level

Fine Motor: _____below age level _____at age level _____above age level

Please indicate any area of concern_____

SELF HELP & ADAPTIVE SKILLS:

Is your child able to complete the following tasks independently? (yes or no)

_____Feeding/Eating _____Undressing _____Dressing _____Unfastening

_____Fastening _____Toileting _____Bathing _____Grooming (brushing teeth/hair)

BEHAVIORAL ISSUES:

Please indicate any areas of concern and provide details in space provided below:

_____Socialization _____Perseveration _____Self-Injury _____Injury to others

_____Tantrums _____Self-Stimulation _____Compliance _____Other:_____

_____Other:_____ _____Other:_____ _____Other:_____

Details: _____

_____

_____

ARE THERE ANY RECENT CHANGES WHICH YOU FEEL ARE CURRENTLY IMPACTING YOUR CHILD?

_____

_____

PLEASE PROVIDE ANY ADDITIONAL INFORMATION WHICH MIGHT BE HELPFUL:

_____

_____

_____

PROVIDENCE COMMUNITY ABA– Medical /Behavioral Health History and Background

Client Name: _____

Date Form Completed: _____

Information provided by: _____

Relationship to client: _____

Mother's Name _____

Natural parent: _____Stepparent: _____Adoptive Parent: _____Relative: _____

Father's Name _____

Natural parent: _____Stepparent:_____Adoptive Parent: _____Relative:_____

What are you seeking help with?

_____

_____

_____

Presenting Problems (check all that apply):

Temper outbursts	___Impulsive	___Shy	___Aggression
Withdrawn	___Stubborn	___Strange behavior	___Abuse***
Daydreaming	___Disobedient	___Stealing	___Other
Fearful	___Infantile	___Lying	_____
Clumsy	___Mean to others	___School trouble	
Overactive	___Destructive	___Bowel/bladder control	
Short attention span	___Bed wetting	___Feeding/eating problems	
Distractible	___Self-Injury	___Sleep problems	
Peer conflict	___Head banging	___Drug/Alcohol use	
Phobic	___Rocking	___Frequently ill	

Please describe in detail any aggressive behavior or self-injury:

*** Please describe & explain abuse: Experienced Abuse _____Perpetrator of Abuse _____

MEDICAL HISTORY:

Has client ever been hospitalized for illness, physical ailments, emotional problems, etc?

___yes ____no. If yes, please explain (where, when and for what) _____

_____

Any history of infectious disease, past or current? _____yes ____no. If yes, please explain.

_____

Has client ever taken, or is he/she currently taking any medications? _____yes _____no

If yes, please list medication name and frequency of dosage._____

_____

Does client have any allergies that you are aware of (ie – latex, peanut, soy, etc.)? If yes, please list: _____

Any adverse event associated with immunizations? _____yes _____no. If yes, please explain.

Name, address and phone of primary care physician: _____

_____

DEVELOPMENTAL HISTORY

Did mother have any illness or complications before delivery? _____yesno. If yes, please explain_____

Did mother abuse alcohol or drugs during pregnancy? Y _____N_____

Length of pregnancy: _____Full Term? Y_____N_____Birth Weight _____lbs. _____oz

Complications at birth? If yes, please explain. _____

_____

Did clients meet developmental milestones at the appropriate age?_____yes _____no

SOCIAL HISTORY

Does client attend extracurricular activities? _____Yes, _____no If yes, please describe.

_____

Does client have friends at school? _____If yes, how many _____

Does the client have friends outside of school? ___If yes, how many _____

Please describe any other information which you feel is important or may impact social history.

_____

LIVING ARRANGEMENTS:

List all members of your household presently and indicate their relation to client.

_____

_____

_____

Present Home: _____house _____apartment

Has a client ever been placed, boarded, or lived away from family? _____yes _____no

LEGAL BACKGROUND:

Do you have any custody issues or order of protection? If yes, please describe.

_____

_____

FAMILY BACKGROUND:

Please indicate any past, present, or impending family issues:

_____Deaths:_____

_____Divorce:_____

_____Abuse:_____

_____Injuries/Illness:_____

_____Other:_____

Has client, or anyone in your family ever had:

Psychiatric problems (depression, anxiety, psychosis, etc.) _____ yes,___no ____unsure

Unhealthy alcohol or drug use? ____ yes,___no ____unsure

Attempted or contemplated suicide? ____ yes,___no ____unsure

Infectious disease? ____ yes,___no ____unsure

Please indicate any cultural, spiritual, or personal/ family values which may impact treatment:

_____

_____

_____

BEHAVIORAL HEALTH HISTORY:

Any instances of psychiatric / behavioral health concerns, past or present? _____

If yes, please provide details:_____

EDUCATIONAL HISTORY:

Name of school / daycare: _____

Type of classes: _____regular _____inclusion _____ exceptional student education

_____other: _____

Does client receive special services at school? _____yes _____ no

If yes, which services and what is the frequency/duration of each?

_____Counseling: _____/week for _____minute sessions

_____Occupational Therapy: _____/week for _____minute sessions

_____Physical Therapy: _____/week for _____minute sessions

_____Speech Therapy: _____/week for _____minute sessions

_____Social Skills: _____/week for _____minute sessions

_____Other _____: _____/week for _____ minute sessions

OTHER SERVICES:

Does the client receive other private services? _____yes, _____ no

If yes, which services and what is the frequency/duration of each?

_____Counseling: _____/week for _____minute sessions

_____Occupational Therapy: _____/week for _____minute sessions

_____Physical Therapy: _____/week for _____minute sessions

_____Speech Therapy: _____/week for _____minute sessions

Any other community services received? _____

.

OTHER:

Please share any other information which may be of importance or which you wish us to consider in our assessment:

_____

_____

_____

Name of person completing information: _____

Relationship to client: _____ Date: _____