UBUNTU AUTISM
CONSULTANTS

GENERAL INTAKE QUESTIONNAIRE

General Information

CHILD

Name of Child: _____ Date of Birth: _____

Gender: _____ Current Age: _____

Primary Address: _____ Secondary Address: _____

_____ (if any) _____

Current Diagnosis: _____ Date of Diagnosis: _____

Diagnosed by: _____ Age at Diagnosis: _____

Affiliation: _____ Referred by: _____

PARENTS AND/OR GUARDIANS

Parent/Guardian: _____ Parent/Guardian: _____

Social Security #: _____ Social Security #: _____

Occupation: _____ Occupation: _____

Employer Name: _____ Employer Name: _____

Home Phone: _____ Home Phone: _____

Mobile Phone: _____ Mobile Phone: _____

Work Phone: _____ Work Phone: _____

Best Number to Reach: ☐ Home ☐ Mobile ☐ Work Best Number: ☐ Home ☐ Mobile ☐ Work

Email Address: _____ Email Address: _____

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Are parents: ☐ married ☐ divorced
☐ separated ☐ other (please explain)

_____

_____

If divorced, who has custody of minor: _____

Who completed questionnaire and relationship to client: _____

Primary language spoken at home: _____

SIBLINGS

Sibling Name	Date of Birth	Gender	Does the Sibling Reside in Your Household?
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐

SCHOOL

School District: _____ Contact Person: _____
School Name: _____ Service Coordinator: _____
Principal / Director: _____ Phone: _____
Teacher(s): _____ Branch Address: _____
School Phone: _____
School Address: _____

Medical Information

PREGNANCY, DELIVERY AND FIRST YEAR

Were there any complications with the pregnancy or delivery? If so, please explain.

Please describe mother's drug/alcohol/tobacco use during the pregnancy?

Did your child experience any illnesses during his or her first year? If so, please list the illnesses and how each was treated.

MEDICATIONS

Please list any medications that your child has previously taken:

Medication Name	Dosage	Length of Time Taken	Reason for Medication

Please list any medications that your child is currently taking:

Medication Name	Dosage	Length of Time Taken	Reason for Medication

Please list any supplements, vitamins, etc. that your child is currently taking:

Medication Name	Dosage	Length of Time Taken	Reason for Medication

MEDICAL TESTING

Please list any medical testing that your child has completed:

Test Name	Month/Year	Reason for Test	Results

MEDICAL HISTORY AND CURRENT MEDICAL CONDITIONS

Please list any current allergies your child has (e.g. food, medication, environmental allergies):

Does your child currently have, or has s/he had, any contagious, or communicable condition? (Circle all that apply)

Hepatitis ☐ Diarrhea ☐ Scabies ☐ HIV ☐ Ear Infection Tetanus ☐ Chicken Pox ☐ Lice ☐
Tuberculosis ☐ Polio ☐ Other _____

Please describe and provide any relevant information:

Please list any special nutritional needs:

O I have attached a copy of my child's immunization records.

CURRENT TREATING PHYSICIANS

Doctor's Name:		Doctor's Name:	
Specialty:		Specialty:	
Address:		Address:	
Phone Number:		Phone Number:	

Treatment History

Please list any treatments that your child has received **in the past** and complete the table accordingly.

Treatment Type	Provider/ Clinician And Contact Information	Hours per week of treatment provided?	Dates of Treatment	Results: Was the treatment beneficial? Please explain.
Special Education Classroom			Start Date: End Date:	
Speech Therapy			Start Date: End Date:	
Occupational Therapy			Start Date: End Date:	
Physical Therapy			Start Date: End Date:	
Other ABA Program			Start Date: End Date:	
Community Services:			Start Date: End Date:	
Other:			Start Date: End Date:	
Other:			Start Date: End Date:	

Current Treatment Information

Please list any treatments that your child is **currently receiving** and complete the table accordingly.

Treatment Type	Provider/ Clinician And Contact Information	Hours per week of treatment provided?	Dates of Treatment	Results: Was the treatment beneficial? Please explain.
Regular Education Classroom			Start Date:	
Special Education Placement	Circle One: Mixed Special Ed. Autism Classroom Partial Inclusion		Start Date:	
Speech Therapy			Start Date:	
Occupational Therapy			Start Date:	
Physical Therapy			Start Date:	
Other ABA Program			Start Date:	
Community Services:			Start Date:	
Other:			Start Date:	

FAMILY HISTORY

Please describe any family history of developmental disorders or mental illness (e.g., family history of autism, depression, etc.). Write the family member's relationship to your child (e.g., grandfather) and his/her specific diagnosis.

Please describe any family history of major medical issues (e.g. heart disease, cancer). Write the family member's relationship to your child (e.g., grandfather) and his/her specific diagnosis. Please also describe if medical issues are on-going or resolved

Are any family members currently or formerly engaged in drug or alcohol abuse and/or do any family members have a history of drug or alcohol abuse? If yes, please describe:

Does any family member currently have, or has had, any contagious, or communicable condition? (Circle all that apply)

Hepatitis ☐ ☐Diarrhea ☐Scabies ☐HIV Ear Infection ☐ Tetanus ☐Chicken Pox
Lice ☐ ☐Tuberculosis ☐Polio ☐Other _____

Please describe and provide any relevant information:

Additional/Other Information

Are there any religious/spiritual issues or belief systems that may impact your child's progress or treatment plan?
Please circle: Yes or No If yes, please describe:

Are there any cultural concerns/issues that may impact your child's treatment? Please circle: Yes or No
If yes, please describe:

Do you keep fire arms in your home?
Please circle: Yes or No If yes, please answer the questions below:

Where are they kept?

How are they secured?

Who is in charge of that security?

Anything else you would like to tell us regarding the fire arms in your home:

Is there anything else you would like to share about your child and/or family that you believe would be helpful?

INSURANCE INFORMATION

Name of Insurance:
Group Number:
Certificate Number:
Name of Primary Insured:
Relationship to Client:

Assessment (Parent Report)

Medical History		
Has your child had any of the following? If yes, check and explain		
Staring Spells	☐	
Seizures	☐	
Head Trauma	☐	
Speech Problems	☐	
Tics or repeated movements	☐	
Weight loss	☐	
Rapid weight gain	☐	
Trouble with appetite	☐	
Unexplained fevers	☐	
Vision problems	☐	
Hearing problems	☐	
Lung problems	☐	
Heart problems	☐	
Stomach or bowel problems such as diarrhea or constipation	☐	
Urinary tract infections	☐	
Kidney problems	☐	
Broken bones/joint problems	☐	
Skin problems	☐	

Endocrine problems	☐	
Anemia	☐	
Immunization reactions	☐	
Pre-natal/Perinatal events	☐	
Allergies to medications, food etc.	☐	
Problems Swallowing	☐	
Infectious Disease	☐	
Any substance abuse problems such nicotine, drugs or alcohol (for children 12 or over)	☐	

Has your child had any of the following tests or evaluations?	**Yes**	**Date**	**No**	**Where was it done? What were the results?**
Psychology or neuro-psychology evaluation **(Please Include Copies)**	☐		☐	

Brain wave test, EEG, electroencephalogram	☐		☐	
CT or MRI of the Head	☐		☐	
Blood Chromosome Test	☐		☐	
Blood Test for Fragile X Syndrome	☐		☐	
Former Evaluation(s) for Autism **(Please Include Copies)**	☐		☐	

Child's Developmental History

By what age did your child sit alone quietly for several minutes?	Age in months:			Not Yet

By what age did your child walk alone?	Age in months:			Not Yet
By what age did your child emit his or her first 5-6 words?	Age in months:			Not Yet
How old was your child when he or she first said something that involved putting words together meaningfully (two-or three-word phrases including a verb)? What did he or she say?	Age in months:			Not Yet
By what age did your child first begin playing with toys appropriately?	Age in months:			Not Yet
By what age did your child gain consistent during control during the day?	Age in months:			Not Yet
By what age did your child gain consistent bowel control over accidents and soiling?	Age in months:			Not Yet

Please list any concerns you have about your child's development not already mentioned above:
Briefly describe your child's infancy (for example, sleeping, crying habits, sleeping, eating…etc.):
Briefly describe your child's toddler years (for example, language use, play with other children, temper tantrums, sleep problems…etc.):
Briefly describe your child's preschool years (for example, behavior problems, activity preferences, playing well with other children, language skills…etc.):
Briefly describe the time of your initial concerns about your child, what those were, and who you took your child to see about them:

How would you describe your child and things you would like us to know about your child? – strengths, personality, etc.

What current communication skills does your child have? (vocal, sign language, PECS, augmentative communication device, etc.) Please explain what degree of functional communication your child has.

Functional Assessment Interview of Possible Functions of Problem Behavior

Does your child engage in any self-injurious behavior(s) (Circle One)? Yes No

If Yes, please list:_____

Does your child engage in any aggressive behavior(s) (Circle One)? Yes No

If Yes, please list:_____

Does your child elope from buildings and/or outdoor areas (Circle One)? Yes No

If Yes, please explain:_____

Please list any other problem behaviors your child exhibits:

1.
2.
3.
4.
5.

Please explain how these behaviors interfere with daily activities throughout the day:

*The following questions address **<u>each</u>** individual problem behavior addressed above*.

1. Does the problem behavior occur during specific times Yes☐ No☐

2. Does the problem behavior occur in specific settings, activities or events? Yes☐ No☐

3. Does the problem behavior occur around specific people? Yes☐ No☐

4. How often does the problem behavior occur?

5. Please identify what appears to cause the behavior:
   - Demands are being placed ☐
   - Preferred items or activities are removed ☐
   - Attention is removed ☐
   - Sensory Stimulation ☐
   - Medical condition ☐
   - Other:_____

6. What typically happens immediately following the behavior?

7. What steps have been taken to address the problem? Please describe:

8. Have you noticed any results from the above steps? Yes☐ No☐
   If so, please describe:

Child Reinforcer Preferences

Please list your child's favorite items, activities, and foods:

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

Goals and Expectations

Please describe your goals or expectations you hold for your child in his/her environment:

School	Home	Community

Please describe any other concerns or expectations regarding your child's current behavior, communication, and social skills:

Who will be involved in your child's treatment? Please list all family members and care agents_____
_____

Are family members or additional care agents available for training in order to ensure appropriate support and services at home? (Please circle) Yes No

Please understand that having an IEP document or a referral from a physical or psychologist does not imply a guarantee or confirmation that services will be provided.

Completed by (Name) _____ Relationship to client: _____

Signature: _____ Date: _____