

INTAKE PACKET FOR (check all that apply): ABA Services Diagnostic Testing Consultation
 Occupational Therapy Speech Therapy

CLIENT INFORMATION

Child's Name (Last, First, Middle Initial): Last Name First Name Middle Initial
Gender: Select Date of Birth: Month Day Type Year Age: Type Age Grade: Select
Height: Feet ' Inches" Weight: Enter Lbs.

The questions listed below are voluntary. Information is requested for demographic/record keeping purposes only.

Child's ethnicity/race (check only one):

- | | |
|---|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Native Hawaiian or Pacific Islander |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Hispanic or Latino |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> White or Caucasian |

Primary language spoken at home: [Click here to enter text.](#)

Secondary language spoken at home (if applicable): [Click here to enter text.](#)

CONTACT INFORMATION

Name of Person Completing this Form: [Click here to enter text.](#)

Relationship to Child: [Click here to enter text.](#)

Today's Date: [Click here to enter a date.](#)

How did you hear about Holland Center? [Click here to enter text.](#)

FAMILY INFORMATION

Mother / Legal Guardian: [Click here to enter text.](#) Date of Birth: Month Day Type Year Age: Type Age

Occupation: [Click here to enter text.](#) Total Years of Education: Enter

Highest Educational Degree: Enter Daytime Phone: Enter Cell Phone: Enter

Address: [Click here to enter text.](#)

E-mail Address(s): [Click here to enter text.](#)

RELATIONSHIP: Biological Parent Step Parent Adoptive/Foster Parent Other: Specify

Father / Legal Guardian: [Click here to enter text.](#) Date of Birth: Month Day Type Year Age: Type Age

Occupation: [Click here to enter text.](#) Total Years of Education: Enter

Highest Educational Degree: Enter Daytime Phone: Enter Cell Phone: Enter

Address: [Click here to enter text.](#)

E-mail Address(s): [Click here to enter text.](#)

RELATIONSHIP: Biological Parent Step Parent Adoptive/Foster Parent Other: Specify

Child lives with (check all that apply): Father Mother Other (specify): [Click here to enter text](#)

Parents are: Married (Number of years: [Enter](#)) Separated (Date: [Enter](#))

Divorced (Date: [Enter](#)) Never Married Widowed (Date: [Enter](#))

Is your child adopted? No Yes Is your child aware of the adoption? No Yes

If your child was adopted, at which age and from where: Age [Location](#)

Siblings:

	Name	Age	Relationship	Living in Home?
1.	Enter Name	Age	Choose an item.	Choose an item.
2.	Enter Name	Age	Choose an item.	Choose an item.
3.	Enter Name	Age	Choose an item.	Choose an item.
4.	Enter Name	Age	Choose an item.	Choose an item.
5.	Enter Name	Age	Choose an item.	Choose an item.

REFERRAL INFORMATION

Primary Physician: [Click here to enter text.](#) Phone: [Enter](#)

Primary Physician Address: [Click here to enter text.](#)

Referring Physician: [Click here to enter text.](#) Phone: [Enter](#)

Referring Physician Address: [Click here to enter text.](#)

Anticipated Source(s) of Funding: MA Private Pay Insurance

Primary Insurance:

Policy Holder: [Click here to enter text.](#) DOB: [Enter](#) Place of Employment: [Click here to enter text.](#)

Insurance Carrier: [Click here to enter text.](#)

Group #: [Enter](#) ID#: [Enter](#) Policy #: [Enter](#)

Secondary Insurance (if applicable):

Policy Holder: [Click here to enter text.](#) DOB: [Enter](#) Place of Employment: [Click here to enter text.](#)

Insurance Carrier: [Click here to enter text.](#)

Group #: [Click here to enter text.](#) ID#: [Enter](#) Policy #: [Enter](#)

Medical Assistance/TEFRA (if applicable):

Policy Holder: [Click here to enter text.](#) DOB: [Enter](#) Place of Employment: [Click here to enter text.](#)

Group #: [Enter](#) ID#: [Enter](#) Policy #: [Enter](#)

*****Please include a copy of all insurance cards (front and back) listed above.*****

Briefly describe the primary reason you are seeking services for your child.

[Click here to enter text.](#)

Please list your three primary questions or concerns you would like addressed:

1. [Click here to enter text.](#)
2. [Click here to enter text.](#)
3. [Click here to enter text.](#)

Describe additional concerns about your child’s development (including social interaction, communication, play, language, and behavior).

[Click here to enter text.](#)

Does the child currently have an Autism Spectrum Disorder diagnosis?

- Autism
 Asperger’s Syndrome
 PDD-NOS
 No Current ASD Diagnosis

Who made this diagnosis? [Click here to enter text.](#)

Date: [Enter](#)

Does the child currently have any of the following diagnoses?

	Diagnosed by:	Date
<input type="checkbox"/> Depression	Click here to enter text.	Date
<input type="checkbox"/> Anxiety Disorder	Click here to enter text.	Date
<input type="checkbox"/> ADHD	Click here to enter text.	Date
<input type="checkbox"/> OCD	Click here to enter text.	Date
<input type="checkbox"/> Tourette's Syndrome	Click here to enter text.	Date
<input type="checkbox"/> ODD/Conduct Disorder	Click here to enter text.	Date
<input type="checkbox"/> Learning Disability	Click here to enter text.	Date
<input type="checkbox"/> Intellectual Disability/MR	Click here to enter text.	Date
<input type="checkbox"/> Sensory Integration Disorder (SID)	Click here to enter text.	Date
<input type="checkbox"/> Epilepsy/Seizure Disorder	Click here to enter text.	Date
<input type="checkbox"/> Other	Click here to enter text.	Date

Has the child you are seeking services for been evaluated in the past? Yes No

If yes, please list the following information on the previous evaluation(s):

Who	Type	When
Click here to enter text.	Click here to enter text.	Date
Click here to enter text.	Click here to enter text.	Date
Click here to enter text.	Click here to enter text.	Date

*****PLEASE INCLUDE COPIES OF ANY PAST REPORTS/EVALUATIONS WHEN RETURNING THIS PACKET*****

FAMILY MEDICAL AND PSYCHOLOGICAL HISTORY

Please indicate all medical conditions that have occurred in the child's biological relatives. Indicate which relative in the space provided. Under sibling, indicate sister (S) or brother (B). For all other relatives, indicate which side of the family, mother (M) or father (F). For example, if the child's mother's sister has a learning disability, you would place an "M" in the box under "Aunt" in the column labeled "learning disability."

	Mother	Father	Sibling	Aunt	Uncle	Cousin	Grandparent	Other
Learning disability	<input type="checkbox"/>	<input type="checkbox"/>						
Attention deficit disorder	<input type="checkbox"/>	<input type="checkbox"/>						
Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>						
Autism	<input type="checkbox"/>	<input type="checkbox"/>						
Pervasive development disorder	<input type="checkbox"/>	<input type="checkbox"/>						
Speech and language disorder	<input type="checkbox"/>	<input type="checkbox"/>						
Hearing loss/deafness	<input type="checkbox"/>	<input type="checkbox"/>						
Tourette's or tic disorder	<input type="checkbox"/>	<input type="checkbox"/>						
Congenital disorder	<input type="checkbox"/>	<input type="checkbox"/>						
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>						
Chronic illness (please list: such as asthma, arthritis, diabetes, lupus)	<input type="checkbox"/>	<input type="checkbox"/>						
Depression	<input type="checkbox"/>	<input type="checkbox"/>						
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>						
Suicide attempt	<input type="checkbox"/>	<input type="checkbox"/>						
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>						
Obsessive Compulsive Disorder	<input type="checkbox"/>	<input type="checkbox"/>						
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>						
Psychiatric hospitalization	<input type="checkbox"/>	<input type="checkbox"/>						
Alcohol dependency	<input type="checkbox"/>	<input type="checkbox"/>						
Chemical dependency	<input type="checkbox"/>	<input type="checkbox"/>						
Other	<input type="checkbox"/>	<input type="checkbox"/>						

Please provide additional information about any checkmarks above.

[Click here to enter text.](#)

Is there any other family history that would be important for us to know?

[Click here to enter text.](#)

PREGNANCY AND BIRTH INFORMATION

The pregnancy was mother's number of number pregnancies with number live births.

Prior to this child, were there difficulties getting pregnant? Yes No

Were there any difficulties getting pregnant with this child? Yes No

Did any of the following occur before the pregnancy? Fertility medications Miscarriages

How many miscarriages did the biological mother have prior to this child? Number

How many abortions did the biological mother have prior to this child? Number

Did any of the following occur during the pregnancy?

- | | |
|--|--|
| <input type="checkbox"/> Maternal injury, describe | <input type="checkbox"/> Abnormal weight gain |
| <input type="checkbox"/> Bleeding, spotting, which months: Enter | <input type="checkbox"/> Excessive vomiting |
| <input type="checkbox"/> Infections, describe | <input type="checkbox"/> Poor weight gain |
| <input type="checkbox"/> X-rays, which months: Enter | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Medication use, describe; which months: Enter | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Alcohol use, amount per day: Enter | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Gestational diabetes | <input type="checkbox"/> Exposure to toxins |
| <input type="checkbox"/> Cigarette use, amount per day: Enter | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Drugs (such as cocaine, marijuana), which months: Enter | <input type="checkbox"/> Toxemia |
| <input type="checkbox"/> Prenatal testing (such as CMV, HIV, TORCH) | <input type="checkbox"/> Abnormal emotional stress (such as work hours, death of a relative) |

Please elaborate on any difficulties experienced during pregnancy. [Click here to enter text.](#)

Mother's age at time of delivery: Enter

Father's age: Enter

Hospital, city, and state of birth: [Click here to enter text.](#)

Did the birth mother receive regular prenatal care? Yes No

Length of pregnancy: Enter weeks (if an infant is born on his due date, the pregnancy is 40 weeks long)

Was it: A single birth Twins Multiples (3+)

How did labor begin? Naturally Induced Emergency

How long did labor last? [Click here to enter text.](#)

What drugs were used to assist with labor/delivery? [Click here to enter text.](#)

How was the child delivered?

- | | |
|--|--|
| <input type="checkbox"/> Vaginal – Normal Vertex Position (Head First) | <input type="checkbox"/> Planned Caesarean Section |
| <input type="checkbox"/> Vaginal – Breech (Leg or Bottom First) | <input type="checkbox"/> Emergency Caesarean Section |
| <input type="checkbox"/> Vaginal – Face First | |

What was the child's weight at birth? Enter Lbs, Enter oz. Length? Enter In/Cm?

Apgar scores: Enter at 1 minute; Enter at 5 minutes

Child's condition at birth? Excellent Good Fair Poor Don't know

Length of hospital stay: Infant Mother

Were any of the following experienced during delivery?

- Excessive bleeding
- Infection
- Infant had difficulty breathing
- Umbilical cord around infant's neck
- Meconium staining
- Fever
- Placenta previa/abruptio
- Forceps/Suction used
- Labor stopped
- Jaundice
- Other:

Were there concerns about the infant's condition immediately after birth? Yes No

Were there any congenital defects/anomalies evident at birth? Yes No

Did the infant need medical intervention (e.g., incubator, oxygen, surgery, blood transfusion, etc.) after birth?
 Yes No

Please elaborate on any difficulties/concerns experienced during labor and deliver. [Click here to enter text.](#)

Is there any other information about the mother or baby that may be pertinent? [Click here to enter text.](#)

DEVELOPMENTAL INFORMATION

Please describe your child's temperament at the following ages:

- Infancy (birth to 12 mo.) Pleasant/happy Fussy Colicky Other
- Toddler (12 to 36 mo.) Pleasant/happy Fussy Colicky Other
- Preschool (36 to 60 mo.) Pleasant/happy Fussy Colicky Other

Was there anything unusual about how your child developed (e.g., didn't like to be held, very early interest in numbers)? [Click here to enter text.](#)

How was the child fed? Breast fed until months Bottle fed Both

Were there any feeding difficulties? Yes No

Did the baby have problems gaining weight? Yes No

If yes, please explain:

[Click here to enter text.](#)

BIRTH TO ONE YEAR

In the first year, did your infant experience any of the following?

- | | | |
|--|---|--|
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Irritability | <input type="checkbox"/> Injury |
| <input type="checkbox"/> Feeding problems | <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Developmental delay |
| <input type="checkbox"/> Weight loss or poor weight gain | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Other infections |

ONE TO THREE YEARS

From age one to three, did any of the following occur?

- | | | |
|--|---|--|
| <input type="checkbox"/> Excessive temper tantrums | <input type="checkbox"/> Separation problems | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Developmental delay | <input type="checkbox"/> Recurrent ear infections | <input type="checkbox"/> Behavior problems |
| <input type="checkbox"/> Ear tubes inserted | | |

THREE TO FIVE YEARS

From age three to five, did any of the following occur?

