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Client Intake Form

Discovery Behavior Solutions requires a comprehensive assessment for each client served. The Client Intake Form will ensure that all required areas of assessment have been met and that your assessment is inclusive of all pertinent information.

CLIENT INFORMATION

Child's Name: _____ DOB ___/___/____ Age: _____ Sex: M☐F☐ Legal status: _____

Address: _____ Date of Assessment _____/___/____ Diagnosis: _____ Sponsor SSN: _____

PARENT INFORMATION

Parent 1 Name:_____ Parent 2 Name:_____

Best way to contact:_____ Best way to contact:_____

Emergency Contact Information

Name:_____ Phone number:_____ Relationship to client: _____

REFERRAL INFORMATION

Reason for Referral to Treatment/Presenting Problem:_____

HEALTH INFORMATION

DSM V Diagnoses:
(Please include the name of the diagnosing clinician and/or practice as well as the date the diagnosis was given)

Axis I:
Axis II:
Axis III:
Axis IV:
Axis V:

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List names and addresses of other medical/behavioral health professionals involved with the client (pediatrician, counselor, other service providers, etc.)

Name Address Phone

1. _____

2. _____

3. _____

4. _____

List all current medical conditions:

_____

_____

_____

Provide client's medical history (including conditions, treatment dates, name of clinician, therapeutic interventions and responses, sources of clinical data, results of laboratory tests and consultation reports):

_____

_____

_____

List history of all hospitalizations/operations:

_____

_____

_____

Is the client currently on any Medications? YES ☐ NO ☐

Medication	Dosage	Assignment	Indications	Date Prescribed

Regularly scheduled lab work required? YES ☐ NO ☐

Allergies to medication /other substances? YES ☐ NO ☐ If yes, please explain: _____

List any recently discontinued medications, including reason for discontinuation: _____

Does the client have seizures? YES ☐ NO ☐

If Yes, Please indicate the frequency, length, type of seizures _____

If no, has the client had seizures in the past? YES☐NO☐

If Yes, Please indicate the frequency, length, type of seizures _____

For clients under the age of 12:
Has the child been exposed to the following in his or her environment? ☐Tobacco ☐Marijuana ☐Drug use ☐Moderate-Severe alcohol use

For clients over the age of 12:
Does the client/has the client used Drugs/Alcohol (includes Nicotine) YES☐NO☐
If yes, please explain (substance, frequency, level of consumption): _____

Does the client/has the client engaged in problem and pathological gambling behaviors? YES☐ NO☐
If yes, please explain:_____

Is this individual under the supervision of WA State Department Of Corrections? YES☐ NO☐
Name of Probation Officer:_____

Is there a court-ordered parenting plan (if Yes, please include provide a copy) YES☐ NO☐

Is client under civil or criminal court-ordered mental health or chemical dependency treatment? YES☐ NO☐
If yes, please explain:_____

Is there a court order exempting the individual from reporting requirements? YES ☐ NO☐
If yes, please explain (a copy of court order must be supplied):_____

Does the client or family report any infectious disease (this information is confidential)? YES☐ NO ☐

If yes, please list: _____

What precautions are currently being taken to prevent the spread of the disease? _____

Are there any medical conditions that need to be considered when delivering therapy? YES☐ NO ☐

If yes, please explain: _____

Are there any psychological and/or social conditions that need to be considered when delivering therapy? YES☐NO☐

If yes, please explain: _____

Does the client have any allergies? YES NO Allergies: _____

Is the client on a special diet? YES NO If yes, please describe: _____

If client requires any other special consideration during treatment not yet listed, please describe in detail (physical limitations, visual deficits, hearing deficits, learning deficits, etc.):

_____

_____

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Client responds best to:

☐Verbal Instruction ☐Demonstration ☐Written Instruction ☐Visual cues/Picture Icons

Client's preferred language: _____ Translation Services Requested? YES☐NO☐

SOCIAL, FAMILY, & DEVELOPMENTAL BACKGROUND

Siblings (list names and ages): _____

Other people living in home (list names and ages): _____

Do family members/caregivers require special consideration during treatment due to special needs (i.e. physical limitations, visual deficits, hearing deficits, learning deficits, etc.)?

_____

Family/Caregiver primary language: _____ Translation Services Requested? YES☐NO☐

Family/Caregiver's preferred method of instruction (for parent/caregiver training):

☐Verbal Instruction ☐Demonstration ☐Written Instruction

Describe the extent of family involvement (role/responsibilities of various family members in care of client as well as information indicating to what extent family members are capable of being involved):

_____

_____

Are parents of the client married, separated or divorced? If separated or divorced, what are the custody arrangements? Have there been any issues with custody arrangements?

Please describe: _____

Is there a history of any significant medical conditions within the family? YES☐NO☐

If yes, please explain: _____

Is there a history of mental illness/substance abuse within the family? YES☐NO☐

If yes, please explain: _____

Are there any legal concerns pertaining to the client or family that are relevant to treatment? YES☐NO☐

If yes, please explain: _____

Does the family have any cultural, spiritual, or religious beliefs that influence the client? YES☐NO☐

If yes, please explain: _____

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Basic Developmental Information

Were there any complications during pregnancy or birth? YES☐NO☐

If yes, please explain: _____

At what age did the client…. sit alone? _____ crawl? _____ walk unassisted? _____ become potty trained?_____

Is the client toilet trained? YES☐NO☐

Are there any feeding issues? YES☐NO☐If yes, please explain _____

Does the client dress him/her self completely, partially, or not at all?_____

Summary of Developmental History (including physical, psychological, social, intellectual/academic):

_____

_____

_____

Speech and Language Development

Is the client verbal? YES☐NO☐ Age of first words? _____ Speech and language problem first noticed at what age? _____

How does the client most often communicate? ☐VERBAL ☐SIGNS ☐PECS ☐AUGMENTATIVE DEVICE ☐OTHER: _____

Describe client's approach to communicating the following (this may include motoric, gestural, vocalization, sign language, use of objects, use of photos, etc.):

Request attention: _____

Request to terminate a non-preferred activity: _____

Request a preferred item: _____

Request for others to perform a specific action: _____

Indicate physical pain: _____

Indicate confusion/need for help: _____

Reject a specific item/situation: _____

Indicate Hunger/Thirst: _____

Indicate Fatigue: _____

Does the client follow verbal instructions without visual cues? YES☐NO☐

Is the client currently receiving speech therapy? YES☐ NO☐ If yes, where? _____

Educational Information

Does the client attend school? YES☐ NO☐

What is the name of the school? _____

What type of program does the client attend? _____

Grade: _____ % of General vs. Special Education: _____

Does the client have an aid/shadow while attending school? YES☐ NO☐

If yes, is the aid/shadow with the client full or part time? _____

Is there a current IEP? (If so, please obtain a copy) YES☐ NO☐

Is the family satisfied with the client's educational program? _____

Therapies, Services, Community Resources

Has the client received ABA Therapy in the past? YES ☐ NO ☐

If yes, please provide agency/provider information/interventions used/client's response to treatment:

_____

_____

Please check other services that the client is *currently* receiving.

☐Early Intervention Services ☐Speech and/or Language Therapy ☐Occupational and/or Physical Therapy

☐Vision Services ☐Hearing Services ☐Respite

☐ABA/Verbal Behavior Therapy ☐Aide/Paraprofessional assistance in school ☐Feeding Therapy

☐Other (list) _____

Is the client or family utilizing any community-based resources? YES ☐ NO☐
If YES, please list:

_____

_____

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PSYCHOSOCIAL INFORMATION: Client/Family Goals & Input

Does the client/family have additional needs that they are requesting be considered when delivering treatment? YES NO
If yes, please explain:

_____

_____

What are the client's immediate goals for him/herself and/or family's immediate goals for the client?

_____

_____

What are the client's long-term goals for him/herself and/or family's long-term goals for the client?

_____

_____

Questions/Concerns: _____

_____

Client's Schedule

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Parents/Caregiver's Schedule

(for parent/caregiver training purposes)

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

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ADDITIONAL NOTES

Language Skills

Social Skills

Behavior Concerns

CLINICAL/BEHAVIORAL OBSERVATIONS

Signature, credentials, and date of MPH completing and reviewing the Intake Forms:

Signature Credentials Date