



JumpStart Autism Center

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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 pregnancy: _____

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
<i>Gastrointestinal (GI):</i>		<i>Obsessive Compulsive D/Os:</i>	
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)	
<i>Developmental Delays:</i>		<i>Tic/Movement Disorders:</i>	
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
<i>Feeding:</i>		<i>Sleep D/O:</i>	
Pica (F98.3)		Insomnia D/O (G47.00)	
Ruminations D/O (F98.21)		Hypersomnolence D/O (G47.10)	
<i>Avoidant/Restrictive Food Intake D/O (F50.8)</i>		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)	
<i>Communication Disorders:</i>		<i>ADHD:</i>	
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)	
<i>Neurodevelopmental Disorder NDD:</i>		<i>Behavior Disorders:</i>	
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
<i>Seizures:</i>		<i>Adjustment Disorder:</i>	
Febrile Seizures		With Depressed Mood	
Petit Mal Seizures		With Anxiety	
Grand Mal Seizures		With Mixed Anxiety and Depressed Mood	
Epilepsy		With Mixed Disturbance	
<i>Anxiety Disorders:</i>		<i>Elimination Disorders:</i>	
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)	
<i>Sensory Deficits:</i>		<i>Intellectual Disability:</i>	
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*):

- | | |
|--|---|
| <input type="checkbox"/> SAT UP | <input type="checkbox"/> CRAWLED |
| <input type="checkbox"/> WALKED ALONE | <input type="checkbox"/> USED SINGLE WORD |
| <input type="checkbox"/> USED TWO-WORD PHRASES | <input type="checkbox"/> USED SENTENCES (3-5 WORDS) |
| <input type="checkbox"/> UNDERSTOOD SIMPLE INSTRUCTIONS | |
| <input type="checkbox"/> WAS ABLE TO HAVE A BACK-AND-FORTH CONVERSATION | |
| <input type="checkbox"/> STARTED RESPONDING TO NAME | |
| <input type="checkbox"/> PLAYED SOCIAL GAMES LIKE (PATTY CAKE OR PEEK-A-BOO) | |
| <input type="checkbox"/> USED GESTURES TO COMMUNICATE | |
| <input type="checkbox"/> WAS TOILET-TRAINED FOR | |
| <input type="checkbox"/> BOWEL | |
| <input type="checkbox"/> 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:

<u>Family Member:</u>	<u>Medical Problem(s):</u>
_____	_____
_____	_____
_____	_____
_____	_____

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 Educa- tion			

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?

- | | |
|----------------------------------|--|
| <input type="checkbox"/> B level | <input type="checkbox"/> Serious emotional/behavioral disorder |
| <input type="checkbox"/> C level | <input type="checkbox"/> Learning Disabled |
| <input type="checkbox"/> D level | <input type="checkbox"/> Communication Disordered |
| <input type="checkbox"/> Mixed | <input type="checkbox"/> 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:

- | | |
|--|---|
| <input type="checkbox"/> suicidal ideation | <input type="checkbox"/> disturbed vision |
| <input type="checkbox"/> temper tantrums | <input type="checkbox"/> impulse control |
| <input type="checkbox"/> excessive fighting | <input type="checkbox"/> noncompliance |
| <input type="checkbox"/> poor organization | <input type="checkbox"/> poor judgment |
| <input type="checkbox"/> learning problems | <input type="checkbox"/> temper control |
| <input type="checkbox"/> hearing difficulties | <input type="checkbox"/> hallucinations |
| <input type="checkbox"/> alcohol/drug abuse | <input type="checkbox"/> poor listening |
| <input type="checkbox"/> poor peer relations | <input type="checkbox"/> running away |
| <input type="checkbox"/> thinking (efficiency) | <input type="checkbox"/> hyperactivity |
| <input type="checkbox"/> difficulty with peers | <input type="checkbox"/> distractibility |
| <input type="checkbox"/> short attention span | <input type="checkbox"/> anxiety/fears |
| <input type="checkbox"/> prefers to play alone | <input type="checkbox"/> bed wetting |
| <input type="checkbox"/> difficulties with the law | <input type="checkbox"/> depression |
| <input type="checkbox"/> concentration problems | <input type="checkbox"/> fire setting |
| <input type="checkbox"/> difficulty making friends | <input type="checkbox"/> headaches |
| <input type="checkbox"/> poor frustration tolerance | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> taste or smell disturbances | <input type="checkbox"/> seizures |
| <input type="checkbox"/> long-term memory problems | <input type="checkbox"/> truancy |
| <input type="checkbox"/> motor coordination problems | <input type="checkbox"/> soiling |
| <input type="checkbox"/> short term memory problems | <input type="checkbox"/> lying |
| <input type="checkbox"/> prefers to play with younger children | |

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:

