Reaching Potentials

Intake Questionnaire

GENERAL INFORMATION:

Today's Date:_____

Scheduled Date for Initial Clinical Consultation or Workshop:_____

Parent/ Guardian Names:_____

StreetAddress:_____Apt_____

City:_____State:_____Zip:_____

Phone #: Home:( )_____ Work:( )_____ Cell:( )_____

Fax: ( )_____ E-Mail:_____

Child's Name:_____ Child's Date of Birth:_____

Diagnosis:_____ Child's Age at Diagnosis:_____

Diagnostician's Name/Title:_____

SIBLINGS- NAMES & AGES:_____

Are siblings also diagnosed ASD or other similar DX?_____

1. When did you realize that there was a problem with your child? _____
Describe your concerns at that time:_ _____
_____
_____
_____

Was there any significant medical event before onset? _____ If yes, explain:

_____
_____

Was birth history normal?_____ If no, explain:_____

_____

_____

2. Did your child have speech and lose it? _____ If yes, please note age when speech was lost_____ and approximate # of words/ phrases your child had:_____
_____

Did your child have any other skills that he/she lost?_____

Describe:_____
_____
_____

3. Has or does your child receive/attend any of the following? Check any that apply:

Private Speech Therapy ____ Diet/Nutrition/Feeding Therapy ____ Physical Therapy ____

Visual Therapy ____ Occupational Therapy ____ Auditory Integration Therapy ____

Allergy Therapy ____ Other_____

Public/ Private School (please describe):_____

Home Programming ABA Therapy: (please describe):

_____
_____
_____

4. Please describe your child's abilities/ traits in the following areas:

a. Speech/ communication: _____
_____

_____

b. Following verbal directions: _____

_____

_____

c. Compliance during adult or teacher directed activities: _____

_____

_____

d. Fine motor and gross motor skills: _____

_____

_____

e. Self stimulatory activities: _____

_____

_____

f. General compliance at home: _____

_____

_____

5. Please list any other information you feel would be helpful at intake.

_____
_____
_____
_____
_____
_____

****

PLEASE ALSO COMPLETE THE ATTACHED PAGES OUTLINING CURRENT SKILL LEVEL AND MEDICAL/BEHAVIORAL HEALTH HISTORY

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Provide original completed form, including the following pages (detailing current skill level and medical/behavioral health history) with a recent photo attached and ***a copy of the original diagnostic report from your child's medical provider*** to:

Reaching Potentials

_____ 10707 Spotsylvania Ave., Suite 101, Fredericksburg, VA 22408-2682

Phone: 540-368-8087 Facsimile: 540-368-8059 Email: info@reachingpotentials.com

MAILING ADDRESS: PO Box 1394, Fredericksburg, VA 22402-1394

Internet: www.reachingpotentials.com

Retain a copy for your files. 2017

PLEASE GIVE US AN EXAMPLE OF YOUR CHILD'S CURRENT SKILL LEVEL:

RELEVANT MEDICAL ISSUES:

Do you feel there is a medical issue which needs to be considered? _____ If so, please give details

_____

LANGUAGE:

How would you describe your child's current language skills? ____Non-Verbal

_____ Spontaneous Conversation _____ Uses some words/ phrases appropriately

_____Echolalic _____Speaks in short sentences _____ Language just emerging

ACADEMICS:

_____ demonstrates skills mostly at pre-school level

_____ demonstrates skills mostly at early primary level (grades K-1)

_____ demonstrates skills mostly at mid primary level (grades 2-4)

_____ demonstrates skills mostly at upper primary level (grades 5-6)

Indicate strongest academic area_____

Indicate weakest academic area _____

Please indicate any area of concern _____

GROSS MOTOR/ FINE MOTOR SKILLS:

At what level (based on chronological age) would you estimate your child:

(Current Age:_____)

Gross Motor: _____below age level _____ at age level _____ above age level

Fine Motor: _____below age level _____ at age level _____ above age level

Please indicate any area of concern_____

SELF HELP & ADAPTIVE SKILLS:

Is your child able to complete the following tasks independently? (yes or no)

_____Feeding/Eating _____Undressing _____Dressing _____Unfastening

_____Fastening _____Toileting _____Bathing _____Grooming(brushing teeth/hair)

BEHAVIORAL ISSUES:

Please indicate any areas of concern and provide details in space provided below:

_____Socialization _____Perseveration _____Self-Injury _____Injury to others

_____Tantrums _____Self-Stimulation _____Compliance _____Other:_____

_____Other:_____ _____Other:_____ _____Other:_____

Details: _____
_____
_____

ARE THERE ANY RECENT CHANGES WHICH YOU FEEL ARE CURRENTLY IMPACTING YOUR CHILD?

