JumpStart Autism Center

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A Behavioral Health Center of Excellence

INTAKE QUESTIONNAIRE

Client Name: ____

Date of Birth: ____________________________ **Age:**_________ **Gender:** ____

Parent's Information:

Mother's Name: ____

Address:____

City:___________________________ **State:**______ **Zip:**______________

Phone: Home:______________________ **Work:** __________________

Email: ____

Father's Name: ____

Address: ____

City:___________________________ **State:**______ **Zip:** ______________

Phone: Home:______________________ **Work:** __________________

Email: ____

Who has primary custody of your child? (Circle One) mother/father/both/guardian/CYFD

Who were you referred by? ____

Most recent diagnosis: ____

Who made this diagnosis and when?__________________________________

Who is your child's Primary Care Physician? __________________________

Primary Care Physician phone number: ______________________________

****PLEASE BRING ANY PSYCHOEDUCATIONAL OR DEVELOPMENTAL EVALAUTIONS WITH YOU TO YOUR FIRST MEETING****

Reason for Referral: (why are you seeking help for your child?)

1. ____

   ____

2. ____

   ____

3. ____

   ____

Person completing this form:______________________ **Date completed:**______________

What do you expect to gain from consultation, assessment, or therapy and behavioral services for your child?____

____

____

FAMILY INFORMATION

Parent Occupation:

Biological Mother: ____

Biological Father: ____

Step-Mother: ____

Step-Father: ____

Sibling Information

1. Name:____________________________ **Age:** __________ **Sex:** ________

2. Name:____________________________ **Age:** __________ **Sex:** ________

3. Name:____________________________ **Age:** __________ **Sex:** ________

4. Name:____________________________ **Age:** __________ **Sex:** ________

Parents Marital Status (circle whichever applies):

Single	**Separated**	**Divorced**
Married	**Living with partner**	**Widowed**

How long married?________ **How long divorced?** _______ **Child's age at divorce:** _______

If parents are separated or divorced, who has custody of this child? ____________________

How often does the other parent see this child?

_____**Weekly or more often** _____ **Once or twice/month** _____ **Few times/year** _____ **Never**

Primary language spoken at home? ______________________________________

List all other languages spoken at home: ________________________________

Approximate Parental Income Level (circle one):

Less than 10,000	**10,000-30,000**	**30,000-50,000**	**50,000-80,000**	**80,000+**

This child is living with:

______ **Both parents** ______ **Mother** ______ **Father**

______ **Mother and Stepfather** ______ **Father and Stepmother**

______ **Legal guardian** ______ **Other (please specify)** ____________________

How long has this child been in current living situation?______________________________

What do you enjoy most about this child?____

What do you find most difficult about raising this child? ____________________________

____

____
______

Who is mainly in charge of discipline in the home? ______________________________
Do all caregivers agree on discipline? ____
____

Describe discipline techniques: ____
____
____

MEDICAL HISTORY

Pregnancy: weeks gestation: ____
Length of labor: ____
Length of hospital stay: ____
Complications: ____
Substances used during pregnancy:
______ Cigarettes: If so, how many? ___________ per (__________ day __________ week)
______ Alcohol: If so, how many drinks? ______ per (_____ day _____ week ____ month)
______ Drugs: Please describe type(s) of drug, frequency of use, and when used during preg-nancy:____
____

Please check any of the following that this child has had and indicate age (year/month).

______Mumps
______Measles
______Anemia
______Asthma
______Allergies
______Poisoning
______Chicken pox
______Tuberculosis
______Scarlet Fever
______Vision problems
______German Measles
______Hearing problems
______Persistent high fever
______Seizures/convulsions
______Meningitis or encephalitis
______Sleep problems (snoring, apnea, etc.)
______Head injuries with loss of consciousness
______Head injuries without loss of consciousness

Please describe any serious illness or operations (include illness and age at time of surgery):
____
____
____
____

MEDICAL SERVICES

Have people raised a concern about ASD for your child? NO / YES
If yes, Who: ____________________________ When: ____________________________

Has your child ever experienced a developmental regression? NO / YES

If yes, please explain: ____

____

____

Has your child experienced a recent developmental regression? NO / YES
If yes, please explain:____

____

____

Does your child have any known allergies,
including food and environmental? NO / YES
If yes, please list and describe reactions: ____________________________

____

____

Is your child currently taking any medications? NO / YES
If yes, please list:

***Medication:* ______________________ Dose:_______ Frequency:________**
***Medication:* ______________________ Dose:_______ Frequency:________**
***Medication:* ______________________ Dose:_______ Frequency:________**
***Medication:* ______________________ Dose:_______ Frequency:________**
***Medication:* ______________________ Dose:_______ Frequency:________**
***Medication:* ______________________ Dose:_______ Frequency:________**

When was your child's last well check-up/annual physical? Date:____________________

When was your child's last dental cleaning/check-up? Date:____________________

When was your child's last vision check? Date: ____________________
Result: [ ] Passed [ ] Needs corrective Lenses

When was your child's last hearing check? Date:____________________
Result: [ ] Passed [ ] Failed

Please list all providers and specialists your child has seen or currently sees through your private insurance, Medicaid, or private pay. (Do not include Early Intervention or school services here. See below.)

Specialists	Name	Phone Number	Date of Last Visit

Pediatrician (current)			
Psychiatrist			
Psychologist			
Neurologist			
GI			
Sleep Specialist			
Feeding Specialist			
Nutritionist			
Ear/Nose/Throat (ENT)			
Allergist			
Physical Therapist			
Occupational Therapist			
Speech/Language Therapist			
Other:			

Please list any previous surgeries, injuries, and hospitalizations:

Surgery	**Age**	**Injuries**	**Age**
Appendix		Head injury	

Hernia		Broken Bone	
Tonsils		Eye Injury	
Adenoids		Abdominal injury	
Other Surgeries		Other Injuries:	
		Hospitalizations:	

Please list all medical diagnoses:

Diagnosis	**Age**	**Diagnosis**	**Age**
Gastrointestinal (GI):		***Obsessive Compulsive D/Os:***	
Celiac disease (K90.0)		OCD (F42)	
Chronic constipation (K59.00)		Trichotillomania (hair pulling) (F63.2)	
Leaky bowel		Excoriation (skin-picking) (L98.1)	
Irritable bowel syndrome (K58.0/K58.9)		OCD and Related D/O due to Another Med Condition (F06.8)	
GERD (K21.0/K21.9)		Other Specified OCD (F42)	
Acid reflux		Unspecified OCD (F42)	
Developmental Delays:		***Tic/Movement Disorders:***	
Gross Motor Delay		Tourette's Disorder (F95.2)	
Fine Motor Delay		Persistent Motor or Vocal Tic D/O (F95.1)	
Lack of Motor Coordination (R27.9)		Provisional Tic D/O (F95.0)	
Motor Apraxia (R48.2)		Other Specified Tic Disorder (F95.8)	
Developmental Coordination Disorder (F82)		Unspecified Tic Disorder (F95.9)	
Diagnosis	**Age**	**Diagnosis**	**Age**
Feeding:		***Sleep D/O:***	

Pica (F98.3)		Insomnia D/O (G47.00)	
Ruminations D/O (F98.21)		Hypersomnolence D/O (G47.10)	
Avoidant/Restrictive Food Intake D/O (F50.8)		Obstructive Sleep apnea (G47.3)	
Other Specified Feeding or Eating D/O		Circadian Rhythm Sleep-Wake D/O (G47.2X)	
Unspecified Feeding/Eating D/O (F50.8)		Sleepwalking (F51.4)	
Feeding difficulty (R63.3)		Sleep/night terrors (F51.4)	
Feeding tubes		Unspecified Insomnia D/O (G47.00)	
Failure to thrive as newborn (P92.6)		Unspecified Hypersomnolence D/O (G47.10)	
Failure to thrive as child (R62.51)		Unspecified Sleep-Wake D/O (G47.9)	
Communication Disorders:		***ADHD:***	
Language Disorder (F80.9)		Attention Deficit/Hyperactivity	
Speech Sound Disorder (F80.0)		- Combined presentation (F90.2)	
Social Communication Disorder (F80.89)		- Predominantly inattentive presentation (F90.0)	
Expressive Language Disorder (F80.1)		- Predominantly Hyperactive/impulsive (F90.1)	
Mixed Receptive/Expressive (F80.2)		---- Specify: Mild, Moderate, Severe	
Childhood-Onset Fluency D/O (Stuttering) (F80.81)		Unspecified ADHD (F90.8)	
Unspecified Communication Disorder (F80.9)		Other Specified ADHD (F90.8)	
Neurodevelopmental Disorder NDD:		***Behavior Disorders:***	
Other Specified NDD (F88)		Oppositional Defiant D/O (F91.3)	
Unspecified NDD (F89)		Intermittent Explosive D/O (F63.81)	
		Disruptive Behavior D/O or Conduct Disorder Unspecified (F91.9)	

