ABC Behavior Therapy In-Take Questionnaire
-CONFIDENTIAL-

Please complete this intake questionnaire regarding your child. Feel free to add any additional information or attach additional reports that you think may be helpful for us in getting to know your child. ***ABC Behavior Therapy*** views all of the information that you provide us with as strictly confidential. This information is helpful for us in developing an initial understanding of your child's needs and provides critical information for us to discuss with your insurance company to get authorization for services.

Please PRINT your responses below.

Today's Date: _____/ _____ / _____

GENERAL INFORMATION

Name of Person Completing this Form: _____

Relationship to Child/Adolescent: _____

Legal Name of Child/Adolescent: _____

Child/Adolescent's Date of Birth: _____ / _____ / _____ Age: _____

How did you hear of our ABA agency? _____
_____

PARENT/GUARDIAN CONTACT INFORMATION

Parent/Guardian 1 Name (First and Last Name): _____

Parent/Guardian 2 Name (First and Last Name): _____

Home Address: _____

Home Telephone: (_____) - _____ - _____

Parent/Guardian 1 Employer: _____ Cell Phone: (_____) - _____ - _____

Parent/Guardian 1 Cell Phone :(_____) - _____ - _____ Email: _____

Parent/Guardian 2 Employer: _____ Cell Phone: (_____) - _____ - _____

Parent/Guardian 2 Cell Phone: (_____) - _____ - _____ Email: _____

_____

MEDICAL INFORMATION

Name of Physician: _____

Physician Address: _____

Physician Phone Number: (_____) - _____ - _____

Child/Adolescent's Current Height: _____ ft. _____ in. Weight: _____ lbs.

Which hand does your child/adolescent show dominance? ☐ Left ☐ Right ☐ No preference

Does your child/adolescent have any current health conditions, including infectious diseases?
☐ Yes ☐ No
* If yes, please explain. _____

Please also provide the following:

Known Medical Conditions	Dates and Providers of Previous Treatment	Current Treating Clinicians	Current Therapeutic Interventions and Responses

List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other special conditions your child/adolescent has had.

Does your child/adolescent have any vision problems? ☐ Yes ☐ No
* If yes, please explain below and if there are any treatments currently being used for correction.

Does your child/adolescent have any hearing problems? ☐ Yes ☐ No
* If yes, please explain below and if there are any treatments currently being used for correction.

Does your child/adolescent have a history of seizures? ☐ Yes ☐ No
* If yes, please describe the types of seizures and current treatment.

Is your child/adolescent currently taking any medications? ☐ Yes ☐ No
*If yes, please provide the following information:

Name of Medication	Amount	How often is the medication taken?	When is the medication taken?	Please state any reactions or side effects your child/adolescent experiences from the medication.

Does your child/adolescent have any allergies to medications? ☐ Yes ☐ No
*If yes, please describe, including any adverse reactions:

Does your child/adolescent have any other allergies (seasonal, food, etc.)? ☐ Yes ☐ No
*If yes, please describe, including any adverse reactions and if any epi pen is needed:

Does your child/adolescent currently have a diagnosis? ☐ Yes ☐ No
*If yes, please provide the following information:

Diagnosis	Diagnosing Physician	Date Diagnosed	Diagnosis Code

Please note that the diagnosis information is required for insurance coverage. By having this information, it assists us when speaking with your insurance company to get authorization for services and providing you with invoices for reimbursement through insurance.

_____

INSURANCE INFORMATION

Name of Insurance Company: _____

Name of Policy Holder: _____

Social Security #: _____ - _____ -_____ Date of Birth: _____ / _____ / _____

Insurance Address: _____

Phone Number: (_____) - _____ - _____

Member ID: _____ Group ID: _____

****** Please provide us with a copy of the front and back of your insurance card if you are going to be seeking reimbursement for services through your insurance company.***

CURRENT/PREVIOUS THERAPY PROVIDER INFORMATION

Please provide us with information regarding the following types of current or previous therapy providers and copies of any recent evaluations that indicate dates of previous treatment and therapeutic interventions and responses.

