ABELS ACADEMY INTAKE FORM

Today's Date	
Child's Full 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?	
Does your student have any scholarships?	
What is your child's matrix score?	
Describe the special support (if any) your child gets at school	
What insurance is your child covered under?	
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*

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?

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

Edible	Tangible	Activity	Social	Other

Academics and Daily Living

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

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: _____

_____

_____

Safety skill deficits your child has	

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:	