INTAKE ASSESSMENT – PARENTS/CAREGIVERS FORM

Thank you for taking the time to fill out our application. Filling this form out will help us get to know your child better. We understand this is a lot of information, please do your best in filling it out accurately. Should you have any questions, please feel free to call our office or ask during your intake.

Thanking you in advance,
Alex Michaels, Executive Director

SERVICES YOU ARE INTERESTED IN: TODAY'S DATE: ___________________________

❑Day School
❑Evaluation and Therapy Center: ❑OT ❑PT ❑Speech ❑Psychological Services
❑Intensive Intervention or Parent Training ❑Floortime ❑ABA ❑Verbal Behavior ❑Other: _______________
❑Practice Pre-School
❑Pragmatic Groups
❑Summer Camp
❑Educational Consultation or Behavior Evaluation
❑Other_______________________________________

How did you hear about us?

List your native language if other than English:

GENERAL INFORMATION:

Child's Name: ____ Date of Birth: ________________________

Social Security Number: ___________________________ Current Grade (if applicable) _________________

Address: ____

____ ______________ ________________________
(town) (state) (zip)

Parent 1: _______________________________________ Parent 2: _________________________________

Home Phone: __________________________________ Home Phone: ____________________________

Cell: ____ Cell: ______________________________________

Work: ____ Work:______________________________________

Email: ____ Email:____________________________________

Address if different than child: ____

Preferred Method of Contact: _____ email _____ phone (please specific which one): ______________

Sibling Names & DOB:____

REASON(S) YOU ARE SEEKING AN EVALUATION OR SERVICES:

WHY DOES YOUR CHILD THINK S/HE IS COMING TO OUR OFFICE?

WHAT ARE YOUR CHILD'S FAVORITE THINGS/INTERESTS?

CURRENT SERVICES: What services does your child current receive?

SERVICE	FREQUENCY	DAY / TIME	PROVIDER

CURRENT SCHOOL PLACEMENT (if Applicable)

School Name: ____

Address: ____

Teacher's Name: ______________________________ Phone: ____________________

WHAT INTERVENTIONS HAVE BEEN TRIED?

Please list all interventions your child has tried in the appropriate columns below

Helpful	So-So	Not Helpful

CHILD'S DIAGNOSIS:

❑ Does not have a diagnosis

Has your child ever been diagnosed with any of the following (check all that are applicable):

CATEGORY	DISORDER	When did you first notice something was wrong? And do the symptoms come and go?	Who Diagnosed this problem (please list all people, even if they said the same thing) Or list if the problem was self-diagnosed	Year Diagnosed
Developmental or Neurological	❑ Autism ❑ PervasiveDevelopmental Disorder (PDD) ❑ Asperger's Syndrome ❑ Nonverbal LD ❑ Down's Syndrome ❑ Mental Retardation ❑ Chromosomal Disorder ❑ Prematurity ❑ Seizure Disorder or LKS ❑ Sleep Disorder (specify) ❑ Other			
Sensory-Motor	❑ Apraxia ❑ General Gross or Fine motor delay ❑ Cerebral Palsy ❑ Spinal Bifida ❑ Developmental Coordination Disorder ❑ Sensory Integration Disorder ❑ Low Muscle Tone (Hypotonia) ❑ High Muscle Tone (Hypertonia) ❑ Other			
Learning	❑ Dyslexia ❑ Dyscacula ❑ Dysgraphia ❑ Other			
Language / Hearing				

Please continue on next page:

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Continued from pervious page:

CATEGORY	DISORDER	When did you first notice something was wrong? And do the symptoms come and go?	Who Diagnosed this problem (please list all people, even if they said the same thing) Or list if the problem was self-diagnosed	Year Diagnosed
Mood Disorder / Anxiety /Tic Other	❑ Generalized Anxiety Disorder ❑ Separation Anxiety Disorder ❑ Mutism ❑ Obsessive-Compulsive Disorder ❑ Panic Disorder ❑ Agoraphobia ❑ Specific Phobia ❑ Social Phobia ❑ Tourette's Syndrome ❑ Depression ❑ Bipolar Disorder ❑ Dysthymic Disorder ❑ Post Traumatic Stress Disorder ❑ Other			
Behavior / Attention / Personality	❑ Conduct Disorder ❑ Oppositional Defiant Disorder ❑ Impulse Control Disorder ❑ Intermittent Explosive Disorder ❑ ADD ❑ ADHD ❑ Substance Abuse ❑ Somatoform or Convergence Disorder ❑ Personality Disorder (please specify) ❑ Other			

If your child has a diagnosis, does s/he know it? ____YES ____NO

If so, what do you call it:

DEVELOPMENTAL PROFILE:

1. How was your child conceived: ❑ naturally ❑ Fertility Treatments ❑ adopted
2. Were there any problems with: ❑Pregnancy ❑ Labor ❑ Delivery
   If you checked any box, please describe:
3. Birth Weight ____lbs ___ oz Length ________ inches Apgar Score _______ 1st _________ 2nd
4. As a baby, how would you best describe your child: ❑ cried excessively (for how long________)
   ❑ Was very quiet ❑ Was very alert ❑ Didn't seem to notice things in his/her environment
5. At what age did your child: _________ first babble __________ First say his/her first word:
6. ________ Say his/her first sentence: ______ my child doesn't talk yet
7. My child is ❑ right handed ❑ left handed ❑ ambidextrous or doesn't seem to have a preference yet
8. How many hours a day of TV/Computer/Videogame time does your child engage in?
   During the week: ❑ none ❑ 1/2 hour -1 ❑ 1-2 ❑ over 2-3 ❑over 3
   On the weekends: ❑ none ❑ 1/2 hour -1 ❑ 1-2 ❑ over 2-3 ❑over 3
9. What time does your child go to bed? _________ get up____________
10. Does your child wake in the middle of the night? ❑ no ❑ Yes ❑ Sometimes How often ___

Please check those items that describe your child (check all the apply):

- ❑ Affectionate
- ❑ Follower
- ❑ Sad
- ❑ Fearful
- ❑ Friendly
- ❑ Self-confident
- ❑ Aggressive
- ❑ Happy
- ❑ Sensitive
- ❑ Nervous, anxious or tense
- ❑ Has temper tantrums
- ❑ Shares easily
- ❑ Careless
- ❑ Immature
- ❑ Cheerful
- ❑ Independent
- ❑ Talkative
- ❑ Cries easily
- ❑ Leader
- ❑ Daydreams
- ❑ Moody
- ❑ Eager to learn
- ❑ Outgoing
- ❑ Unusually fearful
- ❑ Unusually fearless
- ❑ Quiet
- ❑ Very active
- ❑ Even tempered
- ❑ Restless
- ❑ Very dependent

MEDICAL PROFILE:

Child's Pediatrician: ____________________________ Phone Number: _________________

Address: ____________________________Town:_________________State:_____ Zip:________

Psychologist or Neurologist: _________________________ Phone number: ________________

Address: ____________________________Town:_________________State:_____ Zip:________

Are your child's immunizations up to date? ____YES ____NO

If "no", what immunizations are your child missing: _______________________________

Reason:

Was the child ever hospitalized (medical or psych) for any reason or operations? ____YES ____NO

Date of Admission	Hospital's Name	Reason for Admission or Surgery

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Does your child take medication?

Name of Medication / Supplement	Dose	Reason	Prescribing Physician

If your child on a special diet? ____ YES ____ NO. If so, what type: ____

Does your child experience any of the following? If so, please rate from 1-3 (1) Mild (2) Moderate (3) Severe

#	Symptom	#	Symptom	#	Symptom
	Headaches		Dark Circles under eyes		Mood swings
	Sensitive to sounds/noises		Frequent diarrhea/ constipation		Refusal to eat
	Cracking/Peeling of hands or feet		Strong body odor		White spots on nails
	Hyperactive		Bruises easily		Reflux
	Eczema		Easily Tired		Food Allergies
	Ear Infections (more then 2/year)		Congestion/Dripping nose (when not sick)		Other:
	Other:		Other:		Other:

SOCIAL SKILLS / PRAGMATICS: ❑ My child has no socialization difficulty ❑ I don't know

1. General Social Skills: My child has difficulty with (check all that apply):

   ❑ Initiating conversations
   ❑ Staying in conversation
   ❑ Ending Conversations
   ❑ Joining conversations in progress
   ❑ Knowing what and when to say thing
   ❑ Reading nonverbal cues (understanding what other's facial expressions, tone of voice, shoulder shrugs mean)
   ❑Recognizing signs that someone is busy or shouldn't be interrupted
   ❑Using nonverbal Cues (facial expressions, tone of voice, shoulder shrugs) to communicate
   ❑Taking another person's perspective
   ❑Negotiating and Compromise
   ❑Flexibility

2. Would you describe your child as ❑extraverted ❑introverted ❑mixed
3. How many interests does your child have: ❑1 ❑2 ❑3 ❑4 ❑more then 5
4. Does your child interact with other people:

   ❑only interacts if s/he wants something
   ❑only interacts with family
   ❑only with family members, adults, or older children
   ❑with adult and peers

5. What does your child like to do when s/he is alone:____

6. What are your child's favorite things to do with other people:________________________________

   ____

COMMUNICATION/HEARING: ❑ My child has no difficulty ❑ I don't know

1. Does your child have difficulty with any of the following:

   ❑articulation
   ❑ fluency
   ❑ Stuttering
   ❑ Voice disorder
   ❑ Auditory Processing
   ❑ Autism
   ❑ Apraxia
   ❑ Deaf or Hard of Hearing

2. How would you describe your child's language ability (not in terms of social skills, but actually ability to use language to do thing such as ask questions, make comments, basic communication)? My child:

   ❑has no language
   ❑has limited language
   ❑we can understand him/her, but others can't
   ❑can answer basic questions, but doesn't voluntarily speak
   ❑Babbles
   ❑Points to get what s/he wants
   ❑pulls my hand to get what s/he want
   ❑Repeats sounds or words over and over
   ❑Head jerking or eye blinking while talking
   ❑Leaves out certain consonants, sounds or distorts sounds
   ❑Uses a lot of "um" "uh" while talking
   ❑Can't remember the names of things
   ❑Child's voice sounds different than peers

3. Does your child use gestures such as:
   ❑ pointing ❑ shaking head for yes / no ❑ shrugging shoulders for "I don't know"

4. When you smile, does your child smile back? ❑Yes ❑No ❑sometimes

5. When your child doesn't know something, what does s/he do to gain information (check all that apply): ❑Nothing ❑Look towards an adult ❑Look towards a peer ❑Ask questions ❑Other:

6. Do you have concerns that you talk and your child doesn't understand what you are saying?
   ❑yes ❑no ❑sometimes

EXECUTIVE FUNCTIONING: ❑ My child has not executive functioning difficulty ❑ I don't know

1. Does your child have difficulty with: ❑Organization ❑Attention ❑Transitioning

   Please describe: ____

2. Does your child get stuck on certain tasks and can't move from them ❑Yes ❑No ❑sometimes

3. Would you consider your child flexible? ❑Yes ❑No ❑sometimes

4. Can your child ignore things in the environment or thoughts in his/her mind and pay attention to the task at hand? ❑Yes ❑No ❑sometimes

5. Is your child forgetful ❑Yes ❑No ❑sometimes

6. Is your child able to learn from his/her mistakes ❑Yes ❑No ❑sometimes

BEHAVIOR: ❑ My child has no behavior difficulty ❑ I don't know

1. In the past year at ***HOME*** has your child displayed any of these symptoms:

❑Hit	❑Yell	❑Lied
❑Kick	❑Throw things	❑Stole something
❑Bite	❑refuse to do what you ask	❑Intentionally broken other people's property
❑Scratch	❑Fall to the ground and tantrum	
❑Pinch	❑Head banging	
❑Tantrum		

   If you answered yes to any of the above, how many times over the past year ❑1-3 ❑4-8 ❑9+
   What is your best guess to why your child has acted out?

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2. In the past year at EARLY ***INTERVENTION, GROUPS, or SCHOOL*** has your child displayed any of these symptoms:
   ❑Hit ❑Kick ❑Bite ❑Scratch ❑Pinch ❑Tantrum ❑Yell
   ❑Lied ❑Refuse to do what you ask ❑Fall to the ground and tantrum
   ❑Throw Things ❑Stole Something ❑Intentionally broken other people's property

   If you answered yes to any of the above, how many times over the past year ❑1-3 ❑4-8 ❑9+
   What is your best guess to why your child has acted out?

3. Can you take your child and another child in to the community with only one adult without problems?
   ❑yes ❑no

4. Does your child require additional assistance to stay on task (i.e. if you tell your child to do something such as get a toy from another room, will s/he do it on the first request or do you need to ask several times or help your child? ❑yes ❑no

5. If in school, does your child have a 1:1 at school? ❑yes ❑no

6. Has your child ever been asked to leave a program or not come back the following session? ❑yes ❑no
   If yes, which program and why?

7. What interventions work best for your child: ❑ignoring ❑redirection ❑time out ❑I mean it face

   ❑loss of privileges ❑other (please explain)____

8. If applicable, does your child have a behavior plan at school? ❑Yes ❑No If yes, please attach it.

9. If your child is doing something a little wrong how do you handle it? ____________________

10. If your child is doing something very wrong, how do you handle it? ____________________

11. Who is the primary person that handles discipline in your home? ____________________

SENSORY-MOTOR: ❑ My child has no sensory processing difficulty ❑ I don't know

1. Terms which best describes your child:
   ❑Under-aroused ❑Over-aroused ❑Transitioning ❑Mixed/Dysregulate

2. Sensitivities to: ❑sound ❑touch ❑taste ❑movement ❑lots of visual stimulation

3. What interventions do you currently use for sensory regulation?: ____________________

4. Activities of daily Living: Can your child independently or with age-appropriate assistance:

Activity	Not Yet	Yes, but with difficulty or needs assistance	Independently	Age began
Sitting alone				
Crawling				
Walking				
Running				
Jumping with two feet off the ground				
Hopping / Skipping				
Alternating feet up and down stairs				
Using a Spoon				
Using a Fork				
Putting shoes on				
Tying shoes				
Buttoning and Zipping				
Throwing a ball				
Catching a ball				
Brushing teeth				
Combing hair				
Putting self to bed				
Bathing unassisted				
Playing independently				
Making small meals				
Helping around the house				
Writing				
Reading				
Toileting (urine and bowel movements)				
Verbalizes when hurt / inured				
Eating a balanced diet				

5. When your child becomes upset how long does it take until s/he can calm down and return to activities? _____
Does s/he need help to calm down? ❑No ❑Yes

6. What calms your child down?:

ACADEMIC PROFILE (for students age 5 and up)

How would you rate your child's academic ability and please describe.

Subject	GRADE LEVEL			ENJOYMENT		Additional Information
	Below	On	Above	Enjoys	Dislikes	
Math						
Science						
History						
English						
Phys. Ed. / Gym						
Other						

Do you have any academic concerns for your child?

Other
Is there any other information you would like to tell us about your child?

MILESTONES
Excellence in Child Development Since 1994.

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I hereby authorize Milestones, Inc. (and its two subsidiaries: Educational Consultants of New England, Inc. / Camp Good Times, inc.) to have two- way information sharing with the people/agencies listed below. Information may include:

- ☑ Medical, Psychological, Developmental, or Educational evaluations/records
- ☑ Diagnostic, Medical, Psychological, or Educational Testing
- ☑ Laboratory reports
- ☑ Telephone Conversations
- ❑ Other (please specify) ______________________________

Child's Name: ______________________________ DOB: ____________________

AGENCY	Name of Agency or Person	Full Address	Phone Number
School District (even if child is under 3)			
Early Intervention (if applicable)			
Pediatrician			
Other			
Other			
Other			
Other			
Other			

I have carefully read and understood the above statements and do herein expressly and voluntarily consent to disclosure of the above information and/or medical records, including alcohol and drug abuse records, if relevant, to/by those persons /agencies named above. I understand that this information may be protected by Federal Regulation 42 CFR, Part 2. I understand that my protected health information used or disclosed pursuant to this authorization may or may not be subject to re-disclosure by the recipient. I understand that this consent is subject to revocation at any time except after the information has already been released.

Print Your Name: ______________________________ Date: ____________________

Signature: ______________________________ Relationship: ❑Mother ❑Father ❑Other__________