JumpStart Autism Center

8500 Washington St. NE Ste A1
Albuquerque, NM 87113 | 369 Inverness Pkwy Ste 375
Englewood, CO 80112 | 1817 Wellspring Ave SE Ste D
Rio Rancho, NM 87124

A Behavioral Health Center of Excellence

INTAKE QUESTIONNAIRE

*****Please bring to the evaluation any psychoeducational or developmental evaluations, IEPs, and/or other reports that will provide helpful information.*****

Child's Full Legal Name: ______________________________

Date of Birth: ______________ **Age:**________ **Gender:** ______

Parental Information:

Mother's Name: ______________________________
Address: ______________________________
City: ______________State: ____Zip: ________
Cell Phone: ____________Home Phone: ____________
Work Phone:____________
Email: ______________________________

Father's Name: ______________________________
Address: ______________________________
City: ______________State: ____Zip: ________
Cell Phone: ____________Home Phone: ____________
Work Phone:____________
Email: ______________________________

Primary language spoken at home? ______________________
List all other languages spoken at home: ______________________

Person completing this form:____________________ **Date completed:** ________

Who has primary custody of this child?
☐ Mother ☐ Father ☐ Both ☐ Someone else: ____________________

If parents do not both live with the child, is there a legal agreement in place regarding decision-making power? ☐ Yes ☐ No
If yes, please explain: ______________________________

Does the parent who does not live with the child full-time have parental rights/decision-making power? ☐ Yes ☐ No
If yes, please explain: ______________________________

Who were you referred by? ______________________________

Most recent diagnosis: ______________________________
Who made this diagnosis and when?______________________
Who is this child's Primary Care Physician?______________________
Primary Care Physician phone number: ______________________

Reason for Referral (why is help being sought for this child?)

1. ____

____

2. ____

____

3. ____

____

What do you expect to gain from consultation, assessment, or therapy and behavioral services for this 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: ______

Parental Marital Status:

☐ 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, has the parent who does not live with the child had his/her parental rights terminated? ☐ Yes ☐ No

If yes, please explain: ____

How often does the other parent see this child?

☐ Weekly or more often ☐ Once or twice per month
☐ Few times per year ☐ Never

Approximate Parental Income Level:

☐ 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
☐ Drug(s): Please describe type(s) of drug(s), frequency of use, & when used during pregnancy: ____
____
____

Please check any of the following that this child has had and indicate age (year/month):

☐ Mumps ☐ Vision problems
☐ Measles ☐ German Measles
☐ Anemia ☐ Hearing problems
☐ Asthma ☐ Persistent high fever
☐ Allergies ☐ Seizures/convulsions
☐ Poisoning ☐ Meningitis or encephalitis

☐ Chicken pox ☐ Sleep problems (snoring, apnea, etc.)
☐ Tuberculosis ☐ Scarlet Fever
☐ 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):

____
____
____
____

Any known genetic disorders? ☐ **No** / ☐ **Yes**

If yes, please explain: ____
____
____

MEDICAL SERVICES

Have people raised a concern about ASD for this child? ☐ **NO** / ☐ **YES**

If yes, Who:______________________________ When:________________

Has this child ever experienced a developmental regression? ☐ **NO** / ☐ **YES**

If yes, please explain: ____
____
____

Has this child experienced a *recent* developmental regression? ☐ **NO** / ☐ **YES**

If yes, please explain: ____
____
____

Does this child have any known allergies, food and/or environmental? ☐ **NO** / ☐ **YES**

If yes, please explain: ____
____
____

Is this 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 this child's last well check-up/annual physical? **Date:**____________________

When was this child's last dental cleaning/check-up? **Date:**____________________

When was this child's last vision check? **Date: ___________________**

Result:

☐ Passed
☐ Uses Corrective Lenses
☐ Needs corrects lenses but does not have them yet
☐ Vision cannot be fully corrected with lenses (blind/legally blind).

When was this child's last hearing check? **Date:___________________**

Result:

☐ Passed
☐ Uses Hearing aids
☐ Needs hearing aids but does not have them yet
☐ Hearing cannot be fully corrected even with hearing aids (deaf/partially deaf)

Please list all providers and specialists this child has seen or currently sees through their private insurance, Medicaid, or private pay; please do not include Early Intervention or school services here.

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 Thera-pist			
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)	
Diagnosis	**Age**	**Diagnosis**	**Age**
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)	
Diagnosis	**Age**	**Diagnosis**	**Age**
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)	
Diagnosis	**Age**	**Diagnosis**	**Age**
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)	
Diagnosis	**Age**	**Diagnosis**	**Age**
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)	
Diagnosis	**Age**	**Diagnosis**	**Age**
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 this child's development and why?

____

____

Approximate age at which this child did the following *(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 this child ever lost or regressed in any of these skills? ☐ **NO** / ☐ **YES**

If yes, please describe what happened: ____

____

____

Does this child have sensory sensitivities -- either love or hate – to certain sounds, sights, textures, smells, tastes, and/ or touch? ☐ **NO** / ☐ **YES**

If yes, please explain: ____

____

____

Are/were there any concerns about the development of this child? ☐ **NO** / ☐ **YES**

If yes, please explain: ______________________________

____

____

Does/did your child have any problems in learning to speak or understand language? ☐ **NO** / ☐ **YES**

If yes, did your 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 grand-parents:

Diagnosis	Maternal Side	Paternal 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 your child's family members, including immediate family, cousins, aunts, uncles or grandparents, have any other medical problems:

Family Member(s): ______________________ **Medical Problem(s):** ____

______________________ ____

______________________ ____

______________________ ____

SCHOOL HISTORY

Does or did your child attend daycare? ☐ **NO** / ☐ **YES**

If yes, at what age?____________________

How much time was spent attending daycare?

______hours per day

______days per week

Any problems in daycare? ☐ **NO** / ☐ **YES**

If yes, please describe ____

____

____

Does or did your child attend preschool? ☐ **NO** / ☐ **YES**

If yes, at what age?____________________

How much time was spent attending preschool?

______hours per day

______days per week

Any problems in preschool? ☐ **NO** / ☐ **YES**

If yes, please describe ____

____

____

Does or did your child attend kindergarten? ☐ **NO** / ☐ **YES**

Any problems in kindergarten? ☐ **NO** / ☐ **YES**

If yes, please describe ____

____

____

Has your child ever repeated a grade? ☐ **NO** / ☐ **YES**

If yes, which grade(s): ____

Has your child skipped a grade in school? ☐ **NO** / ☐ **YES**

If yes, which grade(s): ____

If your child is of school age, please complete the following:

Current school placement type:

☐ Public ☐ Private ☐ Home School ☐ Other: ______________________

Name of current school: ____________________________________ **Grade:**____________

Name of current teacher(s): ____

Type of classroom settings (*check all that apply):*

☐ General education ☐ Special Education ☐ Other: ________________

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	**hrs/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 your child have any difficulty with reading? ☐ **NO** / ☐ **YES**

If yes, explain: ____

____

____

____

Does or did your child have any difficulty with math? ☐ **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? ☐ **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:

____

____

____

____

____

Does your child participate in any play groups, sports, or other activities?

☐ **NO** / ☐ **YES**

If yes, please describe: ____

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 ☐ disturbed vision
☐ temper tantrums ☐ impulse control
☐ excessive fighting ☐ noncompliance
☐ poor organization ☐ poor judgment
☐ learning problems ☐temper control
☐ hearing difficulties ☐ hallucinations
☐ alcohol/drug abuse ☐ poor listening
☐ poor peer relations ☐ running away
☐ thinking (efficiency) ☐ hyperactivity

☐ 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
☐ distractibility
☐ anxiety/fears
☐ bed wetting
☐ depression
☐ fire setting
☐ headaches
☐ dizziness
☐ seizures
☐ truancy
☐ soiling
☐ lying

What activities does this child enjoy?

Sports:____
____
____

Hobbies:____
____
____

Other:____
____
____

SAFETY (*please select 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**

If yes, please describe: ____

____

Is your child able to wash his/her hands independently? ☐ **NO** / ☐ **YES**

Is your child daytime toilet trained for: Bladder? ☐ **NO** / ☐ **YES** **Bowel:** ☐ **NO** / ☐ **YES**

Is your child nighttime toilet trained for: 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? ☐ **NO** / ☐ **YES**

If yes, please explain: ____

____

____

____

____

Has this child ever been removed from the home because of neglect or abuse? ☐ **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? **☐ 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? **☐ NO / ☐ YES**

If yes, please explain:

Has this child or family ever received professional mental health treatment, such as counseling or psychotherapy? **☐ 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 add any additional information that you would like to include in this questionnaire that has not already been addressed: