Santiago & Friends | Family Center for Autism

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Initial Intake

Today's Date: _____ Client Code: _____

Part I:

Client's Name: _____

Date of Birth: _____ Age: _____

Gender: M or F

Current diagnosis (all)	Age at time of diagnosis
_____	_____
_____	_____
_____	_____

Home Address: _____

Language(s) used in the home: _____(primary) / _____(secondary)

Client presently lives with: _____

_____

Client presently attends (school/ grade/ type of classroom):

_____

Client if presently available (write days/ times – ex. MWF 2:30-5pm, T 4-6pm)

_____

_____

Parent/Guardian (1) Full Name: _____Date of Birth: _____

Home Address (if different from client): _____

Occupation: _____

E-mail address: _____

Home Phone: _____

Business Phone: _____

Cell phone: _____

Parent/Guardian (2) Full Name: _____Date of Birth: _____

Home Address (if different from client): _____

Occupation: _____

E-mail address: _____

Home Phone: _____

Business Phone: _____

Cell phone: _____

Siblings: Name Date of Birth School and grade

1. _____

2. _____

3. _____

4. _____

5. _____

List those authorized to pick-up client. Name: _____ DL #: _____

Method of payment for services (insurance or self-pay): _____

Secondary method of payment (insurance or self-pay): _____

How did you hear about Santiago & Friends? _____

Are there any legal custody or court orders related to the child that we need to be aware of? If yes, please provide information and related documentation: _____

_____

_____

Part II:

Name of Current Medications	Dosage and Frequency	Purpose	Month/Year Medication Started	Prescribing Doctor
i.e. Vyvanse	*10 mg once a day*	*Increase appetite*	*3/2014*	*Dr. Who*

List any medical conditions that may become evident during scheduled sessions (i.e. allergies, asthma, seizures, etc.) and if applicable, procedures to follow (i.e. use of EpiPen):

_____

_____

_____

Previous and Current Therapy: When/ Where/ How long?

Speech Therapy: _____

Occupational Therapy: _____

Physical Therapy: _____

Applied Behavior Analysis: _____

Mental Health Therapy: _____

Other: _____: _____

Does the client engage in behaviors that can escalate to harming himself/ herself or others? Yes/ No
Describe: _____

_____

_____

_____

_____

Please describe the most challenging behaviors displayed by the client (ex. Those that are causing the most stress to the family, those that are interfering with the client's academic and social development):

_____

_____

_____

_____

_____

Please describe the most important skills the client is lacking in order to continue with his/her development (ex. Safety awareness, independent functioning, verbal skills). **Please include, if your child requires potty training:** _____

_____

_____

_____

_____

Please describe what your child's greatest strengths are:

_____

_____

_____

_____

_____

Any additional information you would like us to be aware of? _____

_____

_____

_____

_____

_____

Completed by: _____ _____ _____

Print First and Last Name **Signature** **Date**

Relationship to Client: _____