Behavioral Consulting for Autism, LLC

Client Intake Form

Client Name:____

Date of Birth:___________________________ Current age_______________________________________

Diagnosis________________________________ Diagnosed by____________________________________

Date of Diagnosis_________________________ Age of Diagnosis__________________________________

Referred to BCA by____

PCM ____ PCM Phone Number___________________________

Sponsor's Name___________________________________ Sponsor SSN________________ ______________

Authorization Number________________________ (BCA)

CHILD AND FAMILY INFORMATION:

Parent Information

Mother's Full Name:____________________________________Phone:_______________________

Occupation______________________________ Work Phone:___________________________

Father's Full Name:_______________________________ Phone:________________________

Occupation___________________________________ Work Phone:___________________________

Home Address:

Street Name and Number: ____

Apt Number if Applicable: ____

City/Town: ____

Zip Code: ____

Email Address: ____

Family Information

Siblings

Name:______________________ Gender___________________ Date of Birth_______

Name:______________________ Gender___________________ Date of Birth_______

Name:______________________ Gender___________________ Date of Birth_______

Other Supports (ABA, OT, SLP etc)	**Provided by**	**Start/end date**	**Schedule**

Please include services the child may have received in the past

____________________ ___________________ ________________ _________________

____________________ ___________________ ________________ _________________

____________________ ___________________ ________________ _________________

Have there been any other medical concerns in the past? Were any delays apparent during infancy?

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Does your child have concurring diagnoses (ADHD for example)?

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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.)

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)

Does your child engage in peer play, play with adults or prefer to play alone? Please explain.

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.

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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.

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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.

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Describe your child's functional living skills (if 8 or older).

At home, does your child prepare meals, help with chores such as laundry and dishes? Does your child engage in a variety of leisure activities? Please explain.

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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.

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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.

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What are specific behaviors you would like to *increase*?

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What are specific behaviors you would like to *decrease*?

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Scheduling preferences: (We will do our best to accommodate preferences, but ask for some family flexibility)

CLINIC

8:30-1130________ 12:00-3:00_________ 8:30-3:00________ 3:30-5:30_________

IN HOME

8-12 time frame___________ 11:30-3 time frame__________ Full Day ________ 3:00-6 time frame_______

Days available for home sessions:

Monday________ Tuesday________ Wednesday__________ Thursday_______ Friday______

Questions from client:

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Parent Name

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Parent Signature

______________________________ **Date**___________________________________

Please mail or fax this completed intake form to:

Behavioral Consulting for Autism, LLC
624 US HWY 17 S Ste 5
Holly Ridge, NC 28445
Fax: 910-769-5846

Thank you for taking the time to provide this essential information. We will review the completed form and contact you within 2 days to answer any other questions and to schedule an assessment for services.