Diagnosis	Age	Diagnosis	Age
Seizures:		***Adjustment Disorder:***	
Febrile Seizures		With Depressed Mood	
Petit Mal Seizures		With Anxiety	
Grand Mal Seizures		With Mixed Anxiety and Depressed Mood	
Epilepsy		With Mixed Disturbance	
Anxiety Disorders:		***Elimination Disorders:***	
Generalized Anxiety Disorder (F41.1)		Enuresis (F98.0) Specify: Nocturnal, Diurnal, or both	
Separation Anxiety D/O (F93.0)		Encopresis (F98.1) Specify: W/ Constipation and overflow incontinence or w/o constipation and overflow incontinence	
Specific Phobia (Animal, natural environment Blood-injections, situation, other) (F40….)		Other Specified Elimination D/O	
Social Anxiety Disorder (F40.10)		- with urinary symptoms (N39.498)	
Panic Disorder (F41.9)		- with fecal symptoms (R15.9)	
Anxiety D/O due to Medical Condition (F06.4)		Unspecified Elimination Disorder	
Other Specified Anxiety D/O (F41.8)		- with urinary symptoms (R32)	
Unspecified Anxiety D/O (F41.9)		- with fecal symptoms (R15.9)	
Sensory Deficits:		***Intellectual Disability:***	
Cortical Visual Impairment (CVI)		- Mild (F70)	
Periventricular Bleed		- Moderate (F80.0)	
Functional Visual Impairment		- Severe (F72)	
Hearing Loss		- Profound (F73)	
Chronic Ear Infections			

DEVELOPMENTAL MILESTONES

When did you first become concerned about your child's development and why?

____

____

Approximate age at which your child *(as much as you can remember)***:**

_____SAT UP _____CRAWLED

_____WALKED ALONE _____USED SINGLE WORD

_____USED TWO-WORD PHRASES _____USED SENTENCES (3-5 WORDS)

_____UNDERSTOOD SIMPLE INSTRUCTIONS

_____WAS ABLE TO HAVE A BACK-AND-FORTH CONVERSATION

_____STARTED RESPONDING TO NAME

_____PLAYED SOCIAL GAMES LIKE (PATTY CAKE OR PEEK-A-BOO)

_____USED GESTURES TO COMMUNICATE

_____WAS TOILET-TRAINED FOR

______ BOWEL

______BLADDER

Has your child ever lost/regressed in any of these skills (circle one)? NO / YES

If yes, please describe what happened:______________________________________

____

____

Does Your Child Have sensory sensitivities --either love or hate-- CERTAIN sounds, Sights, textures, smells, tastes, touch (circle one)?

NO / YES

If yes, please describe:____

____

____

Are or were there any concerns about the development of this child (circle one)?

NO / YES

If yes, explain____

____

____

____

Does child or did this child have any problems in learning to speak or understand language (circle one)? NO / YES

If yes, did the child receive any special services? **NO / YES**

If yes, please describe:____

HOW DOES YOUR CHILD LET YOU KNOW WHAT THEY WANT? ________________

EARLY INTERVENTION SERVICES

Does or did your child receive services through Early Intervention (EI)? **NO / YES**

If yes, does your child currently receive those services? **NO / YES**

If yes, please list all services received through Early Intervention, including intensity of service:

Service	**Frequency** (x per week)	**Duration** (min/session)	**How long s/he received the service** (number of months or years)
Speech Therapy			
Occupational Therapy			
Physical Therapy			
Parent Training			
Other:			

FAMILY HISTORY

Please indicate if any members of this child's family have or have had any of the following (including immediate family members as well as the child's cousins, aunts, uncles, or grandparents):

Diagnosis:	Mother' Side	Father's Side
Depression		
Anxiety		
Bipolar Disorder (manic-depression)		
Schizophrenia		
Suicide		
Phobias		
Cerebral palsy		
Epilepsy (seizures, convulsions)		
Autism Spectrum Disorder		
Tourette's syndrome		
ADHD		
Intellectual Disability		
Language/Speech problem		
Stuttering		
Special Education		
Learning Problems/Disorders		
Reading Problem		
Alcoholism		
Drug Abuse		
Emotional Problems		
Hospitalization for mental illness		
Counseling for emotional disturbance		

Please indicate whether any of this child's family members (including immediate family, cousins, aunts, uncles or grandparents) have any other medical problems:

Family Member:	Medical Problem(s):
____________________	____
____________________	____
____________________	____
____________________	____

SCHOOL HISTORY

Current Grade: ________________ School: ________________

Does or did your child attend preschool or daycare (circle one)? NO / YES
At what age? ______________________________

Amount of time per day: _______________ Hours _____________ Days/week

Any problems in preschool (circle one)? NO / YES
If yes, please describe ____
____
____

Does your child participate in any play groups, sports, or other activities? NO / YES
If yes, please describe: ____

If school age, please complete the following:

Current school placement type: [ ] Public [ ] Private [ ] Home School [ ]Other:

Name of current school: _________________________________ Grade:____________

Current teacher(s) name(s): ____

Type of Classroom settings(s): (*Check all that apply)*

[ ] General education [ ] Special Education

Does your child have an assigned Educational Assistant (EA)? NO / YES

If yes, please describe: ____

When was your child's last comprehensive educational evaluation? Date:__________

Please give us a copy of your child's most recent educational or psychological evaluations*

