North Carolina Solutions (NCS) Intake Questionnaire: Please Print

The following questionnaire is to be completed by the child's parent or legal guardian, and turned in before a scheduled assessment. This form has been designed to provide essential information before your initial appointment in order to make the most productive and efficient use of your and our time. Please feel free to add any additional information which you think may be helpful in understanding your child. LAS will regard your information as strictly confidential and this information will only be released in accordance with HIPAA guidelines and as mandated by law. Please fill in **all blanks** and use the backs of the pages or other pages for additional information.

Name of Person Completing this Form: ______________________________

____

Biographical Information:

1. Legal Name of Child/Adolescent:____
2. Nickname or Name Child Routinely Goes By:_____________________________________
3. Child Date of Birth:____/_____/____ Social Security #:_____________________ (required)
4. Home Address: Street:____

   City:_________________, State:_____ Zip Code:_________
5. Guardian Name:_____________________ Guardian Name:_________________________
6. Contact Details:

Work Phone(s)	Cell Phone(s)
Mother: ______________________________	Mother: ______________________________
Father: ______________________________	Father: ______________________________
Other: ______________________________	Other: ______________________________

Home Phone(s)	E-mail
Mother: ______________________________	Mother: ______________________________
Father: ______________________________	Father: ______________________________
Other: ______________________________	Other: ______________________________

7. Mother's Marital Status: ___Married ___Divorced ___Separated ___Single ___Widowed
8. Father's Marital Status: ___Married ___Divorced ___Separated ___Single ___Widowed
9. If divorced, please complete the following:

   Who has physical custody? ___________________ Full or Joint?_________________

   Mother: ___Remarried ___Cohabitating ___Single
   Step-Father's Name: ____

   Father: ___Remarried ___Cohabitating ___Single
   Step-Mother's Name: ____

10. Siblings:

Name	Relationship	Age	Living in Home?

11. Please list all people who currently live in the home, not including your child to enroll:

Name	Relationship

Medical History:

1. Developmental Milestones: Please fill in age the skill was mastered.

   ____crawl ____sit ____stand ____walk ____run

   ____ self-feed ____ first word ____ toilet train

2. Has your child had any medical complications during birth or childhood? If yes, explain.

   ____

   ____

3. Usually children need a diagnosis of autism (ASD) from either an MD or PhD psychologist for insurance to cover the ABA services. Please enter information on ASD diagnosis:

   Diagnosis Date:____/____/____ Location/Center:________________________________
   Professional's Name/Title:____

4. Does your child have any other current medical/behavioral health diagnoses? ___ Y ___ N

   Diagnosis: ______________________________ Diagnosis Date:____/____/____
   Professional's Name/Title:_________________ Location/Center:___________________

   Diagnosis: ______________________________ Diagnosis Date:____/____/____
   Professional's Name/Title:_________________ Location/Center:___________________

5. Current Medications and prescribed use:

Medication/Dosage	Prescriber	Date Prescribed	Used to Treat

6. Does the child have any hearing or vision problems? _____ Yes _____No

7. Please list any serious illnesses, injuries, hospitalizations, or special conditions (**please include allergies**):____
____
____
____
8. Name of Child's Primary Physician(s): ____
   Physician Phone: ___________________________ Fax:__________________________

I consent to Lonestar Autism Solutions sharing information about the above-named child with their primary physician for continuity of care purposes: _____Yes ____No.

School Information and Other Services:

1. Child's School District:_________________ Campus Name:______________________
   Grade Level:______ School Classroom Placement: _____________________________
   Current Teacher(s):____
2. Child's current school schedule, if attending school, including *days* and *times*:
   ____
3. Has your child ever repeated a grade? ______ Yes ______ No
4. Behavioral concerns in school environment? Please describe:_____________________
   ____
5. Does your child currently receive special education services? _____ Yes _____ No
6. Does your child currently receive other private services such as speech or occupational therapy? ______ Yes ______ No If yes, please fill out the tables below:

Service: (e.g., OT, Speech)	Provider Name (e.g., school, private)	Day(s) of the week received:	Hours per week received:

If private services (i.e., outside of school):

Name of Company Provider	Name of Therapist	Contact Information

7. Has your child attended ABA before? _____ Yes _____ No If yes, answer below.
   First Date of Service: ______________ Intensity (Hours per week): _________
   Outcome of Services: ____
   ____
   Reason for discontinuation/change: ____
   ____

Social Communication:

Communication:

- How does your child communicate wants/needs? ______________________________________
  ____
- If vocal, how many words per sentence? ____
- Does your child ask questions? List examples. _______________________________________
  ____
- Types of instructions followed/known? ____
  ____

What is your immediate short term goal for communication for your child? ______________________
____
____

Social:

- How does your child play? ____
  ____
- How does your child play with others? ____
  ____
- Does your child initiate interactions with peers? ____________________________________

What is your immediate/short term goal for social/play skills for your child? _____________________
____
____

Pre-academics:

- Reading/Letter ID: ____
- Number ID/Counting: ____
- Colors/Shapes: ____
- Writing/Name ID: ____

____

Daily Living:

1. Eating Issues (i.e., restrictive): ____
2. Sleeping issues (e.g., falling and staying asleep): _______________________________
   ____
3. Toileting: *Being toilet trained is NOT a requirement for attendance.*
   Please describe your child's level of independence in toileting.
   ____
   ____

____

Behavioral Concerns: (*when* does it occur and *what* do you do)

Behavior Name and Description	
What does it look like?	
What does it happen most often?	
What do you do during or after?	

Insurance/Payment Information:

1. How do you plan to pay for services? _____ Insurance ______ Private Pay
2. If insurance, name of company: ____

(Medicaid not currently covering ABA therapy, sometimes special approval can be sought.)

3. Primary Policy Holder Name on ID Card: ____
4. Subscriber ID #: ___________________________ Group #: __________________________
5. Person Responsible for Payment, if different from above:____________________________
   Street:____
   City:___________________ State:____ Zip Code:_________ Home Phone:______________
   Work Phone:____________________________ Cell Phone:___________________________

Enrollment:

1. How soon would you like to start therapy? ____
2. What days/hours is your child available for therapy? Please list the days and times.

____
____

3. How did you hear about us? ____
4. We strive to provide a positive environment for your child. Please tell us about your child's likes and preferences:
    - Edibles: ____
    - Tangible: ____
    - Activity: ____
    - Social: ____
5. It is important to use your child's strengths while working on goals. What activities and tasks does your child enjoy and/or do well? ____
____
____
____

________________________________ ________________________________
Signature Date

________________________________ ________________________________
Printed Name Name of Client