Piece of Our Puzzle LLC

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**INTAKE ASSESSMENT FORM**

Date of Intake Completion: Click or tap to enter a date.

**Contact Info for Person Completing Form** (must be parent or legal guardian)

Mother’s Name: First name Last name Phone #: Choose an item. Phone #

Father’s Name: First name Last name Phone #: Choose an item. Phone #

Address: Click or tap here to enter text. City: Click or tap here to enter text. Zip: Click or tap here to enter text.

How Did you hear about Piece of Our Puzzle? Choose an item.

What can we help you with? Describe what led you to seek services for your child:

Communication Delays  Social Skills Delays  Behavior Problems  Restrictive Behavior

Difficulties Learning  Developmental Delays Other: List other reasons

**Child’s Information**

Name: Click or tap here to enter text. Child’s Date of Birth: DOB

Address: Click or tap here to enter text.

Siblings: Click or tap here to enter text.

How is the relationship between the siblings if applicable? Choose an item.

**Medical Information**

Diagnosis(es): Autism ADHD/ADD Obsessive Compulsive Disorder Anxiety Seizure Disorder

Other: Insert Other Diagnosis Date of Diagnosis: Click or tap to enter a date.

Who gave diagnosis? Doctor Name Title: Choose an item. Where?: Click or tap here to enter text.

Does your child currently attend a school?  Yes  No

If Yes, indicate school or provider name and frequency of therapies received….

Click or tap here to enter text.

Services Received: Speech- hrs per wk Occupational- hrs per wk Physical- hrs per wk

Feeding- hrs per week Special Instruction- hrs per week

Other: Click or tap here to enter text.

Current Medications: Click or tap here to enter text.

Allergies: Click or tap here to enter text.

Special Diet/Restrictions: Click or tap here to enter text.

**Self-Help Skills Information**

**Describe eating and drinking skills:**

Can feed self finger foods  Can feed self with utensils  Limited food items consumed

Needs assistance to finish food  Drinks from cup  Drinks from straw  Drinks from sippy cup

Describe favorite foods: Click or tap here to enter text.

Describe aversive foods: Click or tap here to enter text.

**Describe sleeping patterns:**

Has difficulty with night time routine  Has difficulty falling asleep  Has difficulty staying asleep  Has difficulty waking up  Takes naps  Is a restful sleeper

Other Comments: Click or tap here to enter text.

**Describe toileting skills:**

Uses diapers  Uses pull-ups at night  Urinates on toilet  Defecates on toilet

Wipes self  Requires help  Is fully independent with toileting

Other Comments: Click or tap here to enter text.

**Describe Verbal Language Skills**:

Requests some items using words  Makes sounds throughout the day

Spontaneously requests at least 5 times an hour  Can label familiar items

Requests at least 5 actions from others  Uses 2 or more words  Requires prompts

Requests at least 15 times in a 30-minute period  Can label at least 10 actions

Fills-in songs  Can state their name when asked  Can imitate words

Has at least a 50 100 200 word vocabulary

Other Comments: Click or tap here to enter text.

**Impeding Behaviors**  Cries  Screams  Hits when told no  inconsolable tantrums

**Describe Listening Skills:**

Responds to name  Follows simple directions  Can go to family members when asked

Can do at least 10 actions when asked  Can identify items by category, i.e. foods, animals

Can pick out items in a book  Can look for an item when asked to

Can show you at least 20 40 60 100 200 items when asked (animals, furniture, toys, etc.)

Other Comments: Click or tap here to enter text.

**Impeding Behaviors**   Unresponsive  Walks away  Doesn’t look  Unintentional

**Describe Play Skills:**

Attends to toys for at least 30 sec  Engages in cause and effect play  Can match items

Explores toys for a minute  Engages in movement play for 2 min  Imitates the actions of others

Shows interest in peers  Follows peers  Parallel play with peers  Searches for missing toys

Plays creatively  Makes requests to peers  Pretend plays  Likes arts and crafts

Can entertain self for 3 5 10 minutes without adult facilitation

Other Comments: Click or tap here to enter text.

**Impeding Behaviors** Fleeting attention Easily distracted Limited interests Possessiveness

**Behavior Assessment:**

Can your child sit with you and do simple activities? Choose an item.

List the top 3 most concerning behaviors your child engages in…

#1 Choose an item. How often does this behavior happen? Choose an item.

#2 Choose an item. How often does this behavior happen? Choose an item.

#3 Choose an item. How often does this behavior happen? Choose an item.

Additional Comments:

List any informational that may be helpful in understanding your child’s individual situation.