- | | | |
|--|--|--|
| <input type="checkbox"/> Excessive temper tantrums | <input type="checkbox"/> Recurrent ear infections | <input type="checkbox"/> Difficulty with transitions |
| <input type="checkbox"/> Developmental delay | <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Ear tubes inserted |
| <input type="checkbox"/> Toileting problems | <input type="checkbox"/> Behavior problems | <input type="checkbox"/> High activity level |
| <input type="checkbox"/> Separation problems | <input type="checkbox"/> Difficulty with structured activity | <input type="checkbox"/> Short attention span |

Did preschool teachers, day care providers, or other caregivers observe difficulty with any of the following?

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Structured activity | <input type="checkbox"/> Peer relationships | <input type="checkbox"/> Attention |
| <input type="checkbox"/> Behavior | <input type="checkbox"/> Group activity | <input type="checkbox"/> Transitions |

At what age did your child first do the following? Please check boxes for skills that have been acquired and indicate the age in months (i.e., such as 16 mo.). If the skill has not yet been acquired, leave this area blank.

- | | |
|---|---|
| <input type="checkbox"/> Smiled: Months | <input type="checkbox"/> Held head erect: Months |
| <input type="checkbox"/> Imitated sounds: Months | <input type="checkbox"/> Rolled over: Months |
| <input type="checkbox"/> Babbled: Months | <input type="checkbox"/> Sat alone: Months |
| <input type="checkbox"/> Said other single words: Months | <input type="checkbox"/> Crawled: Months |
| <input type="checkbox"/> Said "mama" or "dada": Months | <input type="checkbox"/> Walked alone: Months |
| <input type="checkbox"/> Followed simple directions: Months | <input type="checkbox"/> Rode tricycle: Months |
| <input type="checkbox"/> Said 2-3 word phrases: Months | <input type="checkbox"/> Dressed self: Months |
| <input type="checkbox"/> Knew colors: Months | <input type="checkbox"/> Started counting: Months |
| <input type="checkbox"/> Recited total alphabet: Months | <input type="checkbox"/> Tied shoes: Months |
| <input type="checkbox"/> Separated easily from mother: Months | <input type="checkbox"/> Fed self with spoon: Months |
| <input type="checkbox"/> Drank from an open-faced cup: Months | <input type="checkbox"/> Fed self with utensils: Months |
| <input type="checkbox"/> Ate table foods: Months | <input type="checkbox"/> Bowel trained: Months |
| <input type="checkbox"/> Grasped a Crayon | <input type="checkbox"/> Bladder trained: Months |
| <input type="checkbox"/> Read words: Months | <input type="checkbox"/> Dry at night: Months |

Has your child ever gained skills and then lost them in any developmental area (i.e., language, toileting, motor skills?) Yes No

If yes, please explain: [Click here to enter text.](#)

Please comment on the following behaviors for your child as an infant and as a toddler:

How active is your child? [Click here to enter text.](#)

How well does your child deal with transition and change? [Click here to enter text.](#)

How well does your child respond to new places, people, and things? [Click here to enter text.](#)

How is your child's basic mood (e.g., happy, sad, angry, quiet)? If other, please explain. [Click here to enter text.](#)

Is your child predictable in patterns of sleep, appetite, etc.? [Click here to enter text.](#)

PHYSICAL HEALTH INFORMATION

What is the current health status of your child?

- Excellent
 Good
 Fair
 Poor
 Don't Know

Do you have any specific medical concerns about your child? Yes No

Has your child had any of the following? (Check all that apply):

- | | | |
|--|---|--|
| <input type="checkbox"/> Adenoidectomy | <input type="checkbox"/> Head injury/concussion | <input type="checkbox"/> Sleeping difficulties |
| <input type="checkbox"/> Breathing difficulties/Asthma | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Lead poisoning |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> High Fevers | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Hearing problems/hearing loss |
| <input type="checkbox"/> Ear Tubes – When: Enter | <input type="checkbox"/> Ear Infections – How often/many: Enter | <input type="checkbox"/> Prolonged illness: Enter |

Other serious injuries/surgeries: [Click here to enter text.](#)

Hospitalizations (reason)	Dates
Click here to enter text.	Enter
Click here to enter text.	Enter
Click here to enter text.	Enter
Click here to enter text.	Enter

Does your child, or have they in the past, taken medications on a daily basis? Yes No

If yes, please complete the table below and include present and past medications taken for an extended period of time.

Name of Medication	Purpose	Dosage	When Started
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

Is your child allergic to any medications? If yes, please list medications. Yes No

[Click here to enter text.](#)

Please list in detail all known allergies (include food, animal, plants/other): [Click here to enter text.](#)

Are your child's immunizations up-to-date? Yes No Don't Know

When was your child's last complete physical? [Click here to enter text.](#)

Have you ever questioned your child's ability to hear normally? Yes No

If yes, please explain: [Click here to enter text.](#)

When was your child's hearing last screened and what were the results? [Click here to enter text.](#)

Have you ever questioned your child's ability to see normally? Yes No

When was your child's vision last screened and what were the results? [Click here to enter text.](#)

*****PLEASE INCLUDE A COPY OF ALL AUDIOLOGY AND VISION EVALUATION REPORTS*****

Has your child received genetic testing? Yes No

*****IF YES, PLEASE INCLUDE A COPY OF GENETIC TESTING REPORTS*****

Is your child currently seeing any medical specialists or therapists (i.e., neurology, occupational therapy, speech therapy, or physical therapy)? Yes No

If yes, please provide name: [Click here to enter text.](#)

Which hand does your child use to complete tasks? Right Left Both

Does your child have problems with coordination? Yes No

Gross motor coordination (e.g., running, jumping)? Yes No

Fine motor coordination (e.g., grasping objects, holding a pencil, fastening buttons)? Yes No

Visual motor coordination (e.g., puzzles, cutting on a line)? Yes No

Does your child experience any of the following difficulties with sleep? (Select all that apply):

Difficulty falling Waking in the night Nightmares

asleep

Night terrors Sleeps too much Snoring

Falls asleep during day (other than age-appropriate naps)

Other: Describe

Does your child have any of the following difficulties with elimination? Yes No

Daytime wetting Toilet refusal Night wetting

Constipation Soiling Diarrhea

Other: Describe

Does your child frequently complain of physical symptoms not related to a medical problem? Yes No

- Stomachaches
- Fatigue
- Breathing problems
- Headaches
- Dizziness
- Tremors/shakes
- Joint aches
- Heart palpitations
- Other: Describe

Does your child have any of the following difficulties with eating? Yes No

- Difficulty sitting at the table
- Poor food choices
- Chokes on foods or liquids
- Overeats
- Picky eater
- Other: Describe
- Avoids foods due to texture
- Odd eating behavior/habits

Does your child have a very limited number of foods he/she is willing to eat? Yes No

If yes, what foods? : [Click here to enter text.](#)

Is your child currently on a gluten-free/casein-free diet? Yes No

Are there any other diet restrictions? Yes No

If yes, please list: [Click here to enter text.](#)

Do you have any other concerns about your child's current eating habits? [Click here to enter text.](#)

BEHAVIORAL INFORMATION

Does your child currently receive any applied behavior analysis (ABA) services? Yes No

If yes, what type of services (check all that apply): Center-Based Home Program
 Other (specify):

Has your child received any ABA services in the past? Yes No

If you answered yes to either of the questions above, complete the following:

Provider	Frequency / # of Hours per Week	Date Started	Date Ended / Current	Does a BCBA oversee this program?
Provider	Frequency	Date	Date	Select
Provider	Frequency	Date	Date	Select
Provider	Frequency	Date	Date	Select
Provider	Frequency	Date	Date	Select
Provider	Frequency	Date	Date	Select

Behavioral characteristics your child demonstrates (check all that apply):

- | | | |
|---|--|---|
| <input type="checkbox"/> Cooperative/attentive | <input type="checkbox"/> Craves touch | <input type="checkbox"/> Plays/shares well with others |
| <input type="checkbox"/> Willing to try new activities | <input type="checkbox"/> Shy/quiet | <input type="checkbox"/> Poor eye contact |
| <input type="checkbox"/> Usually happy/easy going | <input type="checkbox"/> Easily frustrated | <input type="checkbox"/> Repetitive behavior |
| <input type="checkbox"/> Short attention span/restless | <input type="checkbox"/> Tires easily | <input type="checkbox"/> Impulsive/distractible |
| <input type="checkbox"/> Destructive/aggressive | <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Stubborn/resistant to change |
| <input type="checkbox"/> Difficulty waiting /accepting "no" | <input type="checkbox"/> Avoids touch | <input type="checkbox"/> Self-abusive behavior |
| <input type="checkbox"/> Problems transitioning to other activities | | <input type="checkbox"/> Other: <input type="text" value="Describe"/> |

How frequently does your child display each of the following?

Crying/Screaming:

Please describe:

Tantrums:

Please describe:

Aggressive Behaviors:

Please describe (e.g., kicks, punches, etc.):

Self-Injurious Behaviors:

Please describe (e.g., hits head, pinches, etc.):

Property Destruction:

Please describe (e.g., throws objects, rips materials, etc.):

Has your child ever had a behavior plan to address challenging behaviors? Yes No

*****IF YES, PLEASE INCLUDE A COPY OF YOUR CHILD'S BEHAVIOR PLAN*****

Please explain any additional concern(s) you may have about your child's challenging behaviors:

[Click here to enter text.](#)

How do you discipline your child? Please give an example.

[Click here to enter text.](#)

Does your child display any unusual repetitive movements or noises (tics)?

- | | |
|---|--|
| <input type="checkbox"/> Head, facial or neck twitches | <input type="checkbox"/> Problems with balance |
| <input type="checkbox"/> Walks in unusual manner | <input type="checkbox"/> Walks on tiptoes |
| <input type="checkbox"/> Is generally clumsy | |
| <input type="checkbox"/> Nervous habits, describe: <input type="text" value="Describe"/> | |
| <input type="checkbox"/> Repetitive actions when excited, describe: <input type="text" value="Describe"/> | |
| <input type="checkbox"/> Other: <input type="text" value="Click here to enter text."/> | |

Does your child act in any of the following ways?

- Frequently seems unaware of others in room, fails to react to noise
- Echoes or repeats words or phrases over and over
- High pain tolerance
- Repeats same behavior
- Becomes agitated if not permitted to perform ritual or routine behavior
- Seems unafraid of dangerous activity (e.g., shows no fear when on high playground equipment)
- Speaks using sing-song or high pitched intonation

Does your child currently...

... have an unusually strong interest in particular topic(s)/ subject(s)? Yes No

If yes, what theme(s)/subject(s)? [Click here to enter text.](#)

...play with toys or household objects in an unusual manner? Yes No

If yes, how so? [Click here to enter text.](#)

...have particularly strong reactions to loud noises (e.g., sirens, vacuums)? Yes No

...have particularly strong reactions to bright lights? Yes No

...stare closely at spinning objects or fingers? Yes No

...seem to enjoy running/rocking back and forth or spinning in circles/bouncing? Yes No

...enjoy touching/rubbing certain textures? Yes No

...dislike certain sensations/textures (e.g. tags on shirts, waistbands)? Yes No

...flap his/her arms or hands when excited or overwhelmed? Yes No

...avoid physical affection from others? Yes No

...seek out physical play/stimulation (e.g., deep pressure, swinging in the air, rough housing, hugs, etc.)?

Yes No

...talk excessively without regard for his/her partner's interest? Yes No

...have difficulty tolerating changes to his/her routine? Yes No

...put toys/objects in his/her mouth? Yes No

Please describe any aversions to textures, temperatures, etc. that your child exhibits.

[Click here to enter text.](#)

Does your child have a history of any of the following (check all that apply)?

- | | | |
|---|---|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Unusual thinking |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Sexual abuse | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Suicidal thoughts/attempts | | <input type="checkbox"/> Don't know |

Describe the items and activities that your child enjoys: [Click here to enter text.](#)

Identify typical reinforcers in these groups:

Food items: [Click here to enter text.](#)

Toys: [Click here to enter text.](#)

Praise: [Click here to enter text.](#)

Physical Activities: [Click here to enter text.](#)

Describe what your child would do if left alone to their own devices for a period of time:

[Click here to enter text.](#)

SOCIAL INFORMATION

Does your child interact with other children? Yes No

Describe how your child interacts with other children. [Click here to enter text.](#)

How many close friendships does your child currently have? [Click here to enter text.](#)

Outside of school/daycare settings, on average, how many times a week does your child have play dates with friends? [Click here to enter text.](#)

Does your child have any problems getting along with others? Yes No

Check all that apply:

- | | | |
|---|---|--|
| <input type="checkbox"/> Difficulty making friends | <input type="checkbox"/> Difficulty keeping friends | <input type="checkbox"/> Few friends/loner |
| <input type="checkbox"/> Competitive with siblings | <input type="checkbox"/> Not respectful of authority | <input type="checkbox"/> No best friend |
| <input type="checkbox"/> Plays mainly with older children | <input type="checkbox"/> Plays mainly with younger children | |

How often is your child teased (e.g., called names, verbally harassed)? [Select](#)

How often is your child bullied (e.g. physically harassed, items stolen)? [Select](#)

Does your child prefer to play alone? Yes No

What games and toys does your child prefer? [Click here to enter text.](#)

Describe how your child plays with toys: [Describe](#)

Does your child interact with adults? Yes No

Describe how your child interacts with adults: [Describe](#)

Has your child experienced any parental separations or the death of any family member? Yes No

If yes, please describe circumstances (such as child's age or event): [Describe](#)

Is either parent away from home for several days at a time on a regular basis? Yes No

Does your cultural heritage play a significant role in your daily life? Yes No

Please list any recent stressors, legal issues, or crises that may be affecting the family and/or the child being treated (e.g., death in the family, divorce, illness, financial difficulties, bullying, custody disputes, recent move, court cases, etc.).

