Therapy Connections

of South Texas

Specializing in Direct & Consultation

Music Therapy & Applied Behavior Analysis Services

for individuals with autism and other developmental disabilities

Office Use Only
Date:
Received_____

Intake appt_____

Initial screening/eval appt

_____

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

Name	Age/Date of Birth	Grade	Male/Female
Address	City	State	Zip
Diagnosis Primary: Secondary:	Age at diagnosis:	Diagnosed by whom:	***REQUIRED*** *Please provide a copy of diagnostic report(s)*
Allergies		Special Dietary Needs/Restrictions	
Parent(s) Mom: _____ Dad:	Home Phone _____	Work Phone _____	Cell Phone _____
Primary e-mail address:			
Siblings (list by birth order/oldest first): Name: 1. _____ 2. _____ 3. _____ 4.	Age _____ _____ _____	Male/Female _____ _____ _____	

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

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

*1001 Louisiana Ave., Ste. 200 * Corpus Christi, TX 78404*
*Phone 361-815-2433 * Fax 361-853-7216*
www.therapyconnectionsofsouthtexas.com

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

Primary Insurance:	Address/Phone:	Subscriber Name:
ID#:	Group or Policy #:	Date of Birth:
Deductable:	Copay:	SS#:

Secondary Insurance:	Address/Phone:	Subscriber Name:
ID#:	Group or Policy #:	Date of Birth:
Deductable:	Copay:	SS#:

Medical History: Has your child had any of the following? If yes, check and explain.

Problem:	**YES**	**Please explain:**
Staring spells		
Seizures (with or without fever)		
Head trauma		
Speech problems		
Tics or repeated movements		
Weight loss		
Rapid weight gain		
Trouble with appetite		
Unexplained fevers		
Vision problems		
Hearing problems		
Heart problems		
Lung problems		
Stomach or bowel problems such as diarrhea or constipation		
Urinary tract infections		
Kidney problems		
Broken bones/joint problems		
Skin problems		
Endocrine problems		
Anemia		
Immunization reactions		

Medication History: List current medications

Name of Medication	*Prescribed for:*	*Frequency*
1.		
2.		
3.		
4.		
5.		
Please indicate any drug allergies:		

Family History of Learning, Behavior, Mental Health and Neurological Problems:

Indicate whether any member of the child's biological family experienced any of the following. Please check all that apply.

Difficulty	**Relationship to Child**	**Difficulty**	**Relationship to Child**	**Difficulty**	**Relationship to Child**
Autism		Compulsive behaviors		Learning disabilities	
Asperger disorder		Obsessive behaviors		Mental retardation	
ADD		Anxiety		Social difficulties	
ADHD		Depression		Down's syndrome	
Language delays		Bipolar disorder		Epilepsy	
Verbal apraxia		Schizophrenia		Cerebral palsy	
Migraines		tics		Seizures	
Please list any other brain, spinal cord, nerve problems, cancer, stroke or heart attacks before age 70:					

Educational History –

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

Preschool:	School District:
Dates of Attendance (month/year to month/year):	Classroom Setting (please circle): Special education Inclusion Private community Regular Education
Did staff express any concerns to you about your child's development or classroom behavior? Please describe –	

Elementary:	School District:
Dates of Attendance (month/year to month/year):	Classroom Setting (please circle): Special education Inclusion Regular education
Have teachers reported any academic and/or behavior difficulties? Please describe –	

Middle School:	School District:
Dates of Attendance (month/year to month/year):	Classroom Setting (please circle): Special education Inclusion Regular education
Have teachers reported any academic and/or behavior difficulties? Please describe –	

High School:	School District:
Dates of Attendance (month/year to month/year):	Classroom Setting (please circle): Special education Inclusion Regular education
Have teachers reported any academic and/or behavior difficulties? Please describe –	

Other school related information:

Therapy History:
Please provide copies of any recent evaluations and/or progress notes

Speech Therapy			
Day:	Time:	Therapist:	Facility:

Occupational Therapy			
Day:	Time:	Therapist:	Facility:

Physical Therapy			
Day:	Time:	Therapist:	Facility:

Other:			
Day:	Time:	Therapist:	Facility:

School Based Related Therapies:			
Speech Therapy Frequency:	Occupational Therapy Frequency:	Physical Therapy Frequency:	Other: Frequency:

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

Everyday Behavior Issues

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 any behavioral issues/triggers/defensiveness/sensitivities:

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:

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

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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?

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

Checklist of items to submit with in-take form:

- ☐ Copy of insurance card front and back
- ☐ Copy of IEP or IFSP
- ☐ Copy of Diagnostic Evaluation
- ☐ Copy of Speech, PT and/or OT evaluations/ current progress notes

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