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 EVALUATIONS & IEP'S 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

Biological Mother Occupation: _____
Biological Father Occupation: _____

Step-Mother Occupation: _____
Step-Father Occupation: _____

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, &**
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**
_____**Head injuries with loss of consciousness**
_____**Head injuries without loss of consciousness**
_____**Vision problems**
_____**German Measles**
_____**Hearing problems**
_____**Persistent high fever**
_____**Seizures/convulsions**
_____**Meningitis or encephalitis**
_____**Sleep problems (snoring, apnea, etc.)**
_____**Scarlet Fever**

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)	
Un. Lack of Motor Coord. (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 (F50.9)		Sleepwalking (F51.3)	
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 (F90.9)	
Un. 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)	
		Un. Disruptive, I-C, & C D (F91.9)	

Diagnosis	Age	Diagnosis	Age
Seizures:		***Adjustment Disorder:***	
Febrile Seizures		With Depressed Mood (F43.21)	
Petit Mal Seizures		With Anxiety (F43.22)	
Grand Mal Seizures		With Mixed Anxiety and Depressed Mood (F43.23)	
Epilepsy		With Mixed Disturbance (F43.23)	
		W/Disturbance of Conduct (F43.24)	
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 (F41.0)		- 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 (F71)	
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/were there any concerns about the development of this child (circle one)? NO / YES

If yes, explain_____

_____

_____

_____

Does/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** (times per week)	**Duration** (mins/sessions)	**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's 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

Does your child have an Individualized Education Program (IEP)? NO / YES

Please give us a copy of your child's most recent IEP

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

_____

_____

_____

Please list all educational services your child receives:

Service	Hours per week	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
_____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
_____disturbed vision
_____impulse control
_____noncompliance
_____poor judgment
_____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 / N/A**
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: