Revised
02--26--16

Today's Date:

Initial Intake Evaluation

ABA Midwest Education LTD

General Information

Client's name: _____ DOB: _____

Address: _____

Guardian 1 name: _____ Relationship to client: _____

Guardian 2 name: _____ Relationship to client: _____

Marital status: _____

Address (if different from client): _____

Phone number(s): _____
E--mail(s):
_____
List others in household:
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____

Coordination of Care

Primary Care Physician: _____
Address: _____
E--mail: _____ Phone number: _____ Fax: _____

Prescribing Physician (if different): _____
Address: _____
E--mail: _____ Phone number: _____ Fax: _____

Licensed Clinician referring for ABA services: _____
Address: _____
E--mail: _____ Phone number: _____ Fax: _____

Neurologist: _____
Address: _____
E--mail: _____ Phone number: _____ Fax: _____

Medical History

All Medical Diagnosis and Conditions:
_____

Pregnancy complications:
_____

Known allergies: _____

_____

Suspected allergies:

_____

Family history:

Relative: _____ Age: _____ Diagnosis/illness: _____
Relative: _____ Age: _____ Diagnosis/illness: _____
Relative: _____ Age: _____ Diagnosis/illness: _____
Relative: _____ Age: _____ Diagnosis/illness: _____

Ambulatory: Y N Steady gait: Y N

Vision within normal range: Y N Glasses: Y N

Approximate date of last vision test: _____

Hearing in normal range: Y N Hearing aids: Y N

Approximate date of last hearing test: _____

List any prior hospitalizations:
(*Specify any hospitalizations due to problem behavior or for psychiatric reasons.*)

Date: _____ Reason: _____
Date: _____ Reason: _____
Date: _____ Reason: _____
Date: _____ Reason: _____
Date: _____ Reason: _____

Seizure disorder: Y N

If yes, please describe: _____

_____

_____

Date of last known seizure: _____

Seizure frequency (last 6 months): _____

Severity (last 6 months): _____

Does your child currently take medications for medical or behavioral reasons (including seizures)? Y N

Please list the following for each **current** medication:

	#1	#2	#3	#4	#5
Medication:					
Reason:					
Date started:					
Current dosage:					
Administration instructions:					
Medication change date(s):					
Comments/ observed impact:					
Prescribing doctor:					
Contact information:					
Side effects:					

Dietary considerations: _____

_____

_____

Special diet: _____

_____

_____

Nutritional supplements: _____

_____

_____

Genetic testing:_____ _____

_____

_____

Educational Background

Educational placement: _____

Description: _____

Address: _____

Contact: _____ Phone number: _____

E-mail:
_____

Teacher/aid: _____ Phone number: _____

E-mail:
_____

Please list clients' current school schedule in the table below:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Attach the clients' current year school calendar to this form. If the calendar is on the school website please provide the schools website address on the line below.

_____

Behavioral History

Has the client received ABA services in the past? Y N

Current form of communication (e.g., sign, vocal, PECS): _____

_____

_____

Did or does the client have a behavior intervention/management plan? Y N

Home: Y N School: Y N Center/clinic: Y N

[*Please attach previous behavior plans and graphs as applicable.*]

Please list and generally describe any behavioral issues occurring now or in the past:

_____

_____

_____

_____

Physical aggression to others: Y N Harm to self: Y N

Elopement: Y N Pica: Y N

Sexualized behaviors: Y N History of abuse: Y N

Comments: _____

_____

_____

_____

Has the client injured themselves or others as a result of these behavioral issues? Y N

What is the most dangerous behavior that has been observed?

_____

_____

_____

Does this learner need toilet training support? Y N

Note any details that should be known about toileting:

_____

_____

Previous programming:
[*Please attach previous IEP, ABA/verbal behavior assessments or programming descriptions.*]

Please comment on any particular area of family training or programming you feel would be helpful or has been helpful:

_____

_____

_____

Please describe a few things that you feel makes your child smile (we will find out more later)!

_____

Please tell us of any "eggshells" or things that you child finds aversive:

_____

_____

Does this child receive or have assessments
from speech Therapy, OT, PT? : Y N

Can you get us reports related to these services? Y N

Please attach any skill "mastery" lists you may currently have and/ or
describe your child strengths:

_____

_____

_____

_____

_____

Please describe Parking availability for your home or neighborhood:

Abuse, Exposure & Family Background Questionnaire

Abuse

Does the client have a history of abusing alcohol? Y N
If yes, please describe:

Does the client have a history of abusing nicotine? Y N
If yes, please describe:

Does the client have a history of abusing other drugs? Y N
If yes, please specify what drug(s) and history of abuse:

Exposure

Has the client ever been exposed to alcohol? Y N
If yes, please specify:

Has the client ever been exposed to nicotine? Y N
If yes, please specify:

Has the client ever been exposed to other drugs? Y N
If yes, please specify what drug(s) and extent of exposure:

Family Background

Please list any spiritual and/or cultural values and practices that may impact treatment:

Please list any past and/or present legal issues that may impact treatment:

Parent Signature/s: 1. _____Date: ___/___/___ 2. _____ Date:_____/_____/_____

Reviewing Clinician signature/s_____ Date____/____/____

Supervising BCBA Signature verifying review and clarification with parents as indicated:

Signature:_____ Date____/ _____/ _____