Coastal BEHAVIOR CONSULTING, LLC

Instructional and Behavioral Interventions

Client Intake Questionnaire

CONFIDENTIAL

The following questionnaire is to be completed by the child's parent or legal guardian. This form has been designed to provide essential information before your initial appointment in order to make the most productive and efficient use of our time. Please feel free to add any additional information which you think may be helpful in understanding you child. The Early Intervention Center will hold information provided by you is strictly confidential and will only be released in accordance with HIPPA guidelines and as mandated by law. Please use the backs of the pages for additional information.

Person completing form: **Date Completed:**

Legal Name of Child:

Nickname or Name Child goes by:

Date of Birth: **Age:** **Male** ☐ **Female** ☐

Home Address:

City: **State:** VA **Zip:**

Home Telephone:

Cell Phone: Mother - Father -

Email: Mother - Father -

Preferred Method of Contact: **Other:**

School Attending: **Grade:**

Name of Teacher:

Type of services received: **Other:**

Related Services received at school: **Minutes per week:**

Related Services received at school: **Minutes per week:**

Related Services received at school: **Minutes per week:**

Please List services being received outside of school and provider (i.e. Speech, OT):

Please describe the problems your child is now having and what type of services you are seeking from us for these problems:

INDICATE PARENT/GUARDIANS LIVING IN THE HOME

Marital Status: ☐ Married ☐ Remarried ☐ Divorced ☐ Separated ☐ Widowed ☐ Single ☐Cohabitants

If divorced, who has physical custody?

Is it full or joint? **Who has legal custody?**

Is it full or joint?

Mother's Name:

Date of Birth: **Age:**

Occupation:

Employer:

Father's Name:

Date of Birth: **Age:**

Occupation:

Employer:

Does either parent's job require him/her to be away from home long hours or extended periods?

☐ Yes ☐ No If yes, who?

If married, how long have you been married?

If birth parent(s) do not live in the child's home, how much contact does the child have with the parent not having custody, with stepsiblings, etc?

Siblings:

Name	Age	Relationship	Live in Home?	School	Grade
			Y N		
			Y N		
			Y N		
			Y N		
			Y N		

• Please list additional Siblings in the above format on the back of this page

Please indicate any special needs or concerns regarding the other children living in your home:

Please indicate any concerns you have regarding the child for whom you are seeking services and these siblings' relationship(s):

Others: List any other people who currently, or in the child's lifetime, have lived in your home.

Name	Age	Relationship to Child	Years living in Home

Are there any other people who have a significant role on how this child is raised?

PSYCHOLOGICAL HISTORY:

Is there a history in your immediate or in the mother's or father's extended family, of the following, and if so who?

Yes or No		Condition	Who
Y	N	Autism Spectrum Disorders	
Y	N	Learning Problem/Disabilities	
Y	N	ADHD/ADD/Attention Problems	
Y	N	Depression & Manic Depression	
Y	N	Behavior Problems	
Y	N	Anxiety Disorders (OCD, Phobias, etc)	
Y	N	Cognitive Impairment	
Y	N	Psychosis/Schizophrenia	
Y	N	Substance Abuse/Dependence	
Y	N	Other Mental Concern: _____	

Has the child you are seeking services for been evaluated in the past? ☐ Yes ☐ No

If yes, please list the following information on the previous evaluation(s):

Physician	Type of evaluation	Date of evaluation	Copy Available?
			Y N
			Y N
			Y N
			Y N

If yes, what were their general findings and recommendations?

Please provide us with any other information on the psychological history that you feel would be helpful to us in understanding your child:

MEDICAL INFORMATION

Please indicate if your child is experiencing any of the following:

Issue	Yes or No	Comments

Problems eating	Y	N
Isolated from peers	Y	N
Problems making friends	Y	N
Problems keeping friends	Y	N
Problems sleeping	Y	N
Problems controlling temper	Y	N
Tiredness during day	Y	N
Nightmares	Y	N
Bed Wetting	Y	N
Anxiety	Y	N
Problems with Authority	Y	N
Stress from conflict bw parents	Y	N
Legal Situation	Y	N
History of Abuse	Y	N
School Problems	Y	N
Low Grades	Y	N
Sadness or Depression	Y	N

How well does this child complete each of the following?

Dressing	☐ Completely independent	☐ Needs some help	☐ Needs full assistance
Eating	☐ Completely independent	☐ Needs some help	☐ Needs full assistance
Drinking	☐ Completely independent	☐ Needs some help	☐ Needs full assistance
Toileting	☐ Completely independent	☐ Needs some help	☐ Needs full assistance
Brushing Teeth	☐ Completely independent	☐ Needs some help	☐ Needs full assistance

Describe your child's daily routine (include times to wake up, naps, bedtime, meals, school, etc

Morning

Afternoon

Early Evening

Night

List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other special conditions your child has had.

List any medications your child is currently taking or has taken for extended periods

Medication	Purpose	Dosage	Dates

Which hand does the child write with? ☐ Right ☐ Left ☐ Hasn't identified dominant hand yet

Does the child have any vision problems? ☐ Yes ☐ No

Please list the date of the last vision test and who performed (pediatrician, optometrist, school)

Click here to enter text.

Does the child have any hearing problems? ☐ Yes ☐ No

Please list the date of the last hearing test and who performed (pediatrician, audiologist, school)

Click here to enter text.

Has your child had a speech/language evaluation completed? ☐ Yes ☐ No

Please list the date of the last assessment and who performed it as well as any recommendations.

Click here to enter text.

Please list any Physician that your child sees (Include primary care, provider referring for ABA, etc..)

Physician Name	Group Name	Fax Number	Phone Number

CHILD/FAMILY INFORMATION

How does the child interact with peers/siblings?

How does the child interact with toys?

Describe the child's temperament:

Is the child abusive/aggressive towards him/herself? ☐ Yes ☐ No **Others?** ☐ Yes ☐ No

Does the child have a history of elopement (running from you)? ☐ Yes ☐ No
If yes, list where and when these occurrences usually happen:

Please list all challenging behaviors in the chart below. Please list additional information/behaviors on the back of this page.

List each behavior problem	How often does it happen	How long does it last	What kind of damage does it cause	What could you do to guarantee I would see the behavior?	What could you do that would very likely make it stop?
	Daily Weekly Monthly Several times a year	Seconds 1-5 mins 5-15 mins 15-30 min < 30 min	Red Mark Bruise Broken Skin No tissue damage Other		
	Daily Weekly Monthly Several times a year	Seconds 1-5 mins 5-15 mins 15-30 min < 30 min	Red Mark Bruise Broken Skin No tissue damage Other		
	Daily Weekly Monthly Several times a year	Seconds 1-5 mins 5-15 mins 15-30 min < 30 min	Red Mark Bruise Broken Skin No tissue damage Other		
	Daily Weekly Monthly Several times a year	Seconds 1-5 mins 5-15 mins 15-30 min < 30 min	Red Mark Bruise Broken Skin No tissue damage Other		

Please list your child's favorite foods, toys, activities, etc (what makes him/her happy?)

Please list your child's least favorite foods, toys, activities, etc (what does he/she dislike?)

Please list any fears your child may have (animals, bathrooms, loud noises, etc).

DISCIPLINE INFORMATION

Parents may use a wide range of discipline strategies with their children. Listed below are several examples. Please rate how likely you are to use each of the strategies listed and rate the 3 most effective for your child:

Intervention	Very Unlikely				Very Likely	Effectiveness
Let situation go	1	2	3	4	5	
Take away a privilege	1	2	3	4	5	
Assign another chore	1	2	3	4	5	
Take away something material	1	2	3	4	5	
Send to room	1	2	3	4	5	
Reason with the child	1	2	3	4	5	
Yell at the child	1	2	3	4	5	
Send to time out	1	2	3	4	5	
Physical Punishment	1	2	3	4	5	
Other:	1	2	3	4	5	

How would you describe your child?

What are your child's strengths and abilities?

What are you child's weaknesses and challenges?

Please list the five things you would like for our child to do more of and less of in order of priority to you.

Like Child to do More Often	Like Child to do Less Often
1.	**1.**
2.	**2.**
3.	**3.**
4.	**4.**
5.	**5.**

Insurance Information

Name of Insurance Company:

Policy Number:

Insurance Plan:

If Tricare coverage, please provide sponsor rank for copay purpose:

INFORMED CONSENT FOR ABA SERVICES

I understand that Coastal Behavior Consulting (CBC) will use behavior modification principles, concepts and other methodologies to allow my/our child to learn strategies and approaches. I understand that the individualized program will be designed to maximize my child's success. Methodologies and procedures used will include, but will not be limited to: discrete trials, verbal behavior, natural environment training, prompts, and rewards for correct responses. All procedures will be described and demonstrated at the request of the guardian.

I understand that I will be notified of all interventions implemented for my child and that they are subject to my approval. Furthermore, I understand that I will be given a document outlining any procedures used.

I understand that for the maximum benefit to my child, my/our participation is essential. I understand that I am expected to (a) attend all meetings concerning my/our child, and (b) practice therapy procedures that are taught to me/us by CBC staff so that my/our child's skills will generalize from therapy settings to the home, school, and community environment more easily. Furthermore, I understand that if I do not attend meetings and generalize procedures at home my child's progress may be limited.

I understand that the behavioral techniques that are used by CBC may not necessarily produce observable results during the course of time in which my/our child attends therapy with CBC. The subsequent short- and long-term applications of these techniques have proven to be beneficial for other children with developmental disabilities and CBC expects similar results for my child. I understand however, that my child may or may not benefit. In addition, my child may experience behavioral difficulties during and following therapy sessions. All efforts will be made to prevent, eliminate, and minimize such negative effects of participation.

_____

Parent Signature

_____

Date

_____

Parent Signature

_____

Date