[Click here to enter text.](#)

Child's extracurricular activities (e.g., sports, clubs, hobbies, lessons, etc.):

- | | | |
|---------------------------------------|---------------------------------|---|
| <input type="checkbox"/> Football | <input type="checkbox"/> Karate | <input type="checkbox"/> Dance (type): Describe |
| <input type="checkbox"/> Baseball | <input type="checkbox"/> Piano | <input type="checkbox"/> Music (type): Describe |
| <input type="checkbox"/> Cheerleading | <input type="checkbox"/> Scouts | <input type="checkbox"/> Gymnastics |
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Soccer | <input type="checkbox"/> Other(s): Describe |

COMMUNICATION INFORMATION

Check all statements that describe your child's communicative behavior:

Receptive:

- | | |
|---|---|
| <input type="checkbox"/> Following 1-step directions | <input type="checkbox"/> Understanding age appropriate vocabulary |
| <input type="checkbox"/> Following multiple-step directions | <input type="checkbox"/> Responding correctly to "wh" questions |
| <input type="checkbox"/> Understands what you are saying | <input type="checkbox"/> Able to retrieve common objects upon request |
| <input type="checkbox"/> Able to understand age appropriate jokes/idioms (e.g., "That was a piece of cake") | |

Expressive:

- Has not yet started to talk
- Was late in starting to talk
- Does not talk very much
- Uses a lot of gestures
- Able to engage in a conversation (i.e., initiating a conversation, maintaining the conversation)
- Tries hard and seems to want to communicate
- Is able to sequence stories from start to finish
- Uses age appropriate vocabulary
- Asks questions of others

Articulation/Speech:

- People have trouble understanding the child
- Has specific sound errors; Describe
- Difficulty with sequencing long words
- Is not making age expected speech sounds correctly

Voice:

- Pitch level is unusual (e.g., too high, too low)
- Speech is too loud or too soft
- Frequent laryngitis
- Has an unusual voice quality (e.g., hoarse, harsh, whispery)

Fluency:

- Frequently stutters or stammers
- Says “um” or “uh” a lot
- Hesitates or repeats sounds and words excessively

Please include any further information regarding communicative behavior or elaboration on the above statements can be included here: [Click here to enter text.](#)

Does your child have a means to indicate “yes” or “no”? Yes No

If yes, please describe: [Click here to enter text.](#)

Do you think your child can understand more than they can say? Yes No

If yes, please explain or give an example: [Click here to enter text.](#)

Do you think your child gets frustrated when he or she cannot communicate effectively? Yes No

If yes, please explain or give an example: [Click here to enter text.](#)

Please mark the statement(s) that would best describe your child’s current means of communication:

- Crying or tantrums
- Body language (e.g., pointing, looking, gesturing)
- Sign language
- Pictures
- Augmentative device (please describe): [Click here to enter text.](#)
- Sounds (e.g., vowel sounds, consonant sounds, grunting)
- Single words; please list several words used regularly
- 2-4 word sentences (please provide examples): [Click here to enter text.](#)
- Sentences longer than 4 words (please provide examples): [Click here to enter text.](#)
- Other: [Click here to enter text.](#)

Does your child use their communication to (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Initiate communicative interaction | <input type="checkbox"/> Ask questions |
| <input type="checkbox"/> Comment on the past | <input type="checkbox"/> Reject non-preferred items |
| <input type="checkbox"/> Comment on the present | <input type="checkbox"/> Request people |
| <input type="checkbox"/> Comment on the future | <input type="checkbox"/> Request activities |
| <input type="checkbox"/> Respond to questions | <input type="checkbox"/> Request objects |

Has your child's communication ever been evaluated by a Licensed Speech Language Pathologist?