Does your child/adolescent currently receive behavioral services with another provider?
☐ Yes (Please provide information below.)
☐ No

Name of **Behavioral Provider**: _____

Provider Address: _____

Provider Phone Number: (_____) - _____ - _____ Email: _____

Does your child/adolescent currently receive speech therapy services?
☐ Yes (Please provide information below.)
☐ No

Name of **Speech Therapy Provider**: _____

Provider Address: _____

Provider Phone Number: (_____) - _____ - _____ Email: _____

Does your child/adolescent currently receive occupational therapy services?
☐ Yes (Please provide information below.)
☐ No

Name of **Occupational Therapy Provider**: _____

Provider Address: _____

Provider Phone Number: (_____) - _____ - _____ Email: _____

Does your child/adolescent currently receive physical therapy services?
☐ Yes (Please provide information below.)
☐ No

Name of **Physical Therapy Provider**: _____

Provider Address: _____

Provider Phone Number: (_____) - _____ - _____ Email: _____

Does your child/adolescent currently receive psychiatric services?
☐ Yes (Please provide information below.)
☐ No

Name of **Psychiatric Provider**: _____

Provider Address: _____

Provider Phone Number: (_____) - _____ - _____ Email: _____

Does your child/adolescent currently receive any other services?
☐ Yes (Please provide information below.)
☐ No

Name of **Other Provider**: _____

Provider Address: _____

Provider Phone Number: (_____) - _____ - _____ Email: _____

_____

EDUCATIONAL HISTORY

Please list all schools your child/adolescent has attended in order starting with the most current school.

Name of School	School System	Year(s)	Grade	Special Education Services
				☐ Yes ☐ No
				☐ Yes

				☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Is your child/adolescent currently classified for special education services? ☐ Yes ☐ No

**** Please provide us with copies of any reports from evaluations that you may have, as well as a copy of the current 504 plan or IEP.***

FAMILY BACKGROUND

Does either parent/guardian's job require him/her to be away from home for long hours or extended periods of time that might prevent them from being involved in ABA services and parent training?

☐ Yes ☐ No

* If yes, which parent/guardian and for how long? _____

Marital Status:

☐ Married
☐ Civil Union
☐ Remarried
☐ Divorced
☐ Separated
☐ Widowed
☐ Single
☐ Cohabitants

* If divorced, who has legal custody? _____ Is it full or joint custody? _____

Are there siblings? ☐ Yes ☐ No

*If yes, please provide the following information:

	Name	Age	Relationship	Living in Home?	School	Grade
1.				☐ Yes ☐ No		
2.				☐ Yes ☐ No		
3.				☐ Yes ☐ No		

Please indicate and describe whether any of the siblings have any special needs, diagnoses, or concerns.

Are you also interested in seeking services for any of the siblings with special needs?

☐ Yes ☐ No ☐ Not applicable

*If yes, you will need to complete a new intake packet for that child.

Are there any other individuals residing in the house or that play a significant role on how this child is raised?

☐ Yes ☐ No
*If yes, please identify who else is involved in raising the child and their relationship to the child.

PSYCHOLOGICAL HISTORY

Please indicate below whether or not there is a history of the following in your immediate family or in either biological parent's extended family.

Yes	**No**	
☐	☐	Autism Spectrum Disorders
☐	☐	Learning Problems/Disabilities
☐	☐	ADD/ADHD-Attention Problems
☐	☐	Clinical Depression
☐	☐	Bipolar Disorder
☐	☐	Behavior Problems in School
☐	☐	Anxiety Disorders (e.g., OCD, etc.)
☐	☐	Intellectual Disability
☐	☐	Psychosis/Schizophrenia
☐	☐	Substance Abuse/Dependence
☐	☐	Other Mental Health Concerns (Please specify: _____)

If yes, please indicate who in the family currently has or has had these diagnoses:

Has your child/adolescent had an outside psychological or psychiatric evaluation? ☐ Yes ☐ No

Has your child/adolescent ever been hospitalized for a psychiatric condition? ☐ Yes ☐ No

Please provide us with any other information on the psychological history that you feel would be helpful to us in understanding your child/adolescent.

_____

BIRTH AND DEVELOPMENTAL HISTORY

Did the birth mother receive regular prenatal care? ☐ Yes ☐ No

Were there any complications with the pregnancy? ☐ Yes ☐ No
*If yes, please describe the complications below and treatment details.

Was birth at full term? ☐ Yes ☐ No
* If no, please provide details.

What was the type of delivery? ☐ Spontaneous ☐ Induced ☐ Vaginal ☐ C-Section

Were there any complications during delivery? ☐ Yes ☐ No
*If yes, please describe the complications below and treatment details.

What was your child/adolescent's birth weight? _____lbs._____ oz.

Were there any concerns at birth? ☐ Yes ☐ No
*If yes, please describe the concerns and treatment details.

Were there any developmental milestones that your child was delayed in or did not achieve?
☐ Yes ☐ No
*If yes, please identify those milestones below.

CURRENT BEHAVIORAL CONCERNS

Please indicate if your child/adolescent engages in any of the following behaviors (check all that apply):

☐ Aggression (specify below)
- ☐ Hitting (e.g., punch, slap, etc.)
- ☐ Kicking
- ☐ Biting
- ☐ Pinching
- ☐ Head-butting
- ☐ Scratching
- ☐ Spitting
- ☐ Other (Please specify): _____

☐ Self-Injurious Behavior (specify below)
- ☐ Hitting self with hands or fists (Where on body?:_____)
- ☐ Kicking self (Where on body?:_____)
- ☐ Biting self (Where on body?:_____)
- ☐ Head-butting walls, windows, etc.
- ☐ Pulling teeth
- ☐ Scratching skin
- ☐ Cutting/burning
- ☐ Other (Please specify): _____

☐ Property Destruction (describe: _____)

☐ Eloping (i.e., running out of a building, room, vehicle, etc.)

☐ Sensory issues (describe: _____)

☐ Sexualized behaviors (describe: _____)

☐ Self-urinating/defecating

☐ Fecal smearing

☐ Rectal digging

☐ Difficulty with toileting

☐ Defiance or problems with authority

☐ Problems with eating

☐ Tantrums
☐ Screaming/yelling
☐ Vocalizations
☐ Repetitive behaviors
☐ Other (Please specify): _____

Additionally, please indicate if your child is experiencing any of the following (check all that apply)?

☐ Isolated socially from peers
☐ Difficulty making friends
☐ Problems keeping friends
☐ Sleep problems (describe: _____)
☐ Bedwetting
☐ Fire setting
☐ Anxiety
☐ Sadness or depression
☐ Hallucinations
☐ Delusions
☐ Suicidal ideation/attempts
☐ Legal situations
☐ History of physical abuse
☐ History of sexual abuse
☐ Alcohol use/abuse
☐ Drug use/abuse including nicotine and/or illegal drugs (list drugs: _____)
☐ Difficulty concentrating

Are there any current or past relevant legal issues pending with your child/adolescent?
☐ Yes ☐ No *If yes, please describe below.

Please state the goals that you have for your child/adolescent while engaging in a behavioral program.

DISCIPLINE INFORMATION

Please rate what percentage of discipline is handled by each of the following:

Parent/Guardian 1: _____% Relationship to Child/Adolescent: _____
Parent/Guardian 2: _____% Relationship to Child/Adolescent: _____

What is typically used for disciplining your child/adolescent (e.g., timeout, assigning chores, physical/corporal punishment, etc.)?

Are there any spiritual beliefs or values that you think may impact how you provide discipline or behavioral supports to your child? ☐ Yes ☐ No *If yes, please describe below.

Are there any cultural beliefs or values that you think may impact how you provide discipline or behavioral supports to your child? ☐ Yes ☐ No *If yes, please describe below.