metamorphosis
THERAPY CENTER
Transforming through Therapy
behavior * speech * occupational

behavior therapy intake form

Thank you for your interest in our clinical services. To help us better serve you, please provide us with the information requested below. Please be assured that this information will be held confidential, and is necessary for the staff to determine appropriate evaluation and services.

General Information	
Child's Last Name	
Child's First Name	
Middle Name	
Child's Gender	
Child's Date of Birth	
Child's Age	
Child's Current Address	
Primary Family Email	
Mother's Full Name	
Mother's Occupation	
Mother's Place of Employment	
Mother's Cell Number	
Mother's Work Number	
Father's Full Name	
Father's Occupation	
Father's Place of Employment	
Father's Cell Number	
Father's Work Number	
Family History	
Who does the child live with?	
Are parents married or divorced?	
If divorced, who has custody?	
If divorced, please list stepparents	
If divorced, list for how long	
Name and age of sibling/stepsibling	
Name and age of sibling/stepsibling	
Name and age of sibling/stepsibling	
Name and age of sibling/stepsibling	
Other family in child's home	
Primary Doctor	
Primary Pediatrician/Doctor's Name	
Doctor's Phone and Fax	
Address Including City and Zip	
Child's Medical Diagnosis and Date	

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Pregnancy:	**Yes, Mark X**	**Comments:**
Any complications or health problems		
Any emotional trauma or stress		
Any medications during pregnancy		
Was birth mother physically active		
Was bed rest recommended		
Any exposure to smoke or alcohol		
Labor and Delivery	**Yes, Mark X**	**Comments**
Full Term		
Early Delivery		List Gestational Age
Vaginal Delivery		
Induced Labor		
Forceps or Vacuum Assist		
Caesarean Birth		If Caesarean was it planned?
Breech Delivery		List Why
Oxygen Assist Needed		List Why
Any Structural Abnormalities i.e. cleft lip		
Other Complications		
Birth Weight	lbs oz	
Extended Family Psychological History	**Yes, Mark X**	**Comments: List who in the family had this condition**
Autism Spectrum Disorder		
Learning Problems		
Disabilities		
ADD/ADHD (Attention Problems)		
Depression		
Bipolar Disorder		
Anxiety Disorders (OCD, Phobias, etc.)		
Mental Retardation		
Psychosis/Schizophrenia		
Substance Abuse/Dependence Other		
Mental Health Concerns?		
Other:		
Developmental Milestones:	**Age**	**Comments:**
Rolled over consistently		
Crawled (was crawling phrase brief?)		
Walked unassisted		
Fed self		
Dry through the night for 6+ months		
Said first word understood by strangers		
Used sentences regularly		
Sat up unsupported		
Drank from a cup		

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Developmental Milestones Continued:	**Age**	**Comments:**
Was toilet trained during the day for 6+ months		
Dressed self		
Said two-three word phrases		
Friendship: Please check all that apply	**Yes, Mark X**	**Comments:**
Does your child have problems relating or playing with others?		
Fights frequently with playmates?		
Prefers playing with younger children?		
Has difficulty making friends?		
Prefers to play alone?		
Is your child the aggressor in group games?		
Is your child a follower in group games?		
Is your child a leader in group games?		
Other:		
Education:	**Yes, Mark X**	**Answer questions below**
Does your child attend school? Please list name of school		
Does your child have a primary teacher? Please list name		
Does your teacher have concerns about your child?		
Does your child have a favorite class/subject? If so what?		
Does your child have a least favorite class/subject? What?		
Has your child ever repeated a grade? If so what grade?		
Other:		
Childhood Health:	**Yes, Mark X**	**Comments:**
Has your child been diagnosed with Autism?		
Pervasive Developmental Disorder?		
Nonverbal Learning Disorder?		
Sensory Integration Disorder?		
Has your child had any significant falls or injuries?		
Has your child ever been hospitalized?		Reason:
Does your child have any allergies?		
Does your child have any compulsive behaviors?		
Has your child had a head injury: occurrence, location on skull?		
Any hearing problems?		Date of last test:
Any vision problems?		Date of last test:
Other		

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Developmental Team: *List any specialists your child has seen or is currently seeing for an evaluation or treatment*.

Please send a copy of any current reports you may have.

Specialist	Doctor's Name	Dates Seen	Findings
Allergist			
Audiologist			
Speech Pathologist			
Gastroenterologist			
Neurologist			
Nutritionist/Dietitian			
Occupational Therapist			
Ophthalmologist			
Physical Therapist			
Psychiatrist			
Psychologist			
Cardiologist			
Other			
List All Current Medication	**Dosage**	**Frequency**	**Reason**
List Allergic Reactions to Medication	**✓ Mild**	**✓ Severe**	**Reaction**
Name of Med:			

Problems	X	Age/Grade	Comments:
Problems with eating?			
Socially isolated from peers?			
Problems making/keeping friends?			
Problems getting to sleep?			
Problems controlling temper?			
Problems sleeping through night?			
Problems waking up?			
Fatigue/tiredness during the day?			
Soiling?			
Nightmares?			
Bed wetting?			
History of abuse?			
Alcohol/drug use/abuse?			
School concentration?			
Grades dropping?			
Sadness or Depression?			

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Medical Conditions:	X	Age	Medical Conditions:	X	Age
Sinus Conditions			Constipation		
Ear Infections			Chronic Stomach Aches		
Chronic Cough			Limited Food Intake		
Asthma			Measles		
Frequent Colds			German Measles		
Strep Throat			Mumps		
High Fever			Whooping Couch		
Difficulty Falling Asleep			Chicken Pox		
Fitful Sleep			Tuberculosis		
Bedwetting			Scarlet Fever		
Antibiotic Use			Rheumatic Fever		
Nail Biting			Meningitis		
Extended Thumb Sucking			Diphtheria		
Skin Problems			Encephalitis		
Seizures			Anemia		
Allergies			Diarrhea		
Special Education:	X	**Age**	**Special Education:**	X	**Age**
Enrolled in a special ed class			Consultation		
504 Plan			Collaborative Education		
Psychological Evaluation			Pull-Out		
Occupational Evaluation			Special Program		
Speech Evaluation			Resource Classroom		
Behavior Intervention Plan			Team Taught Classes		
Adaptive Technology Evaluation			Self-Contained Classroom		
Physical Therapy Evaluation			Psychoeducational Center		
I.E.P			Psychoeducational Center		
Other:			Other:		
Extracurricular Activities:	X	**Age**	**Extracurricular Activities:**	X	**Age**
Football			Baseball		
Karate			Piano		
Dance			Music		
Cheerleading			Basketball		
Scouts			Soccer		
Gymnastics			Other		
Other:			Other:		

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Skills Assessment		
Language:	**Yes, Mark X**	**Comments:**
Does your child look at books?		
Play with cause/effect toys (i.e.: Jack in the Box)?		
Complete task completion toys (i.e.: puzzles, beads)?		
Play with toys like they are real items?		
Play games like ring around the rosy?		
Construct items using blocks, Legos?		
Play games with rules (i.e.; memory)?		
Engage in dress up or role play (i.e. pretending to be a barber?)		
Play appropriately on his or her own for up to 5 minutes?		
Do you have any concerns regarding your child's play skills?		
Social Skills:	**Yes, Mark X**	**Comments:**
Does your child respond to his or her name by looking at you?		
Make eye contact when speaking to you?		
Greet you when you arrive home?		
Respond to other's emotions?		
Attempt to involve you in something that he/she is doing		
Observe other children playing?		
Join in with other children when they are playing?		
Take turns in games?		
Verbally interact with peers?		
Do you have any concerns regarding your child's social skills?		
Academic Skills:	**Yes, Mark X**	**Comments:**
Identify shapes, colors, numbers and letters?		
Identify locations, occupations, and functions of objects?		
Use pronouns, plurals, and prepositions appropriately?		
Identify cause/effect relationships?		
Do you have any concerns regarding your child's academic skills?		
Gross Motor Skills:	**Yes, Mark X**	**Comments:**
Walk up and down stairs alternating feet?		
Walk around or step over items that are on the floor?		
Jump off the ground with both feet?		
Kick a playground ball to you?		
Throw a playground ball to you?		
Catch a ball when thrown?		
Show interest in sports?		
Any concerns about your child's gross motor skills?		

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Self Help Skills:	**Yes, Mark X**	**Comments:**
Sleep through the night?		
Sleep in his/her own bed without supervision?		
Drink from a cup?		
Eat a variety of foods (i.e. fruits, veggies, meats, grains)?		
Use a spoon and a fork to feed himself or herself?		
Remove pull-down garments independently?		
Remove socks and shoes independently?		
Remove shirts independently?		
Put on pull-up garments independently?		
Put on socks and shoes?		
Independently?		
Put on shirts Independently?		
Use the toilet Independently?		
Any concerns about your child's self-help skills?		
Fine Motor Skills:	**Yes, Mark X**	**Comments:**
Does your child unwrap presents?		
Pour water or sand from one object to another?		
Turn doorknobs to open doors?		
Use one hand consistently?		
Use a crayon with hand NOT fisted?		
Copy lines and simple shapes?		
Write his or her own name?		
Use scissors?		
Any concerns about your child's fine motor skills?		
Discipline: Please rate frequency of method	**Yes, Mark X**	**Comments:**
Let it go		
Send to room		
Assign an additional chore		
Take away something material		
Send to room		
Physical punishment		
Reason with child		
Ground child		
Yell at child		
Send to time out		
Other		
List who is most likely to discipline the child		

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General Information:
Please list the five things you would like for your child to do more of and less of in order of priority to you. For example, instead of saying, "I want my child to be more responsible," translate that into actual behaviors such as do household chores, care for brothers and sisters, etc.

Would like child to do more often	***Would like child to do less often***
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
List any behaviors you are concerned about and how you would like to see them addressed.	
Please list the expectation/goals that you have for your child while in a behavioral program.	
Please list any other information that may be helpful while assessing and/or conducting therapy with your child.	
Please list the things that reinforce your child:	
Food Items:	
Activities or outings in the community:	
Activities at Home:	
Toys and Objects:	
Other:	

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Treatment History: ***Please list any treatments that your child is receiving or has received in the past:***

Type of Treatment	Service Provider Clinician and their Contact Info	How many hours per week is/was this treatment provided?	Dates of Treatment Start/End Date:	Do you feel that this Treatment is/was beneficial?
Special Education Classroom				
Speech Therapy				
Occupational Therapy				
Physical Therapy				
Other ABA Program				
Other:				

S**elf-Stimulatory Behaviors:** ***Please list any self-stimulatory/repetitive behaviors that your child may exhibit.***

Types of Behavior	Please describe the behavior.	What typically happens immediately before, or triggers the behavior?	How many times per day or week does this behavior occur? If the behavior lasts for more than 10 seconds, list the average duration of the behavior as well.	What typically happens after the behavior, or, what do you do when this behavior occurs?
Vocal (repeating vocalizations, words or phrases)				
Preoccupations with items, topics, etc.				
Repetitive motor mannerisms (hand flapping, spinning items, lining up objects, etc.)				
Routine behaviors (insisting on the same cup, same route in the car)				