- Yes No

*****IF YOUR CHILD HAS RECENTLY BEEN EVALUATED, PLEASE INCLUDE A RECENT EVALUATION REPORT *****

If your child has recently been evaluated, summarize the results of the speech and language evaluation in terms of language comprehension, language production and speech production (how he produces his/her sounds):

[Click here to enter text.](#)

EDUCATIONAL INFORMATIONPlease complete for children in schoolIs your child currently enrolled in a school or preschool? Yes NoSchool: [Click here to enter text.](#)Type: [Select](#)District: [Click here to enter text.](#)Grade: [Select](#)Address: [Click here to enter text.](#)Teacher(s): [Click here to enter text.](#)Phone: [Click here to enter text.](#)Type of classroom: [Choose an item.](#)If other, specify: [Click here to enter text.](#)

In your child's main classroom setting, what is the number of:

Typically developing students: [Number](#)Students with special needs: [Number](#)Teachers: [Number](#)Instructional Aides/Assistants: [Number](#)Does your child currently receive special education services? Yes NoIf yes, what age and grade did these start? Age: [Type Age](#) Grade: [Select](#)If yes, under what category did your child qualify for special education? [Click here to enter text.](#)If yes, date of last complete evaluation: [Click here to enter a date.](#)Does your child currently receive section 504 accommodations? Yes NoIf yes, what age and grade did these start? Age: [Type Age](#) Grade: [Select](#)If yes, why did your child qualify for 504 accommodations? [Click here to enter text.](#)Does your child have an aide (also known as paraprofessional or teaching assistant)? [Choose an item.](#)Please specify the type of support: [Choose an item.](#) Indicate number of hours: [Number](#)Are you satisfied with the services your child has received at school? Yes NoComments: [Click here to enter text.](#)

*****IF YOUR CHILD HAS RECENTLY BEEN EVALUATED OR CURRENTLY RECEIVES SPECIAL EDUCATION SERVICES, PLEASE INCLUDE A RECENT EVALUATION REPORT AND AN IEP OR IFSP *****

Do you have specific concerns regarding your child's school progress? Yes No

Indicate the specific concerns you have (check all that apply):

Academics Social Teacher Peer relationships

Are your concerns related to achievement? Yes No

For: (check all that apply) Reading Math Language

Do you have concerns related to (check all that apply):

Off-task behavior Organization Attention Concentration

Currently or in the past, has your child's teacher discussed any of these problems (check all that apply)?

- | | |
|--|---|
| <input type="checkbox"/> Getting along with peers | <input type="checkbox"/> Following rules (classrooms, bus, recess, lunch) |
| <input type="checkbox"/> Turning in assigned work | <input type="checkbox"/> Rushing to complete work |
| <input type="checkbox"/> Disrupting classroom | <input type="checkbox"/> Staying on task during work periods |
| <input type="checkbox"/> Getting along with teachers | <input type="checkbox"/> Making frequent careless errors |
| <input type="checkbox"/> Difficulty waiting turn | <input type="checkbox"/> Completing large or long-term projects |
| <input type="checkbox"/> Excessive socializing | <input type="checkbox"/> Organization of work materials |
| <input type="checkbox"/> Completing work on time | <input type="checkbox"/> Forgetting to bring homework materials home or |
| <input type="checkbox"/> Following directions | to return completed work |

Has your child ever experienced any of the following?

- Delayed kindergarten entry
- Retained in grade(s): Enter
- In-school suspension, reason(s): Click here to enter text.; in grade(s): Enter
- Suspended for Enter days, reason(s): Click here to enter text.; in grade(s): Enter
- Expelled, reason(s): Click here to enter text.; in grade(s): Enter

Please describe your child's classroom performance or participation in the classroom (if appropriate):

[Click here to enter text.](#)

What are your child's strengths and/or best subjects?

[Click here to enter text.](#)

Services

What services does your child currently receive?

Service Provider	Frequency (i.e., twice a week)	General Goals (i.e., increase vocabulary, increase fine motor skills, increase articulation)
Speech-Language Pathologist	Enter	Click here to enter text.
Occupational Therapist	Enter	Click here to enter text.
Physical Therapist	Enter	Click here to enter text.
Other: Specify	Enter	Click here to enter text.
Other: Specify	Enter	Click here to enter text.
Other: Specify	Enter	Click here to enter text.

*****IF YOUR CHILD RECEIVES SERVICES, PLEASE INCLUDE THE MOST RECENT EVALUATION AND TREATMENT PLAN WHEN RETURNING THIS PACKET*****

What do you enjoy most about raising your child?

Click here to enter text.

What are your child's main strengths?

Click here to enter text.

What are your child's main weaknesses?

Click here to enter text.

Thank you for taking the time to complete this form. Please address any additional concerns or comments below:

Click here to enter text.