



Tri-State Learning Center, Inc.

"A school without walls"
www.tristatelearningcenter.com

Date Received by TLC

Initial Client Questionnaire

Date Intake Completed: _____ Completed By: _____

Name of Child: _____ Sex: _____

Date of Birth: _____

Child's Address: _____

City State Zip Code

Has there been evaluations completed within the last year yes No

Type of Evaluation	Completed By/Date:	Enclosed
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Diagnosis Given: _____ Given By: _____

Age when Diagnosed: _____

Referred by: _____ Title: _____

School Background Information

Year in School: _____ Name of School: _____

Date of IEP: _____

Placement: Mainstream Partial /full inclusion Autistic Mixed Class Other

Does parent feel child is benefiting? _____

SECTION II

Parent Information

Mother's Name: _____	Father's Name: _____
Mother's Occupation: _____	Father's Occupation: _____
Home Phone Number: _____	Pager/Voice mail: _____
Work Phone Numbers: _____	Other Numbers: _____
E-mail Address: _____	E-mail Address: _____

Family History

Marital Status: Married Separated Divorced Single

Parent with Custody of Child: _____

Siblings

Name: _____	Age: _____
Name: _____	Age: _____
Name: _____	Age: _____
Name: _____	Age: _____

Emergency Contact Person:

Name: _____	Relationship to Patient: _____
Phone: _____	Address: _____

Family history of mental illness or developmental disorders

Family Member: _____	Condition: _____
Family Member: _____	Condition: _____

Section III (Related Service Information)

Related Services

1. Occupational Therapy for _____ hours per week by _____ (Provider)
Agency Address: _____ Phone: _____
May we contact yes no
Progress Observed _____

=====

2. _____ Speech Therapy for _____ hours per week by _____ (Provider)

Agency Address: _____ Phone: _____

May we contact yes no

Progress Observed _____

=====

3. _____ Physical Therapy for _____ hours per week by _____ (Provider)

Agency Address: _____ Phone: _____

May we contact yes no

Progress Observed _____

=====

4. _____ Other Services for _____ hours per week by _____ (Provider)

Agency Address: _____ Phone: _____

May we contact yes no

Progress Observed _____

=====

Section IV (Developmental Profile)

Medical History

Current Treating Physician: _____

Physician Phone Number: _____

Current Medications: 1. _____

Dosage/Frequency _____

2. _____

Dosage/Frequency _____

3. _____

Dosage/Frequency _____

4. _____

Dosage/Frequency _____

5. _____

Dosage/Frequency _____

Where there complications with your pregnancy? _____ If yes, please explain: _____

Did the child have ear infections prior to age 2? _____ If so, how many _____ Were Antibiotics used as treatment? _____
Please give a brief description of the child's diet _____

Where there any other childhood illnesses? _____

Is child Hypersensitivity to sounds: Yes No
If yes, please list all those that apply _____

Developmental Progress

When did parents first suspect there was a problem with child's development? _____

What were the child's presenting symptoms? _____

Developmental Milestones (please complete as accurately as possible)

Crawling:	age _____	normal _____	delayed _____
Sitting:	age _____	normal _____	delayed _____
Walking:	age _____	normal _____	delayed _____
Eating solids:	age _____	normal _____	delayed _____
Sleeping through the night:	age _____	normal _____	delayed _____
Speech (if applicable):	age _____	normal _____	delayed _____ regressed after some gains _____

Section V (Current Levels of Functioning)

Self-Help Skills (please provide as much detail as possible)

Toileting: _____

Dressing Skills: _____

Eating Skills: _____

Grooming: _____

Social Emotional Behavior

Did the child like to be held or cuddled? Yes No

Explain _____

Who is child attached to now?

Does the child turn to parents for comfort?

Does the child exhibit unusual separation anxiety _____?

Does the child exhibit appropriate eye contact? If so, when and with whom? _____

Does the child respond to his/her name with appropriate eye contact? _____

Play Behavior

Explain the social play of the child: ___Parallel ___Interactive ___Indifference to peers ___Isolates from peers

Does the child attempt to involve others in activities (i.e. pointing out items of interest): _____

Additional Comments: _____

Does the child play with toys appropriately? ___Yes ___No

Please Describe: _____

Child's toy play tends to be: _____Cause/Effect _____Symbolic _____Imaginary _____Repetitive

What are the child's favorite toy play or leisure activities? _____

Language Skills

Receptive Understanding (Child's ability to understand what is said):

How many phrases? _____ How many object labels? _____ Abstract concepts? _____

General comments: _____

Expressive Language (Child's spoken language):

What sounds or words can the child imitate? _____

What words does the child say in a meaningful manner? _____

How many phrases does the child use when speaking? _____

What is the average number of words does the child uses? _____

Could a stranger understand the child's speech? _____

Does the child engage in conversational speech? _____

Parent Report: Can the child complete any of the following? (Please indicate as yes or no)

- _____ Follow single or complex directions _____ Uses language to request
- _____ Use language to comment _____ Use language to describe
- _____ Use language to direct others _____ Engages in joint references
- _____ Identify Emotions of others _____ Imitate the actions of others
- _____ Identifies Numbers _____ Identifies Letters
- _____ Identifies Colors _____ Identifies people
- _____ Understanding of Prepositions (can place objects in locations when requested)
- _____ Points to others engaging in actions in books when requested

Does the child show strength or weakness in gross motor activities? _____

Does the child show strength or weakness in fine motor activities? _____

Section VI (Behaviors)

Self-Stimulatory Behavior

<u>Behavior Observed</u>	<u>Frequency of Behavior</u>	<u>What causes the Behavior</u>	<u>How do you respond</u>
Body Self-stimulatory Behaviors (flapping, Gazing jumping, running, etc.)			
Object SSB (linear objects, sand, cars, stuffed animals, etc.)			
Verbal SSB (vocal sounds, noises, etc.)			
Rituals or Obsessive Compulsive type SSB (wearing same clothes, driving a certain direction, sit is certain chair, etc.)			

Compliance

<u>Behavior Observed</u>	<u>Frequency of Behavior</u>	<u>What causes the Behavior</u>	<u>How do you respond</u>
Non-Compliance			
Tantrums			
Aggression Includes:			

<u>Behavior Observed</u>	<u>Frequency of Behavior</u>	<u>What causes the Behavior</u>	<u>How do you respond</u>
Self-Injurious Behavior (SIB) Includes:			
Running Away			
PICA (e.g., consuming objects)			
Other:			
Other:			

VII (Funding Information)

Client Funding information

Early Intervention (0-3) []

Preschool (3-5) []

School aged (5 and over) []

Funding Source: Private []

School District []

State/County/B-to-3 []

Contact Person: _____

Address: _____

Phone Number: _____

Please complete the following schedule indicating your child's current activities (i.e., Naps, school, speech, occupational Related services, gym, and family time. Please highlight those activities that are flexible and can be moved to provide ABA services)

VIII (Available Hours)

M

T

W

TH

F

SA

SUN

(Morning)

8:00

9:00

10:00

11:00

12:00

(Afternoon)

1:00

2:00

3:00

4:00

5:00

(Early Evening)

6:00

7:00

8:00

IX (Parent Acknowledgment)

PARENT UNDERSTANDING OF INTAKE AND PAYMENT RESPONSIBILITY

We, _____ and _____, parents/guardian of _____, have been informed that submission of this intake does not warrant the initiation of services. We also recognize that if we are called and an initial intake occurs that the amount of this intake will be a non-refundable (EI county and preschool cases may be excluded). This non-refundable intake fee will cover the cost of an initial meeting and follow-up report that will be provided to the family. We further understand that once TLC conducts an intake evaluation, that one of several options may occur:

- A) TLC may accept case and immediately provide services
- B) TLC may accept case, and place child of the TLC waiting list for the initiation of services
- C) TLC may identify my child as a workshop case and initiate workshop services
- D) TLC may not be able to provide services to my child (explanation will be provided).

If we, Parents of _____ are unable to secure funding for all or part of the services provided by TLC, we guarantee to provide payment in full for the service hours we utilize. We further agree to these terms throughout the duration of our child's treatment

Parent / Guardian Name

Parent / Guardian Signature

Date

Parent / Guardian Name

Parent / Guardian Signature

Date

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Clinician's Recommendations

Date for Intake assessment: _____ Evaluated By: _____

Therapy Hours: _____ Therapists _____ Workshop Status Recommended _____ Referred Out

Number of home based hours recommended: _____

Recommended school hours: _____ Total school hours with shadow _____ Total school hours without shadow

Recommended placement (if applicable): _____

Level of Supervision: _____

Additional Comments: _____

Approximate Therapist Wait list time: _____

Approximate Supervision Wait list time: _____

Approximate Workshop Wait list time: _____

Date file submitted for report: _____

Date report completed and sent: _____

Senior Clinician: _____

Date: _____