Please check which service(s) you are interested in:

Applied Behavior Analysis (ABA) ( ) Social Skills Training ( )

Before a therapy assessment can take place, we need ***written confirmation of a diagnosis as well as a diagnostic assessment and a prescription stating the diagnosis and referral for ABA or Social Skills Training.***

Question	Answer If Yes, please explain:
1. Does the client have any history of anxiety?	☐Yes ☐No
2. Does the client have any history of depression?	☐Yes ☐No
3. Does the client have any history of suicidal ideations or acts?	☐Yes ☐No
4. Does the client have any history of homicidal threats or acts?	☐Yes ☐No
5. Does the client have any experience of being physically or sexually abused?	☐Yes ☐No
6. Does the client have any experience with being the perpetrator of sexual or physical abuse?	☐Yes ☐No
7. Has the client sought treatment for their autism diagnosis in the past (including Early Intervention)? Please list dates	☐Yes ☐No

8. If yes, list any community based programs or assistance used:	1. 2. 3.
9. Who diagnosed your child and when?	______ ______ ______
10. Has the client been or is being seen by another behavioral health clinician?	☐Yes ☐No ______ ______ ______
11. Please list all medications and dosages.	1. 2. 3.
12. List the presenting problems and the reasons the client is entering The Family Center for Autism's program and the psychological/social conditions affecting their status:	1. 2. 3. 4.
13. List all family members or related providers involved in the client's treatment for this diagnosis (explain their capacity - including parents or guardians):	1. 2. 3.
14. Please name all family members living in the home and the relationship to your child.	1. 2. 3.
15. Does the client have any family member with a history of medical or behavioral health concerns?	☐Yes ☐No ______ ______ ______
16. How many hours of ABA are being requested? List available days and times. (Minimum of 6 hours is recommended)	______ ______ ______

17. List all sources of support, barriers and influence that may impact the client and family:	Vocational: ____________ Spiritual: ____________ Cultural: ____________ Educational: ____________
18. Relevant Legal Matters	Divorce: ____________ Custody: ____________ Records Subpoenaed: ____________
19. Please describe your pregnancy: full term, complications, natural or C-section, medications during, complications after etc.	☐ C-section ☐ natural ____________ ____________ ____________ ____________
20. Did your child reach developmental milestones? Please indicate when and what milestone.	☐ on time ☐ delayed ____________ ____________ ____________ ____________
21. Does your child attend public school and what type of classroom are they in? Please indicate the ratio if your child is in a Self-Contained classroom.	☐ Self-contained ☐ Inclusion ☐ Mainstream ☐ Public ☐ Private
22. Does your child receive related services (Speech, PT, OT, Counseling, Social Group etc.) and if so, how often?	☐ Speech ☐ Physical Therapy ☐ Occupational Therapy ☐ Counseling ☐ Social Group Other: ____________
23. How does your child communicate their wants and needs? (For example, gestures, one word requests, full sentences)	☐ Full Sentences ☐ 2-3 word requests ☐ 1 word requests ☐ Gestures ☐ PECS/Augmentative Device
24. Can your child engage in a conversation (at least 5 volleys) with information that is relevant to the conversation?	☐ Yes ☐ No ____________ ____________ ____________ ____________

25. Please list likes and dislikes. For example, likes the iPad, dislikes loud noises.	____________________ ____________________ ____________________ ____________________
For clients over the age of 12 <u>ONLY</u>: If Yes, please explain:	
Does the client drink alcohol?	☐Yes ☐No If yes list amount/type:
Has the client ever felt he/she ought to cut down on drinking?	☐Yes ☐No
Does the client use drugs?	☐Yes ☐No If yes list amount/type:
Has the client ever felt he/she ought to cut down on the use of drugs?	☐Yes ☐No ____________________
Has the client ever felt bad or guilty about drinking or drug use?	☐Yes ☐No
Has the client ever had a drink or used drugs first thing in the morning to steady their nerves, to start their day or to get rid of a hangover (eye-opener)?	☐Yes ☐No ____________________