

**ABELS ACADEMY INTAKE FORM**

|  |  |
| --- | --- |
| Today’s Date |  |
| Child’s Name |  |
| Date of Birth |  |
| Gender |  |
| Current Diagnosis (All)and age at time of diagnosis  |  |
| Current School |  |
| Grade Level |  |
| Is there an IEP in place?*\*Please provide us with a copy of the IEP for the last 2 years*Date of last IEP meeting? |  |
| What type of classroom is your child in at school? | □ Mainstream□ Self-contained□ Combination |
| If home-schooled, does your child participate in any co-op opportunities? |  |
| What is your child’s matrix score? |  |
| Describe the special support (if any) your child gets at school |  |
| Language(s) spoken in the home |  |
| Child currently lives with |  |
| Child’s primary caregiver(s) |  |
| Parent’s full name |  |
| E-mail address |  |
| Best contact number |  |
| Parent’s Full Name |  |
| E-mail address |  |
| Best contact number |  |

**Medical History**

If your child’s medical history includes any of the following, please report your child’s age at occurrence, number of occurrences and any other pertinent information.

|  |  |
| --- | --- |
| Allergies |  |
| Asthma |  |
| Childhood diseases |  |
| Seizures(please be specific regarding severity and frequency) |  |
| Other |  |
| Comorbid Conditions |  |

**Current Medications**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of Medication | Dosage and Frequency | For what diagnosis? | Age when medication started | Prescribing Doctor |
| *EXAMPLE:**Vyvance* | *10 mg once a day* | *ADHD* | *4 years* | *Dr. Who* |
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|  |  |  |  |  |

**Allergies**

|  |  |
| --- | --- |
| Food Allergies |  |
| Drug Allergies |  |
| Insect Allergies |  |

**Current Treatment or Intervention**

* Speech Therapy
* Occupational Therapy
* Physical Therapy
* Behavior Intervention
* Psychotherapy

Any assessments? SLP, VBMAPP, ABLES, OT?

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List special things your child likes (sugar cookies, Disney movies, toys, etc.)

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| --- | --- | --- | --- | --- |
| **Edible** | **Tangible** | **Activity** | **Social** | **Other** |
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|  |  |  |  |  |

**Academics and Daily Living**

Answer yes or no where indicated, and mark the appropriate columns.

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| --- | --- | --- | --- | --- | --- | --- |
| **ACADEMIC SKILLS** | **YES** | **NO** | **ONLY w/HELP** | **INDEPENDENTLY** | **Is ability consistent with age? Y/N** | **REFUSES** |
| Read |  |  |  |  |  |  |
| Identify letters |  |  |  |  |  |  |
| Identify numbers |  |  |  |  |  |  |
| Hold a crayon |  |  |  |  |  |  |
| Hold a pencil |  |  |  |  |  |  |
| Cut |  |  |  |  |  |  |
| Color |  |  |  |  |  |  |
| Write |  |  |  |  |  |  |
| Sit in a chair |  |  |  |  |  |  |
| Sit for a story |  |  |  |  |  |  |
| Look when name is called |  |  |  |  |  |  |
| **LIFE SKILLS** | **YES** | **NO** | **ONLY w/HELP** | **INDEPENDENTLY** | **Is ability consistent with age? Y/N** | **REFUSES** |
| Brush Teeth |  |  |  |  |  |  |
| Wipe after toileting |  |  |  |  |  |  |
| Wash in the bath |  |  |  |  |  |  |
| Shower |  |  |  |  |  |  |
| Pick out clothes |  |  |  |  |  |  |
| Dress |  |  |  |  |  |  |
| Undress |  |  |  |  |  |  |
| Tie shoes |  |  |  |  |  |  |
| Use a fork |  |  |  |  |  |  |
| Use a spoon |  |  |  |  |  |  |
| Drink from sippy cup |  |  |  |  |  |  |
| Drink from open cup |  |  |  |  |  |  |
| Additional concerns related to academic or daily living skills |  |

**Sensory Issues**

|  |  |
| --- | --- |
| Does your child have any sensory difficulties? (ie: tactile, visual, auditory, etc)? If yes, please describe |  |
| Describe any sensory seeking behaviors |  |
| Describe any sensory defensiveness behaviors |  |

**Self Injurious Behaviors and Safety Issues / Maladaptive Behaviors**

Does your child self-injure? Examples: Head banging, cutting, self-biting, skin picking? □Yes □No

If so, describe behaviors: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- |
| Safety skill deficits your child has |  |

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| --- | --- |
| Does your child feel pain? |  |
| What are the indicators that your child is in pain? |  |

**Maladaptives**

|  |  |  |
| --- | --- | --- |
| Aggression | Hitting | Pica |
|  | Kicking | Mouthing |
|  | Scratching | Fecal Smearing |
|  | Biting |  |
| Eloping |  |  |
| Self-Injurious Behavior | Skin Picking |  |
|  | Head Banging |  |
|  | Self-Biting |  |
|  | Hair Pulling |  |
|  | Cutting |  |

**Feeding and Nutrition**

|  |  |
| --- | --- |
| Does your child use utensils independently? |  |
| Was feeding your child ever difficult? If so, please explain. |  |
| Does your child have difficulty sucking, chewing or swallowing? Please describe: |  |
| Is your child a picky or fussy eater? |  |

Does your child eat a variety of foods? Please check all that apply.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Soft |  | Chewy |  | Crunchy |  |
| Sticky |  | Pureed |  | Hot |  |
| Cold |  | Meats |  | Breads |  |
| Fruits |  | Vegetables |  | Sour |  |
| Sweet |  | Spicy |  | Dairy |  |

|  |  |
| --- | --- |
| If your child does not eat a variety of foods, please describe their current diet. |  |

**Attending Skills**

|  |  |
| --- | --- |
| How long will your child sit and work on one activity? |  |
| What does your child do if requested to complete a non-preferred activity? |  |

**Transitions**

|  |  |
| --- | --- |
| In general, how does your child transition from one activity to the next? |  |
| Does your child transition cooperatively from preferred activities to non-preferred activities? If not, what happens? |  |
| How does your child respond to changes in the environment or routine? |  |
| Does your child insist on routines? |  |
| Does your child engage in behaviors when things change, are out of order or otherwise different? Please describe behaviors. |  |

**Narrow or Limited Interests**

|  |  |
| --- | --- |
| Does your child have limited interest in things? (only plays with one toy, watches same move, eats only certain food) Please specify. |  |

**Stereotypical Behaviors**

|  |  |
| --- | --- |
| Does your child engage in repetitive behaviors such as spinning, hand flapping, echoing things heard, staring at lights, flicking fingers in front of eyes? If so, what are those behaviors? |  |

**Play Skills**

|  |  |
| --- | --- |
| Describe your child’s play skills. What is played with?  |  |
| Are toys played with as their intended purpose? |  |
| Who does your child play with?  | □ Adults □ Children □ Alone |
| Describe how your child interacts with adults. |  |
| What does your child’s interaction look like when playing with other children? |  |
| What are your child’s favorite toys and/or play activities? |  |
| Describe how your child plays with their favorite toys |  |

**Communication Development**

|  |  |
| --- | --- |
| When you talk to your child, how much do you feel is understood? | □ A few words □ Many words and phrases□ Simple directions and questions □ Almost everything I say |
| How does your child communicate wants and needs?Check all that apply | □ Cries □ Points □ Signs □ Pulls toward object□ Gestures □ Vocalizes sounds □ Uses single words□ Uses many words but only one at a time □ Uses phrases □ Uses long sentences |
| How does your child gain attention? |  |
| Does your child answer when you call? |  |
| Does your child answer yes/no and “wh” questions? |  |
| Does your child ask for help? |  |
| Does your child talk about what he/she is doing |  |
| What does your child like to talk about? |  |
| Does your child get stuck on a favorite topic or insist on only talking about what he/she wants to talk about? |  |
| What percentage of your child’s speech do you understand? |  |
| Can people outside the family understand your child’s speech? |  |
| Does your child stutter or stammer? |  |
| Did you ever notice a change in your child’s behavior, language, or social skills? If so, please describe the change and when it occurred. |  |
| Does your child’s communication difficulty cause frustration? |  |

**Concerns**

Please describe concerns regarding the areas listed below.

|  |  |
| --- | --- |
| Speech |  |
| Behaviors |  |
| Feeding |  |
| Play |  |
| Following directions |  |
| Social development |  |

|  |  |
| --- | --- |
| When did you first notice the difficulty/difficulties listed on the previous page?  |  |
| Has the problem changed since you first noticed?  |  |
| Is your child aware of the problem? |  |
| What have you done to help your child with these difficulties? |  |
| How do his/her peers and teachers react to the communication difficulty? |  |

|  |  |
| --- | --- |
| Completed by (print first and last name) |  |
| Signature: |  |
| Date: |  |
| Relationship to child: |  |

I certify that the information provided on this application is accurate. I understand that withholding of information or giving false information may negatively impact my child’s treatment plan or may result in termination of services.

|  |  |
| --- | --- |
| Signature: |  |
| Date: |  |