Santiago & Friends | Family Center for Autism

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Initial Intake

Date of Completion:_________________________ Person Completing: _________________________

Client's Name: ____

Date of Birth: ______________________________ Age: ____________________ Gender: M or F

Home Address:____

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

How did you hear about us? ____

Availability for ABA Services *(N/A for Santiago & Friends Academy. Students will receive ABA during school hours if a client of Santiago & Friends)*:

Available Days/Times

Monday	Tuesday	Wednesday	Thursday	Friday

- 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: _______________________________________

Client presently lives with: _________________________

Please answer the following if parents are divorced/ separated/ never married:

List the amount of time with each parent:

Mother:___________________________________ Father: ___________________________________

Other Family: ___________________________________

Are there any legal custody or court orders related to the child that we need to be aware of?

___yes_____no

Santiago and Friends requires a copy of divorce decree or child custody agreement to be on file.

Siblings: **Name** **Date of Birth** **School and grade**

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Reason for Referral

List your reasons for seeking services, your main concerns. This can include medical issues, problem behaviors, skill deficits, etc.

____

____

____

Does you child require toilet training?_____yes _____no

Medical Issues:

Pregnancy

Did the mother develop any medical conditions before or during pregnancy?

____

____

____

Were there any complications during your child's birth?

____

____

____

CURRENT DIAGNOSES

Diagnosis	Age at time of diagnosis	Doctor

Milestones:

Please indicate at what age your child reached the following developmental milestones

Sitting up: ______________________ Crawling:________________________

Walking:________________________ Talking: _________________________

CURRENT MEDICATIONS

Medication	Doseage	Physician	Purpose

Do any of these medications have effects on the child's behavior? If so, what effects?

____

____

____

Programs and Services: Please list all *current and past* programs and services.

Document Review: We require copies of any past evaluations, IEPs, 504s, etc.

Does your child have an IEP/504?_____yes _____no

Does your child have a speech/occupational/physical evaluation?____yes_____no

Educational Programs (include school/ grade/ type of classroom/ how many kids per teacher):

School:____Grade: ____________________

Type of classroom:______________________Teacher to student ratio: ____________________

Therapeutic Services (name of company/ how often per week/ start & end date):

Speech Therapy: ____

Occupational Therapy: ____

Physical Therapy: ____

Applied Behavior Analysis: ____

Mental Health Therapy: ____

If therapies were discontinued, please state why below:

____

____

____

Additional medical or physical problems:

Diagnosis	Y/N	Description
Gastrointestinal problems		
Allergies		
Ear infections		
Sinus infections		
Headaches		
Other:		

Communication Skills:

How does your child communicate his or her needs (check all that apply)?

Words	Signs	Gestures	Other (please describe)

If your child does not easily use words to communicate, please briefly summarize your child's language abilities (known words, known sounds, amounts of words said each day, etc.).

____

____

____

Problem Behaviors: Please list and fill in descriptions for problem behaviors your child exhibits (tantrums, aggressions, defiant behavior, elopement-running away, etc.)

Behavior	Description	Frequency	Duration	Severity
		Hourly____ Daily ___ Weekly ___	Seconds___ Minutes___ Hours ___	High Medium Low

		Hourly____ Daily ___ Weekly ___	Seconds___ Minutes___ Hours ___	High Medium Low

		Hourly____ Daily ___ Weekly ___	Seconds___ Minutes___ Hours ___	High Medium Low
		Hourly____ Daily ___ Weekly ___	Seconds___ Minutes___ Hours ___	High Medium Low

Does the client engage in behaviors that can escalate to harming himself/herself or others (ex. Bite him/herself, hit his/her head, throw items, etc.)? If yes, please describe.

____

____

____

____

How does your child express that he/she is upset?

____

____

____

____

Environmental & Social Setting Events

Provide a list of the activities where the child is most successful and those in which they have the greatest difficulties.

Successful Activities	Problematic Activities
____________	____________
____________	____________
____________	____________
____________	____________

Times of the day when behavior is more and less likely to occur

Most Likely	Less Likely
____________	____________
____________	____________

Situations that are most and least likely to trigger problem behavior (asked to do a task, change in routine, removal of a toy, told “no,” loud environments, etc.)

Most Likely	Less Likely

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

Preferred items and activities:

Please least the child's favorites from each of the following categories:

Favorite foods	Toys, games, or other items	In-home activites:	Community activities	Social stimulation

Print First and Last Name: ____________________________

Signature: ____ Date: ____________________

Relationship to Client: ______________________________