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

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).

_____Measles	**_____German Measles**	**_____Mumps**
_____Chicken pox	**_____Tuberculosis**	**_____Hearing problems**
_____Vision problems	**_____Scarlet Fever**	**_____Allergies**
_____Seizures/convulsions	**_____meningitis or encephalitis**	
_____Anemia	**_____Persistent high fever**	**_____Asthma**
_____Poisoning	**_____ 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):		***Sensory Deficits:***	
Celiac disease (K90.0)		Cortical Visual Impairment (CVI)	
Chronic constipation (K59.00)		Periventricular Bleed	
Leaky bowel		Functional Visual Impairment	
Irritable bowel syndrome (K58.0/K58.9)		Hearing Loss	
GERD (K21.0/K21.9)		Chronic Ear Infections	
Acid reflux			
		Seizures:	
Feeding		Febrile Seizures	
Pica (F98.3)		Petit Mal Seizures	
Ruminations D/O (F98.21)		Grand Mal Seizures	
Avoidant/Restrictive Food Intake D/O (F50.8)		Epilepsy	
Other Specified Feeding or Eating D/O			
Unspecified Feeding/Eating D/O (F50.8)		**Elimination Disorders**	
Feeding difficulty (R63.3)		Enuresis (F98.0) Specify: Nocturnal, Diurnal, or both	
Feeding tubes		Encopresis (F98.1) Specify: W/ Constipation and overflow incontinence or w/o constipation and overflow incontinence	
Failure to thrive as newborn (P92.6)		Other Specified Elimination D/O	
Failure to thrive as child (R62.51)		- with urinary symptoms (N39.498)	
		- with fecal symptoms (R15.9)	
Sleep D/O:		Unspecified Elimination Disorder	
Insomnia D/O (G47.00)		- with urinary symptoms (R32)	
Hypersomnolence D/O (G47.10)		- with fecal symptoms (R15.9)	
Obstructive Sleep apnea (G47.3)			
Circadian Rhythm Sleep-Wake D/O (G47.2X)			
Sleepwalking (F51.4)			
Sleep/night terrors (F51.4)			

Unspecified Insomnia D/O (G47.00)			
Unspecified Hypersomnolence D/O (G47.10)			
Unspecified Sleep-Wake D/O (G47.9)			
Communication Disorders		***Intellectual Disability***	
Language Disorder (F80.9)		- Mild (F70)	
Speech Sound Disorder (F80.0)		- Moderate (F80.0)	
Social Communication Disorder (F80.89)		- Severe (F72)	
Expressive Language Disorder (F80.1)		- Profound (F73)	
Mixed Receptive/Expressive (F80.2)			
Childhood-Onset Fluency D/O (Stuttering) (F80.81)		***Neurodevelopmental Disorder (NDD)***	
Unspecified Communication Disorder (F80.9)		Other Specified NDD (F88)	
		Unspecified NDD (F89)	
Developmental Delays:			
Gross Motor Delay		***Obsessive Compulsive D/Os***	
Fine Motor Delay		OCD (F42)	
Lack of Motor Coordination (R27.9)		Trichotillomania (hair pulling) (F63.2)	
Motor Apraxia (R48.2)		Excoriation (skin-picking) (L98.1)	
Developmental Coordination Disorder (F82)		OCD and Related D/O due to Another Med Condition (F06.8)	
		Other Specified OCD (F42)	
Adjustment Disorder		Unspecified OCD (F42)	
With Depressed Mood			
With Anxiety		***Anxiety Disorders***	
With Mixed Anxiety and Depressed Mood		Generalized Anxiety Disorder (F41.1)	
With Mixed Disturbance		Separation Anxiety D/O (F93.0)	
		Specific Phobia (Animal, natural environment Blood-injections, situation, other) (F40….)	
ADHD		Social Anxiety Disorder (F40.10)	
Attention Deficit/Hyperactivity		Panic Disorder (F41.9)	
- Combined presentation (F90.2)		Anxiety D/O due to Medical Condition (F06.4)	
- Predominantly inattentive presentation (F90.0)		Other Specified Anxiety D/O (F41.8)	
- Predominantly Hyperactive/impulsive (F90.1)		Unspecified Anxiety D/O (F41.9)	
---- Specify: Mild, Moderate, Severe			
Unspecified ADHD (F90.8)		**Tic/Movement Disorders**	
Other Specified ADHD (F90.8)		Tourette's Disorder (F95.2)	
		Persistent Motor or Vocal Tic D/O (F95.1)	
Behavior Disorders		Provisional Tic D/O (F95.0)	
Oppositional Defiant D/O (F91.3)		Other Specified Tic Disorder (F95.8)	
Intermittent Explosive D/O (F63.81)		Unspecified Tic Disorder (F95.9)	
Disruptive Behavior D/O or Conduct			

Disorder Unspecified (F91.9)			

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

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?_____

_____

If yes, please describe: _____

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:

____learning problems	**____headaches**	**____temper control**
____poor listening	**____disturbed vision**	**____impulse control**
____short attention span	**____ hearing difficulties**	**____hallucinations**
____difficulties with the law	**____dizziness**	**____alcohol/drug abuse**
____seizures	**____depression**	**____running away**
____hyperactivity	**____noncompliance**	**____poor judgment**
____bed wetting	**____soiling**	**____fire setting**
____lying	**____temper tantrums**	**____truancy**
____difficulty with peers	**____excessive fighting**	**____difficulty making friends**
____poor peer relations	**____ poor organization**	**____anxiety/fears**
____prefers to play alone	**____ prefers to play with younger children**	
____short term memory problems		**____concentration problems**
____long-term memory problems		**____thinking (efficiency)**
____motor coordination problems		**____suicidal ideation**
____poor frustration tolerance		**____taste or smell disturbances**
____distractibility		

What activities does this child enjoy?
Sports: _____

_____

_____

Hobbies: _____

_____

_____

Other: _____

_____

_____

Safety: (*Circle NO or YES)*

Does your child <u>ALWAYS</u> respond to his/her name across <u>ALL</u> 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:

What is your current application status for the Developmentally Disabled Waiver (DD Waiver)? _____

GENERAL COMMENTS

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