Therapy Connections

of South Texas

Specializing in Direct & Consultation

Music Therapy & Applied Behavior Analysis Services

for individuals with autism and other developmental disabilities

INTAKE FORM

The following information 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 your child. All information provided by you is strictly confidential and will only be released in accordance with HIPPA guidelines. Thank you!

Robin Palmer Blue, MA Ed., BCBA, MT-BC

Client Information

Child's Name:_____ DOB:_____

Address:_____

_____

Parent's Name(s):_____

Home #:_____ Primary e-mail address:_____

Mother's Work #:_____ Cell #(s):_____

Father's Work #:_____ Cell #(s):_____

Sibling name(s) and age(s):_____

_____

Primary Diagnosis:_____ Secondary Diagnosis:_____

Age at diagnosis:_____ Diagnosed by whom:_____

Additional information:_____

_____

Insurance: PLEASE PROVIDE ENLARGED COPIES OF INSURANCE CARD(S) – FRONT AND BACK

Primary: _____ ID#:_____

Member Name:_____ SS #:_____ DOB:_____

Secondary: _____ ID#:_____

Member Name:_____ SS #:_____ DOB:_____

Emergency Contact Information (if unable to reach parents directly):

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

*1001 Louisiana Ave., Ste. 204 * Corpus Christi, TX 78404*
361-815-2433 phone/fax
e-mail: therapyconnections@um.att.com

Medical Information

Current Medication(s):_____

_____

Allergies:_____

_____

Special Dietary Needs/Restrictions:_____

_____

_____

Other Medical Information:_____

_____

General Questions

What are your immediate goals for your child?

How would you describe your child & things you would like us to know about your child? - strengths, personality, etc.

What current communication skills does your child have? (vocal, sign language, PECS, augmentative communication device, etc.) Please explain what degree of functional communication your child has.

Please check all that apply:

Expressive:
___Babbles
___Repeats words/perseverates/echolalic
___One-two word responses
___Talks in sentences
___Gives hand signals or uses sign language-Which?

Receptive:
___Comprehends verbal directions (touch, give me, point, etc.
___Comprehends descriptions
___Comprehends facial and body gestures

Evaluations – Please provide copies of any recent evaluations.

Check all that are enclosed:
____speech therapy ____occupational therapy ____physical therapy ____psychological

____school related ____diagnostic ____other:_____

Educational History

School District:_____ School Name:_____

Dates Attended:_____

Setting:_____Days/hours per week:_____

Current teaching
procedure(s)/program(s):_____

Type of assistance provided:_____

Additional information:_____

_____

_____

Other:
_____

_____

_____

_____

_____

_____

_____

Please provide a current copy of your child's IFSP, IEP and/or applicable service plans.

Instructional Control

Does your child come willingly to a table and sit for instructional demands?_____
Please describe behavioral challenges within a teaching setting:_____

_____

_____

In-Home Program

Type of Programming:_____ Dates:_____

Current Consultant:_____

Ph#:_____ e-mail:_____

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Other Therapies

OT: _____ session(s)/hours per week:_____ Therapist:_____

Goals:_____

PT: _____ session(s)/ours per week:_____ Therapist:_____

Goals:_____

Speech: _____ session(s)/ours per week:_____ Therapist:_____

Goals:_____

Other:_____ session(s)/ours per week:_____ Therapist:_____

Goals:_____

Everyday Behavior Issues

Please describe how your child responds when told "no."_____

_____

Please describe how your child responds when you take away reinforcers (items the child likes)._____

_____

Please describe how your child responds when asked to "wait."_____

_____

Please describe how your child follows/complies with instructions in everyday situations._____

_____

Please describe how your child responds/acts in public places?_____

_____

Please check any of the following behaviors that your child frequently exhibits:

___screaming	___throwing	___self injury (biting/banging)
___aggression toward others	___self-stimulatory (stimming)	___inattention
___hyperactivity	___non-compliance	___crying
___tantrums	___breaking objects	

Please describe the problems (circumstances, response to behaviors, etc.):_____

Please describe any behavioral issues/triggers/defensiveness/sensitivities:_____

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Other Issues

Potty Training: Is your child potty trained?_____

If not, describe the history and issues regarding potty training:_____

_____

_____

Eating: Does your child have significant eating issues? _____

Please describe:_____

_____

_____

Sleep: Does your child have significant sleep issues? _____

Please describe:_____

_____

_____

Below, on the back of this page, or on a separate sheet of paper, please list out your child's daily schedule, including wake, eating and nap times, as well as school and therapy schedules.

I affirm that the above information is a complete and true statement of all facts and circumstances relative to my child.

_____ _____

Parent(s)/Guardian Date

Additional comments or concerns (please use back if more space is needed):

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