



Responding to Autism Center

RTAC Client Intake Form

Please complete the following information ~ This information will be kept on file for participation in future programs and services at the Responding to Autism Center.

Child's name: _____ Date of birth: _____ Gender: _____

Parent(s) name: _____

Address: _____

Telephone #: Home _____ Work _____

Cell #: _____ Cell #: _____

Email Address: _____

Emergency Contacts other the parent/guardians:

Name/Phone #: _____

Name/Phone #: _____

Do you receive our monthly newsletter? _____ If not, would you like to? _____

Does your child currently have a diagnosis of an Autism Spectrum Disorder? _____

If yes, please specify: _____

What age was your child diagnosed? _____

Who Diagnosed your child? _____

Please list any other diagnoses your child has:

Name of person completing form: _____

Relationship to child:

Date form completed:

Who referred you to us?

What difficulties is your child experiencing? Medical, developmental, academic, behavioral, social?

How have these difficulties changed over time? Have they worsened, stayed the same, or improved?

Please describe your child's communication style (PECS, verbal, sign, etc.).

Family History

Mother's name: _____ Age: _____

Occupation: _____ Work telephone #: _____

Father's name: _____ Age: _____

Occupation: _____ Work telephone #: _____

Step-parent's name (if applicable): _____ Age: _____

Occupation: _____ Work telephone #: _____

Parents are (*circle one*): Married Separated Divorced Unmarried Widowed

If parents are divorced, who has legal custody? _____

If parents are separated or divorced, please describe physical custody and visitation arrangements:

This child is (*circle one*): biological foster adopted other

Please list any Siblings (*include names and ages*):

Please list anyone in the immediate or extended family that has a diagnosis of an autism spectrum disorder:

Does your family currently receive any government services? (*SSI, DDD, etc.*):

Medical/Developmental

Child's current physician: _____

Other doctor's or specialists: _____

Does your child have any allergies?

If yes, please specify: _____

Does your child have any vision problems or wear glasses?

If yes, please specify: _____

Does your child have any hearing problems?

If yes, please specify: _____

Does your child have a history of frequent ear infections?

If yes, please specify: _____

Does your child regularly take any medications or supplements?

If yes, please specify: _____

Does your child have any sleep problems, such as difficulty falling asleep, frequent nighttime waking, or early morning rousing? If yes, please describe:

Does your child have any eating problems, such as restrictive food preferences, or any recent, noticeable weight gain/loss?

If yes, please describe: _____

Is your child on a special diet?: _____

Compared to other children, do you feel your child was slower in learning...

Yes

To talk? _____

To understand other people talk? _____

To build with blocks, play with puzzles, draw pictures? _____

Gross motor skills (walking, hopping, riding bicycle, etc.)? _____

Fine motor skills (fastening buttons, zippers, drawing, etc.)? _____

Early school-related skills (naming colors, saying alphabet)? _____

To sit still for TV or stories? _____

To play or socialize with other children? _____

Where there any other developmental milestones your child did not reach “on time” or they seem to lose as they got older?

This portion should be completed by the parent(s) and should be answered in accordance with social behaviors perceived by the parent(s) on a day-to-day basis.

Does your child look and/or come when their name is called? Yes or No

Does your child imitate 1 step motor tasks? Yes or No

Does your child sit and attend to simple tasks? Yes or No

Will your child sit next to peers? Yes or No

Will your child pass an item to a peer? Yes or No

Does your child say “Hi” in response to greetings? Yes or No

Does your child share toys? Yes or No

Does your child end play appropriately (without problem behavior)? Yes or No

Can your child sit and play simple games with adults directing? Yes or No

Is your child able to tolerate new demands/tasks with support? Yes or No

Does your child ask for help when engaged in a difficult task? Yes or No

Does your child state their wants/needs 30+ times per day? Yes or No

Does your child identify others by name? Yes or No

Can your child answer 1-3 social questions i.e.name, age, pet names. Yes or No

Does your child answer yes/no questions appropriately? Yes or No

Does your child ask for information: “What is that?” “Where is it?” Yes or No

Does your child ask for attention i.e. “Watch me” “Look at me?” Yes or No

Does your child offer information about his/her school day? Yes or No

Does your child label their emotions appropriately?	Yes or No
Does your child guess others imitations of emotions?	Yes or No
Does you child understand the concept: First, Then?	Yes or No
Can your child sit and listen to group stories?	Yes or No
Does your child show others objects with intent to share?	Yes or No
Does your child follow instructions to go get items/supplies?	Yes or No
Does your child greet/wave “Hi” with person’ s name?	Yes or No
Can your child joint play/build/work on simple projects together, with peer?	Yes or No
Does your child ask 1-3 peers to join in their play?	Yes or No
Does your child sustain play for up to 20 min. with peers?	Yes or No
Does your child tolerate other’ s choice in play?	Yes or No
Does your child tolerate new tasks willingly?	Yes or No
Is your child able to tolerate a delay in reinforcement: 1-2 hours	Yes or No
Does your child raise his/her hand and wait to talk?	Yes or No
Does your child accept “no” for an answer without problem behavior?	Yes or No
Does your child recognize his/her own space (doesn’t touch others)?	Yes or No
Does your child answer question of non-interest (w/adult/peers)	Yes or No
Does/can your child tell simple jokes?	Yes or No
Does your child respect the personal space of family, friends, and strangers?	Yes or No

Does your child retell events of that day/yesterday?

Yes or No

Does your child have the ability to use self talk
as a reminder of what to do?

Yes or No

Does your child give others compliments?

Yes or No

Does your child invite friends over for play dates?

Yes or No

What are some of your child's strengths?

What are your child's biggest obstacles?

Does your child have any difficulty with peers?

Please describe their unusual social behavior:

My child has a special interest in the following activities:

My child has some behavior difficulties as follows:

My child is comforted by the following things:

Is your child able to take care of their bathroom needs?

Does your child enjoy watching TV, playing video games, or using the computer?

How long does your child stay at an activity?

If applicable to your child's skills - how would you describe your child's behavior in conversation? (one-sided?, non-responsive?, does/doesn't ask questions about others?, better with some people rather than others?) Please Describe:

How does your child respond to changes in routine, or in changes for the plan for that day?

Does your child engage in repetitive play behavior? (i.e. spinning, flapping, toe walking, playing with the same toy over and over....etc)?

Are there other behaviors we should be aware of?

Please describe how your child demonstrates emotion and give examples of the context e.g., is s/he able to calm his/herself?

Can he/she express frustration without anger?

Does he/she get physical when agitated?

Does he tend to stay in an emotional state for any length of time?

Is she/he able to be calmed by others – how?

What is your child's general mood at home/school?

What sorts of rewards and consequences have worked for your child at home/school?

What motivates your child? Special interests?

What sorts of rewards and consequences (or interactions) have *NOT* worked well for your child at home/school?

School History

Current grade placement: _____ Home Schooled: _____

School name: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Is your child currently on an IEP or 504 Plan?

Is your child on an Behavior Plan? If yes, please summarize plan.

Are there any subjects/activities that are difficult for your child? Yes/No
If so, please describe:

Has your child ever received any of the following services? *(if yes please state age, grade, therapist's name and where):*

Speech/language therapy:

Physical therapy:

Occupational therapy:

Tutoring:

ABA:

Counseling:

Other (please describe:)

Is your child in a regular education classroom?

What accommodations if any, does your child receive?

Has your child ever been placed in a special education or autism program?

Is there anything else you would like to share about your child?

Thank you for taking the time to provide us with this needed information so that we can better meet you and your child's needs.

Parent/Guardian signature _____

Date: _____