_____

_____

PLEASE PROVIDE ANY ADDITIONAL INFORMATION WHICH MIGHT BE HELPFUL:

_____

_____

_____

REACHING POTENTIALS – Medical /Behavioral Health History and Background

Client Name: _____

Date Form Completed: _____

Information provided by: _____

Relationship to client: _____

Mother's Name _____

Natural parent: ____ Step Parent:____ Adoptive Parent: ____ Relative:_____

Father's Name _____

Natural parent: ____ Step Parent:____ Adoptive Parent: ____ Relative:_____

What are you seeking help with?

_____
_____
_____
_____

Presenting Problems (check all that apply):

___Temper outbursts	___Impulsive	___Shy	___Aggression
___Withdrawn	___Stubborn	___Strange behavior	___Abuse***
___Daydreaming	___Disobedient	___Stealing	___Other
___Fearful	___Infantile	___Lying	_____
___Clumsy	___Mean to others	___School trouble	
___Overactive	___Destructive	___Bowel/bladder control	
___Short attention span	___Bed wetting	___Feeding/eating problems	
___Distractible	___Self Injury	___Sleep problems	
___Peer conflict	___Head banging	___Drug/Alcohol use	
___Phobic	___Rocking	___Frequently ill	

Please describe in detail any aggressive behavior or self injury:

*** Please describe & explain abuse: Experienced Abuse ____ Perpetrator of Abuse _____

MEDICAL HISTORY:

Has client ever been hospitalized for illness, physical ailments, emotional problems, etc?

___yes ___no. If yes, please explain (where, when and for what) _____

_____

Any history of infectious disease, past or current? ___yes ___no. If yes, please explain

_____

Has client ever taken, or is he/she currently taking any medications? ___ yes ___ no

If yes, please list medication name and frequency of dosage _____

_____

Does client have any allergies that you are aware of (ie – latex, peanut, soy, etc.)? If yes, please list: _____

Any adverse event associated with immunizations? ____yes _____no. If yes, please explain

Name, address and phone of primary care physician: _____

_____

DEVELOPMENTAL HISTORY

Did mother have any illness or complications before delivery? ___yes___no. If yes, please explain_____

Did mother abuse alcohol or drugs during pregnancy? Y___ N___

Length of pregnancy: _____ Full Term? Y____ N____ Birth Weight ____ lbs ____ oz

Complications at birth? If yes, please explain _____

_____

Did client meet developmental milestones at appropriate age? ____ yes _____ no

SOCIAL HISTORY

Does client attend extracurricular activities? _____ yes _____no If yes, please describe

_____

Does client have friends at school? _____ If yes, how many _____

Does the client have friends outside of school? _____ If yes, how many _____

Please describe any other information which you feel is important or may impact social history

_____

LIVING ARRANGEMENTS:

List all members of your household presently and indicate their relation to client

_____

_____

_____

Present Home: _____house _____apartment

Has client ever been placed, boarded or lived away from family? ____yes ____no

LEGAL BACKGROUND:

Do you have any custody issues or order of protection? If yes, please describe

_____

_____

FAMILY BACKGROUND:

Please indicate any past, present or impending family issues:

____ Deaths :_____

____Divorce: _____

____Abuse: _____

____Injuries/Illness: _____

____Other: _____

Has client, or anyone in your family ever had:

Psychiatric problems (depression, anxiety, psychosis, etc) ___yes ___no ___unsure

Unhealthy alcohol or drug use? ___yes ___no ___unsure

Attempted or contemplated suicide? ___yes ___no ___unsure

Infectious disease? ___yes ___no ___unsure

Please indicate any cultural, spiritual or personal/ family values which may impact treatment:

_____

_____

_____

BEHAVIORAL HEALTH HISTORY:

Any instances of psychiatric / behavioral health concerns, past or present? _____

If yes, please provide details:_____

EDUCATIONAL HISTORY:

Name of school / daycare: _____

Type of classes: _____ regular ____ inclusion ____ exceptional student education

_____other: _____

Does client receive special services at school? ____yes ____no

If yes, which services and what is the frequency/duration of each?

_____ Counseling: _____/week for _____ minute sessions

_____ Occupational Therapy: _____/week for _____ minute sessions

_____ Physical Therapy: _____/week for _____ minute sessions

_____Speech Therapy: _____/week for _____ minute sessions

_____Social Skills: _____/week for _____ minute sessions

_____Other _____: _____/week for _____ minute sessions

OTHER SERVICES:

Does the client receive other private services? _____yes _____no

If yes, which services and what is the frequency/duration of each?

_____ Counseling: _____/week for _____ minute sessions

_____ Occupational Therapy: _____/week for _____ minute sessions

_____ Physical Therapy: _____/week for _____ minute sessions

_____Speech Therapy: _____/week for _____ minute sessions

Any other community services received? _____

OTHER:

Please share any other information which may be of importance or which you wish us to consider in our assessment:

_____

_____

_____

Name of person completing information: _____

Relationship to client: _____ Date: _____