What is your child's educational exceptionality to receive special education services?____
____
____
______

Please give us a copy of your child's most recent IEP
Please list all educational services your child receives:

Service	**Hours/wk**	**Therapist Name**	**Contact (email or phone)**
Special Education			
Speech/Language (SLP)			
Occupational Therapy (OT)			
Social Work			
Physical Therapy			
Music Therapy			
Recreational Therapy			
Adaptive Physical Education			

Does or did this child attend kindergarten/preschool (circle one)? NO / YES

Any problems in kindergarten/preschool (circle one)? NO / YES

If yes, please describe ____
____
____

Has this child ever repeated a grade (circle one)? NO / YES

If yes, which grade(s): ____

Has this child skipped a grade in school (circle one)? NO / YES

If yes, which grade(s): ____

Does or did this child have any difficulty with reading (circle one)? NO / YES

If yes, explain: ____
____

Does or did this child have any difficulty with math (circle one)? **NO / YES**

If yes, explain: ____

Has this child ever been tested before (e.g., special education, intellectual, academic, speech/language, psychological, developmental)?

NO / YES

If yes, when, and by whom, why, and what were the results: ____________________

Has or is this child receiving special education services (circle one)? **NO / YES**

If yes, what type of services?

( ) B level **( ) Serious emotional/behavioral disorder**
( ) C level **( ) Learning Disabled**
( ) D level **( ) Communication Disordered**
( ) Mixed **( ) other** ______________________

Please describe any behavioral concerns that you or your child's teacher have at this time:

CURRENT BEHAVIORAL CONCERNS

Please indicate if your child currently has or has had in the past any of the following problems or difficulties:

____suicidal ideation
____temper tantrums
____excessive fighting
____poor organization

____disturbed vision
____impulse control
____noncompliance
____poor judgment

____learning problems
____hearing difficulties
____alcohol/drug abuse
____poor peer relations
____thinking (efficiency)
____difficulty with peers
____short attention span
____prefers to play alone
____difficulties with the law
____concentration problems
____difficulty making friends
____poor frustration tolerance
____taste or smell disturbances
____long-term memory problems
____motor coordination problems
____short term memory problems
____prefers to play with younger children

____temper control
____hallucinations
____poor listening
____running away
____hyperactivity
____distractibility
____anxiety/fears
____bed wetting
____depression
____fire setting
____headaches
____dizziness
____seizures
____truancy
____soiling
____lying

What activities does this child enjoy?

Sports:____
____
____
____

Hobbies:____
____
____
____

Other:____
____
____
____

Safety: (*Circle NO or YES)*

Does your child ALWAYS respond to his/her name across ALL settings? **NO / YES**

Does your child only respond to his/her name when you have his/her attention? **NO / YES**

Does your child stop engaging in a behavior when told, "wait," "stop," or "no?" **NO / YES**
If no, please describe: ____
____

Does your child have difficulty following single-step instructions given by any caregivers? **NO / YES**

Does your child have good environmental awareness or stranger danger

awareness? **NO / YES**

Is your child aware of his/her immediate surroundings when in the community? **NO / YES**

Do adults have to be vigilant about your child's safety when in public? **NO / YES**
If yes, please describe: ______________________________

____

Does your child elope or wander? **NO / YES**

Do you have to lock your house to prevent them from eloping during the day or at night? **NO / YES**

Is your child an immediate danger to yourself or others? **NO / YES**
Please explain: ______________________________

____

Is your child able to wash his/her hands independently? **NO / YES**

Is your child daytime toilet trained? **Bladder: NO / YES** **Bowel: NO / YES**

Is your child nighttime toilet trained? **Bladder: NO / YES** **Bowel: NO / YES**

Has your daughter experienced her first menses? **NO / YES / NA**
If yes, is she fully independent in completing female hygiene? **NO / YES**
Please explain: ______________________________

____

Are you concerned that the lack of toileting puts your child at risk for physical/sexual abuse? **NO / YES**

Has this child ever been physically or sexually abused (circle one)? **NO / YES**
If yes, please explain: ______________________________

____

____

____

Has this child ever been removed from the home because of neglect or abuse (circle one)? **NO / YES**
If yes, please explain: ______________________________

____

____

____

____

Has this child had any unusual, traumatic, or possibly stressful events that you think may have had an impact on his/her development and current functioning (circle one)? **NO / YES**
If yes please describe and include incident, age at the time, and any additional comments.

____

____

____

Has this child ever been in trouble with the law (circle one)? **NO / YES**

If yes, please explain:____

Has this child or family ever received professional mental health treatment, such as counseling or psychotherapy (circle one)? **NO / YES**

If yes, please list any past or current treatments, including type of counseling, person counseled, name of counselor, when treated, and length of treatment:

GENERAL COMMENTS

Please indicate any other information that you would like to include in this information packet that has not already been addressed: