Date of initial contact: _____

Pacific Northwest Autism

4152 Meridian Street #105-146 Bellingham, WA 98226

360-348-6414

Intake Form

(will be completed within 10 days of referral unless otherwise documented)

Child's Name: _____ Date of Birth: _____

Diagnosis:

_____

Evaluator who made diagnosis:

_____

Date of Diagnosis: _____

Location/Facility:

_____

Concerns:

_____

Insurance Information:

_____

Insurance Carrier:

_____

ID Number:

_____

Subscriber:

_____

Subscribers DOB: _____

Place of Employment:

_____

Parent Information

Mother's Name:_____ **Father's Name:**_____

Mother's Education:

_____

Father's Education:

_____

Mother's Occupation:

_____

Father's Occupation:

_____

Home Address:

_____

home / mobile phone:

_____

work:

_____

email: _____

Siblings / Ages:

_____

Caretakers:

_____

Other people living in the home:

_____

What language is spoken in the home?

_____

Referred to PNWA by:

_____

Chief Problem or concern:

_____

What do you hope to gain from this consultation?

_____

_____

<u>Current School Placement</u>

Present Grade: _____ Has your child repeated a grade? Y/N

Name of School:

_____

School Address:

_____

School Contact Person:

_____

Teacher:

_____

Phone Number:

_____

Teacher assistant or one-to-aide:

_____

May we collaborate with your child's Teacher to coordinate care? Y/N

ABA (Applied Behavior Analysis) Instructor or Behavior Therapist:

_____

May we collaborate with your child's Behavior Therapist to coordinate care? Y/N

Behavior Analyst or Specialist:

_____

May we collaborate with your child's Behavior Analyst to coordinate care? Y/N

Number of hours of ABA per week: _____

Number of hours of consultation per week: _____

Occupational Therapy Services (per week): _____

May we collaborate with your child's Occupational Therapist to coordinate care? Y/N

Physical Therapy Services (per week): _____

May we collaborate with your child's Physical Therapist to coordinate care? Y/N

Speech Language Services (per week): _____

May we collaborate with your child's SLP to coordinate care? Y/N

Pediatrician/PCP: _____

May we collaborate with your child's PCP to coordinate care? Y/N

On an <u>average school day,</u> how much time does your child spend:

- **Doing homework (if applicable)? _____ Alone? _____ With your help? _____**
- **Socializing with peers? _____ family members? _____ With other adults? _____**
- **Watching TV? _____ Using computer (non-academic)? _____**
- **Reading for pleasure (or being read to)? _____**

Has your child been evaluated under Chapter 766 (Core Evaluation)? Y/N *If yes, please include a copy of all Individualized Educational Programs (proposed and/or accepted)*

Has an independent evaluation been conducted? Y/ N *If yes, please include a copy of the assessment.*

Evaluator: _____

Date of Evaluation: _____

<u>Communication</u>

How does your child communicate?

_____

_____

1. Does he/she show an interest in other people (peers/adults)? Y/N

2. Will he/she engage in other activities with people (peers/adults)? Y/N

3. What types of activities will/she engage in with other people (peers/adults)? Y/N

<u>Play Behavior</u>

1. Will he/she play independently? Y/N

2. What toys will he/she play with? Y/N

3. How long will he/she independently play with toys? Y/N

Daily Routine

Please describe your child's regular schedule (including naps):

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7:00 – 8:00							
8:00 – 9:00							
9:00 – 10:00							
10:00 – 11:00							
11:00 – 12:00							
12:00 – 1:00							
1:00 – 2:00							
2:00 – 3:00							
3:00 – 4:00							
4:00 – 5:00							
5:00 – 6:00							
6:00 – 7:00							
7:00 – 8:00							

Self Help Skills

Eating:

Dressing:

Bathing:

Toilet:

Behavior

Aggression/Injury to others:

Stereotype (any repetitive movement without apparent purpose):

Self Injurious Behavior including suicidal behavior or thoughts:

Other Maladaptive Behavior:

Has your child ever received psychotherapy or counseling? Y/N ***If yes, why?***

Have you ever worked with a behavioral consultant? Y/N ***If yes, please give the name(s) of the consultants:***

Please describe the child's strengths:

Please describe the child's weaknesses:

Is your child on any medication? (Please list):

<u>Developmental History</u>

Pregnancy:

Infancy:

Feeding Problems?

Sleeping Problems?

<u>Developmental Milestones</u>

Sat at age: _____

Walked at age: _____

Smiled at age: _____

Spoke in two-word phrases at age: _____

Do you have a current Developmental Assessment? Y/N ***If yes, please attach***

Family History

Please list family members/relatives with academic problems (e.g. reading, mathematics, spelling, etc.) and the types of problems:

Please list family members/relatives with behavioral problems (e.g. overactive, withdrawn, trouble with the law, aggressive behavior, etc.):

Please list family members/relatives with psychiatric problems including self harm or suicide (e.g. depression, schizophrenia, etc.)

Please list family members/relatives with neurological problems (e.g. seizures, mental retardation, etc.)

Any History of pathological gambling with the child or family? Y/N ***If Yes, please explain***

Are there any legal issues impacting the family?

Are there any recent changes in family dynamics (new siblings, divorce or separation etc)?

Are there any religious or cultural beliefs in your household you would like us to be aware of?

Is the child court ordered for treatment? Y/N ***If yes, please explain:***

Child's Health

Please describe the child's general health:

Please describe the parent's general health:

Does your child have any specific medical problems?

Serious Illness?

History of seizures/convulsions?

Operations?

Other Hospitalizations?

Allergies and reactions?

Sensitivities?

Ear Infections?

Visual Problems?

Diet Restrictions?

Self Harm or Suicide?

Substance Abuse Concerns (including tobacco) / History for Child or Family?

Is the child or any family member under the supervision of the Department of Corrections? Y/N

Any Concerns or history about depression in your child?

Please feel free to note any other concerns below:

I have read and understand the terms of the Informed Consent and Consent to Treatment.

I have received the information packet on Autism.

Signature	**Date**
Name	**Name of Child**

OBSERVATION (to be completed by BCBA)

Instructions: Set the timer for 20 minutes for each observation. Observation 1 should be during a structured activity that is not preferred and is the parent's choice such as a chore, homework, etc. Observation 2 should be during a leisure activity. If challenging behavior occur red at any point during the 1-minute interval record "yes" and if no behavior occurred record "no." If the child was off- task at any point during the 1-minute interval record "yes" and if there were not off task during the interval record a "no."

Observation 1 **Date:** **Time:** **Activity:**

People present:

Minute	**Challenging Behavior?**		**Off-Task?**	
1	Yes	No	Yes	No
2	Yes	No	Yes	No
3	Yes	No	Yes	No
4	Yes	No	Yes	No
5	Yes	No	Yes	No
6	Yes	No	Yes	No
7	Yes	No	Yes	No
8	Yes	No	Yes	No
9	Yes	No	Yes	No
10	Yes	No	Yes	No
11	Yes	No	Yes	No
12	Yes	No	Yes	No
13	Yes	No	Yes	No
14	Yes	No	Yes	No
15	Yes	No	Yes	No
16	Yes	No	Yes	No
17	Yes	No	Yes	No
18	Yes	No	Yes	No
19	Yes	No	Yes	No
20	Yes	No	Yes	No

Observation 1 **Date:** **Time:** **Activity:**

People present:

Minute	Challenging Behavior?		Off-Task?	
1	Yes	No	Yes	No
2	Yes	No	Yes	No
3	Yes	No	Yes	No
4	Yes	No	Yes	No
5	Yes	No	Yes	No
6	Yes	No	Yes	No
7	Yes	No	Yes	No
8	Yes	No	Yes	No
9	Yes	No	Yes	No
10	Yes	No	Yes	No
11	Yes	No	Yes	No
12	Yes	No	Yes	No
13	Yes	No	Yes	No
14	Yes	No	Yes	No
15	Yes	No	Yes	No
16	Yes	No	Yes	No
17	Yes	No	Yes	No
18	Yes	No	Yes	No
19	Yes	No	Yes	No
20	Yes	No	Yes	No

To Be Completed By BCBA:

Treatment Recommendations including crisis plan:

_____

_____

_____