



Will anyone else accompany/drop off/pick up your child? Y N

If yes, please list their contact information:

Name: _____ Phone:(____)_____

Name: _____ Phone:(____)_____

Developmental Milestones

Milestone	What age did your child perform on their own?
Sitting Up	
Crawling	
Babbling	
Walking	
One Word Phrases	

Family History

Parents are (circle one): Married Living Together Separated Divorced Remarried

Is patient adopted? Y N If yes, at what age and from where/what country? _____

Are other languages spoken at home? Y N If yes, please list: _____

Who lives in the house with the patient? _____

Name(s) of sibling(s) _____

Have there been any instances of the following in your immediate/extended family members? (please circle):

ADD/ADHD Autism/PDD Communication Disorders Mental Illness Learning Disabilities

Other: _____

Are there any cultural/spiritual variables that may impact treatment? Y N If yes, please explain: _____



Medical Information

Child's Primary Diagnosis: _____ Date of Diagnosis: _____ Age: _____

Diagnosing Physician _____ Most recent date of diagnosis _____

Secondary Diagnosis: _____ Date of Diagnosis: _____ Age: _____

Other Diagnoses: _____ Date of Diagnosis: _____ Age: _____

Referring Physician/PCP: _____ Phone: (____) _____

May we communicate with the PCP if needed? Y N (If yes, please also indicate on the release form)

Has your child's hearing been screened in the last 6 months? Y N If yes, were the results within normal limits? _____

****Please include copies of any previous assessments or evaluations****

Is your child currently on any medications: YES NO If yes, please list below:

Medication	Date Prescribed	Dosage	Administration Times	Used for

Were there any complications during pregnancy? Y N If yes, please describe: _____

Length of pregnancy? _____

What was the child's birth weight? _____

Were there any concerns or trauma during birth? _____



Has your child ever been admitted to a hospital/treatment center for psychiatric, medical, behavioral or crisis situations: _____

Has your child been diagnosed with any medical conditions (e.g., infectious diseases, seizure disorders, cerebral palsy, etc.): _____

Does your child have food or other types of allergies: _____

Describe your child's eating habits: _____

Describe your child's sleeping habits: _____

Is there any history of abuse? _____

Educational Services Information

What school does your child attend? _____

of students in classroom: _____ Staff to student ratio: _____

Special Education or General Education Days/time of attendance: _____

May we communicate with school? Y N (If yes, please indicate on release form)

School contact information (teacher's email/phone): _____

Does your child have current in-home services? If yes, please describe:

Date started: _____ Public Agency: _____ Private provider: _____



Previous Educational Services

Has your child attended school other than the school mentioned above? Y N

If yes, please provide name of school: _____

of students in classroom: _____ Staff to student ratio: _____

Special Education or General Education Days/time of attendance: _____

History of ABA Services

Has your child received ABA services in the past? Y N

If yes, please provide when, where, and how long: _____

Describe other services and/or activities your child participates in:

Service/Activity/ Provider Info.	Date Started	Hours/Minutes per week
_____	_____	_____
_____	_____	_____
_____	_____	_____

****Please attach the most recent reports including goals & objectives statements****

Reinforcement/Child Preferences

Describe the items and activities your child enjoys: _____

Identify typical reinforcers in these groups:

Food: _____

Toys: _____



Praise: _____

Physical Activities: _____

Describe what your child would do if left alone for a period of time: _____

Behavioral Language Assessment

Expressive Verbal Skills

Describe your child's ability to babble speech sounds: _____

Describe your child's spontaneous language: _____

Describe how your child indicates what he/she wants: _____

Describe the type and number of items that your child asks for: _____

Describe your child's ability to imitate vocal sounds, words, phrases: _____

Describe your child's ability to label items, events, or actions (spontaneous? how many? how often?): _____

Describe your child's ability to answer questions: _____

How well is your child understood by familiar and unfamiliar listeners? _____



List what sounds your child has the most difficulty with : _____

Estimate how many words are in your child's vocabulary:

___ under 50 ___ 50-100 ___ more than 100

Receptive Language Skills

Describe your child's ability to follow directions and routines within context or with model: _____

Describe your child's ability to follow directions and routines out of context or without a model: _____

Is your child able to follow directions given to a group of children? _____ How large of a group? _____

Is your child able to select a named item from a field of two or more items? _____

How many items is your child able to identify receptively? _____

Is your child able to select an item from a field of two or more when given a description of the item? _____

Is your child able to receptively identify body parts, colors, big/little? _____

Motor Imitation

Is your child able to imitate simple motor movements such as clapping, waving? _____

Is your child able to imitate actions using objects---using "do this" with a model? _____

Is your child able to imitate finger-play actions with a song? _____ With a group? _____

Social Skills

Your child makes eye contact with (circle all that apply): Mom Dad Siblings Familiar people Others

Describe your child's response when addressed by others: _____



Describe your child's interest in being with others (children, adults, familiar, unfamiliar): _____

Describe your child's interest in doing what others are doing: _____

Describe your child's ability to participate in turn-taking activities: _____

Is your child conversational? Y N Describe: _____

Does he/she get "stuck" on certain topics? Y N Describe: _____

Play Skills

Describe your child's play with toys (identify the toys and length of time involved): _____

Does your child use the toys as intended or as self stimulatory objects? _____

Describe your child's interactive play with other children: _____

Describe your child's imaginative and pretend play skills: _____

Academic Skills

Check skills that your child is able to demonstrate:

____ Recites Alphabet ____ Labels Each Letter Counts to ____



___ Counts with one-to-one Correspondence

___ Reads words ___ w/ comprehension

___ Stacks Blocks

___ Completes Simple Puzzles

___ Orders Items Smallest to Biggest

___ Identify Letters Receptively

___ Identify numerals Receptively

___ Labels Numerals up to ___

___ Reading Level

Fine Motor and Gross Motor Skills

Describe your child's gross motor skills in general: _____

Check the skills your child is able to demonstrate:

___ Throw a Ball ___ Kick a Ball ___ Bounce a Ball ___ Catch a Ball

___ Roll a Ball ___ Raise Arms Up ___ Jump on One Foot ___ Twirl Arms

Describe your child's fine motor skills in general: _____

Check the skills your child is able to demonstrate:

___ Scribbles ___ String Beads ___ Writes Letters ___ Writes Words

___ Draws pictures ___ Uses Scissors ___ Draws Lines ___ Draws Shapes

___ Itsy Bitsy Spider ___ Writes Name

Self-help Skills

Describe how your child feeds him/herself: _____

Does your child wash and dry his/her hands independently? _____



Is your child toilet trained completely? Y N If not, what program did you use or have you tried with your child? _____

Does your child dress independently: Y N Describe: _____

Describe any household tasks that your child assists with: _____

Describe how your child responds to situations of danger: _____

Challenging Behaviors

Can you tell your child no? Y N If not, describe the behavior: _____

Can you take away preferred items? Y N If not, describe the behavior: _____

Are you able to take your child to public places? Y N If not, describe your child's behavior in public places:

Can your child wait appropriately? Y N Describe: _____

Does your child follow/comply with instructions in everyday situations? Y N Describe: _____

Describe in general your child's behavior at home: _____



Describe any of the following that pertain to your child and the conditions under which they occur:

Repetitive behaviors: _____

Physical Aggression: _____

Property Destruction: _____

Obsessive/Ritualistic Behaviors: _____

Self Injurious Behavior: _____

Stereotypic Behavior: _____

Unsafe/Dangerous Behavior: _____

Narrative

Describe your child's development from birth to present (including abilities and how he/she learns best): _____

Expectations/Goals

Rank from 1-5 the order of your prioritized goals and skill areas for your child (eg. Language, socialization, reducing challenging behaviors, play, self-help, toileting):

1. _____
2. _____
3. _____
4. _____
5. _____



Please indicate your child’s weekly schedule (nap times, preschool, sports practices, sibling activities, other therapy services, etc.). This schedule will serve as a guideline, not a guarantee, for CTAC to use when finding a session time that works for best for your child. **ABA sessions typically run 2-4 hours in length and are blocked Monday/Wednesday/Friday or Tuesday/Thursday.**

Time	Monday	Tuesday	Wednesday	Thursday	Friday
8:00					
8:30					
9:00					
9:30					
10:00					
10:30					
11:00					
11:30					
12:00					
12:30	CTAC Lunch/Planning - No therapy at this time				
1:00					
1:30					
2:00					
2:30					
3:00					
3:30					
4:00					
4:30					
5:00					
5:30					

How many total hours were you hoping to receive? _____

Do you prefer therapy be in-clinic _____, in-home _____ or both _____?