BEHAVIORAL CONSULTING FOR AUTISM LLC

# CLIENT INTAKE FORM

BEHAVIORALCONSULTINGNC.COM - 910-599-5307

Client Name: | Date:

Date of Birth: | Age: | SS#:

Diagnosis: | Diagnosed by:

Date of Diagnosis: | Age of Diagnosis

Referred to BCA by:

Physician: | Physician Phone Number

Type of Insurance:

Member ID #: | BENE DOB:

## PARENT INFORMATION

Mother's Full Name: | Phone:

Occupation: | Work Phone:

Birthday:

Father's Full Name: | Phone:

Occupation: | Work Phone:

Birthday:

Parent/Caregiver relationship status: Never Married / Married / Partnered / Widowed / Divorced / Legally Separated

Home Address:

Street Name and Number:

Apt Number if Applicable:

City/Town:

Zip Code:

Email:

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## FAMILY INFORMATION

Sibilings

| | | |
|---|---|---|
| Name: | Gender: | DOB: |
| Name: | Gender: | DOB: |
| Name: | Gender: | DOB: |

| OTHER SUPPORTS (ABA, OT, SLP, etc) Please include services the child may have received in the past, including ABA | PROVIDED BY | START/END DATE | SCHEDULE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## HAVE THERE BEEN ANY OTHER MEDICAL CONCERNS IN THE PAST? WERE ANY DELAYS APPARENT DURING INFANCY?

## DOES YOUR CHILD HAVE CONCURRING DIAGNOSES? (ADHD FOR EXAMPLE)

## WHAT MEDICATIONS IS YOUR CHILD CURRENTLY TAKING? PLEASE TELL THE DATE THE MEDICATION WAS STARTED AND THE PURPOSE FOR THE MEDICATION.

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DOES YOUR CHILD CURRENTLY ATTEND SCHOOL? WHERE? SCHEDULE? SETTING? (GENERAL EDUCATION, ETC.) ARE THEY IN AGE APPROPRIATE GRADE?

DOES YOUR CHILD HAVE ANY ALLERGIES? IF SO, PLEASE LIST.

HOW DOES YOUR CHILD COMMUNICATE? (NON-VERBAL, GESTURES, CRYING, SIGNING, WORDS, PHRASES)

WHAT DOES YOUR CHILD FIND REINFORCING? (TOYS, ACTIVITIES, EDIBLES)

DESCRIBE PAST AND PRESENT ENVIRONMENTAL STRESSORS AND THE IMPACT ON PATIENT: (DEPLOYMENT, RELOCATION, ETC.)

DOES YOUR CHILD ENGAGE IN PEER PLAY, PLAY WITH ADULTS OR PREFER TO PLAY ALONE? PLEASE EXPLAIN.

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DOES YOUR CHILD HAVE A RESTRICTED DIET OR FOOD AVERSIONS? IF SO, PLEASE LIST THE FOODS YOUR CHILD WILL AND WILL NOT EAT.

PLEASE DESCRIBE ANY SENSORY PREFERENCES OR AVERSIONS. FOR EXAMPLE, IS YOUR CHILD HYPERSENSITIVE TO SOUND OR OTHER SENSORY STIMULI? DOES YOUR CHILD AVOID OR SEEK PHYSICAL AFFECTION?

PLEASE DESCRIBE IF YOUR CHILD ENGAGES IN ANY REPETITIVE BEHAVIORS (SUCH AS HAND FLAPPING, LINING UP OBJECTS, PACING, REPEATING WORDS OR PHRASES), HAS DIFFICULTY IN CHANGES IN ROUTINE, OR HAS ANY OBSESSIVE BEHAVIORS OR INTERESTS.

WHAT ARE YOUR BEHAVIORAL AND SAFETY CONCERNS FOR YOUR CHILD? FOR EXAMPLE, DOES YOUR CHILD ENGAGE IN TANTRUMS, SELF-INJURY, AGGRESSION, NON-COMPLIANCE, RUNNING AWAY, ETC. PLEASE TELL HOW OFTEN BEHAVIORS OCCUR.

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**WHAT ARE YOUR PRIMARY CONCERNS THAT YOU WOULD LIKE TO HAVE ADDRESSED? FOR EXAMPLE, YOU MAY WANT TO FOCUS ON COMMUNICATION, BEHAVIOR, EATING, TOILETING, OR SOCIAL SKILLS.**

**TELL US ABOUT ANY OTHER GOALS YOU WOULD LIKE YOUR SON OR DAUGHTER TO ACHIEVE BY PARTICIPATING IN BEHAVIORAL INTERVENTION SERVICES. WITHIN 6 MONTHS. WITHIN A YEAR. WITHIN 5 YEARS.**

Describe your child's functional living skills.

**AT HOME, DOES YOUR CHILD GET DRESSED, PREPARE MEALS, HELP WITH CHORES SUCH AS LAUNDRY AND DISHES? DOES YOUR CHILD ENGAGE IN A VARIETY OF LEISURE ACTIVITIES? PLEASE EXPLAIN.**

**DESCRIBE YOUR CHILD'S INDEPENDENT LIVING SKILLS. IS YOUR CHILD GROOMING HIMSELF, MAINTAINING DENTAL HYGIENE, DRESSING HIMSELF APPROPRIATELY, AND USING SELF-MANAGEMENT TO MONITOR AND MANAGE HIS DISRUPTIVE BEHAVIORS? PLEASE EXPLAIN.**

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AT SCHOOL, DOES YOUR CHILD FOLLOW ROUTINES, PARTICIPATE IN GROUP ACTIVITIES, ENGAGE WITH OTHERS SOCIALLY, AND USE TECHNOLOGY APPROPRIATELY? PLEASE EXPLAIN.

IN THE COMMUNITY, DOES YOUR CHILD SOLVE PROBLEMS OR SEEK APPROPRIATE AND SAFE ASSISTANCE? DOES HE OR SHE EAT IN PUBLIC, MANAGE MONEY, USE THE PHONE SAFELY, AND EXHIBIT RESPECTFUL AND FLEXIBLE BEHAVIOR IN COMMUNITY SETTINGS? PLEASE EXPLAIN.

WHAT ARE THE SPECIFIC BEHAVIORS YOU WOULD LIKE TO INCREASE?

WHAT ARE SPECIFIC BEHAVIORS YOU WOULD LIKE TO DECREASE?

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## FAMILY MEDICAL HISTORY:

| | Comments (include family member relationship to the benefishiary |
|---|---|
| ☐ Anxiety | |
| ☐ Depression | |
| ☐ Psychosis | |
| ☐ ADHD | |
| ☐ ASD | |
| ☐ Panic | |
| ☐ OCD | |
| ☐ Substance Abuse | |
| ☐ Mania | |
| ☐ Emotional/Physical Abuse | |
| ☐ Cognitive Impairment | |
| ☐ Eating Disorder | |
| ☐ Homicidal/Suicidal Behavior | |
| ☐ Other | |

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## SCHEDULING PREFERENCES: (WE WILL DO OUR BEST TO ACCOMMODATE PREFERENCES, BUT ASK FOR SOME FAMILY FLEXIBILITY)

8:30-11:30 | 12:00-3:00 | 8:30-3:00 | 3:30-5:30

## DAYS AVAILABLE FOR SESSIONS:

Monday: | Tuesday: | Wednesday: | Thursday: | Friday:

## QUESTIONS FROM CLIENT:

Parent Name:

Parent Signature: Date:

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**Please email or fax this completed intake form along with a copy of the front an back of your insurance card to:**

Behavioral Consulting for Autism, LLC

Fax: 910-406-1255
bca@behavioralconsultingnc.com

Thank you for taking the time to provide this essential information. We will review the completed form and contact you within 3 days to answer any other questions and to provide you with additional information.