New Client Enrollment Information

Form Filled Out By:_____Relationship to Client:_____
_____

IDENTIFYING INFORMATION

Client's Name:_____DOB:_____

Address:_____

Mother's Name:_____DOB:_____

Father's Name:_____DOB:_____

CONTACT INFORMATION

	Phone Numbers	Email Address
Mother		
Father		
Guardian		
Other		

FAMILY INFORMATION

Brothers, Sisters, and Others Living in the Home

Name	Age	Learning or Medical Concerns?

Child's Legal Guardian		**Marital Status of Natural Parents**	
	Both Parents		Not Married
	Birth Mother		Married
	Birth Father		Separated
	Adoptive Parents		Divorced
	Department of Human Resources		Mother Remarried
	Other – please explain		Father Remarried

If divorced, who has physical custody? Is it full or joint custody?

_____

_____

_____

Who has legal custody? Is it full of joint?

_____

_____

_____

*If divorced, please provide a copy of the custody agreement.

SCHOOL INFORMATION

Schools Child Attended	Address	Date Attended

BACKGROUND INFORMATION

Does your child have an Individualized Education Plan (IEP)? **If so, please provide a copy of the IEP.**

_____

Does your child have a medical diagnosis of Autism Spectrum Disorder by a Licensed Psychologist? Who made the diagnosis and when was it made? **If so, please provide a copy of the report.**

_____

Behavioral Health and Medical Treatment History

Please provide the following information regarding any specialists who have evaluated and/or treated your child:

Type of Service	*Agency/Provider*	*Agency/Provider Complete*	*Dates Seen*
Hospitalizations			
Pediatrician			
Family Physician			
Neurologist			
Psychiatrist			
Psychologist			
Eye Specialist			
ABA Services			
Speech/Language			
Occupational			
Geneticist			
Children's Rehab Service			

Public Health Dept.			
Dept. of Human Resource			
Others:			
Others:			

If you child has been seen for previous therapies, please give a brief description of their response to these interventions:

_____

_____

_____

_____

_____

Prenatal and Birth History

	Response	*Notes and Description*
Length of Pregnancy		
General Condition		
Length of Labor		
Birth Weight		
Type of Delivery		
Miscarriages		
Other:		

Mother's general health during pregnancy (illnesses, accidents, medication, ect.)_____

_____

_____

_____

Were there any unusual conditions that may have affected the pregnancy or birth?_____

_____

Family History

Is there any family history of the following? Please specify who (ie. mother, father, siblings, grandfather, ect.)

Condition	*Family Member*	*Notes*
ADD/ADHD		
Anxiety Disorder		
Autism Spectrum Disorder		
Behavioral Problems		
Chronic Illness		
Depression		
Diabetes		
Drug or Alcohol Abuse		
Emotional Difficulties		
Hearing Impairment		
Intellectual Disabilities		
Learning Disabilities		
Psychosis/Schizophrenia		
Seizure Disorder		
Speech/Language Impairment		
Thyroid Problems		
Tics or Involuntary		
Visual Impairment		

Developmental History

Provide the approximate ages at which your child began to reach the following developmental milestones. You may use early, late, or on time if age is unknown.

Milestones	*Age Occurred*	*Notes*

Smile		
Coo/Babble		
Roll Over		
Sit Alone		
Single Words		
Phrases		
Short Sentences		
Crawl		
Stand Alone		
Walk Alone		
Feeds Self		
Dresses Self		
Toilet Trained – Bladder		
Toilet Trained – Bowel		
Toilet Trained – Night Time		

Additional Information:_____

_____

_____

_____

_____

How does your child communicate? Please check all that apply.

Communication Style	*Check all that apply*	*Notes*
Crying		
Playful Sounds		
Pointing with Index Finger		
Words		
Phrases		
Sentences		

Sign Language		
Picture Communication		
Communication Device		
Problem Behavior		

How much of your child's speech is understandable to you? Some_____Most_____

All_____

How much of your child's speech is understandable to others? Some_____Most_____

All_____

Does your child exhibit difficulty with the following?

Understanding what someone says: Yes___No____

Talking: Yes___No____

Please answer the following questions about your child's motor coordination.

Motor Area	*Concerns?*	*Notes*
Walking		
Running		
Gross Motor Coordination		
Fine Motor Activities		
Playground Activities		
Hand Preference	Right / Left / Both /	

How would you describe your child? Please check all that apply:

	Usually very active		Sometimes active, but can play
	Usually not active		Unusually happy compared to others
	Unusually sad compared to others		Can be moody
	Demands attention (peers or adults)		Aggressive towards self or others
	Difficulty attending to activities		Prefers motor activities
	Prefers sit-down activities		Other:

Feeding

Weight:_____

Feeding Method (circle): Bottle Fed / Baby Food / Table Food / Special Diet

Are there or have there been any feeding problems? If yes, please describe:_____

_____

_____

_____

Do you consider your child a picky eater? If yes, what foods will he/she eat?_____

_____

_____

_____

Is your child on any special diet or take any nutritional supplements? If yes, please describe:_____

_____

_____

Sensory

Describe your child's response to sounds (e.g. responds to all sounds, loud sounds only, sensitivity, ect): _____

_____

_____

Does your child have any specific sensory interests, sensitivities, or concerns? If yes, please describe:_____

_____

_____

Behavior

Does your child engage in problem behavior? If yes, please describe:_____

_____

_____

_____

_____

Why do you think he/she engages in the problem behavior?_____

_____

_____

_____

_____

What do you do immediately following your child's problem behavior?_____

_____

_____

_____

Play and Social Skills

Please describe your child's independent play skills:_____

_____

_____

_____

_____

Please describe your child's play skills with other peers:_____

_____

_____

_____

_____

Community Integration

What activities is your child involved in outside of school/therapy hours?_____

_____

_____

_____

_____

Are you and/or your child involved in any Autism Spectrum Disorder support groups outside of school/therapy hours? If yes, please describe:

_____

_____

_____

_____

Goals of Therapy

Please list three social goals you would like for your child to accomplish this year?

1._____

_____

2._____

_____

3._____

_____

Please list three academic goals that you would like your child to accomplish this year?

1._____

_____

2._____

_____

3._____

_____

Other Information

Are there any spiritual/cultural variables that you feel we should be aware of that may affect the way we provide services to your child? If yes, please describe:

_____

_____

_____

_____

Are there any relevant legal issues involving you or your child that you feel we should be aware of that may affect the way we provide services to your child? If yes, please describe:

_____

_____

_____

_____

Medical Information

List child's medications (name and reason for taking the medication):

_____

_____

_____

_____

Does your child have any allergies (drug or food)? If yes, please provide a copy of your child's Allergy & Anaphylaxis Emergency Care Plan or another written emergency care plan:

_____

_____

_____

_____

Does your child have a specific medical diagnosis or significant health problem?

_____

_____

_____

_____

Is your child currently being treated for a medical condition? If yes, please provide the current treating clinician, current therapeutic interventions, and response to that intervention:

_____

_____

_____

_____

Has your child had any surgeries? If yes, what type and when:

_____

_____

_____

_____

Please describe any major accidents or hospitalizations, including visits to the ER:

_____

_____

_____

_____

If applicable, please provide the approximate age at which your child had the following illnesses/ conditions:

	Allergies		Asthma		Chicken Pox
	Colds		Croup		Dizziness
	Draining Ear		Ear Infections		Encephalitis
	Feeding		Growth Problems		Headaches
	High Fever		Influenza		Measles
	Meningitis		Mumps		Pneumonia
	Seizures		Sinusitis		Sleep Problems
	Tonsillitis		Other:		Other: