INTAKE QUESTIONNAIRE

Instructions: To better acquaint us with your child, please print, complete this form, scan and return to info@beyond-autism.com. Please attach your child's current IEP, MET, BIP and/or other pertinent documents.

Student's Name:_____**Nickname:**_____

Address:_____

Lives with:_____**DOB:**_____ **Age:**_____

Please share a cool attribute or talent that you'd like us to know about your child:

_____
_____
_____
_____

Medical/health

Diagnosis(es):_____

Medications:_____

Dietary restrictions:_____

Allergies:_____

Toileting habits: (please circle) Independent Some assist Total assist

Please explain:_____

Does your child: place inedible objects in his/her mouth? Y N Choking hazard? Y N
If yes, please explain:_____
_____

Educational

Current school:_____ **Grade:**_____

Please circle one: Public Charter Private Home school

What additional services is your child receiving: ST PT OT Music In home services

Other:_____

In order of priority, please rate your goals for your child: (1= greatest, through 5=least)

Social ____ Life Skills_____ Community Involvement _____ Academic_____ Behavioral management_____

Social/Communication

What form (s) of communication does your child use? (circle all that apply)
Vocal PECS Augmentative communication Signs Pointing/pulling you to item

Does your child request desired items or activities spontaneously? Yes No

Does your child react appropriately when asked to hold their hand/arm for safety purposes? Yes No

Is your child able to follow directions when asked to complete small tasks around the house (i.e. shut the door, come here, wash your hands)? Yes No

Behavioral

Does your child have a current Behavior Intervention Plan? Yes No

Does your child currently require a 1:1 aide to assist during the school day? Yes No

Does your child exhibit different behaviors at school than you see in the home? Yes No If yes, please explain:

_____

_____

Does your child exhibit unwanted/negative behaviors with any of the following:

	Y / N	Behavior(s) observed
noisy environments		
changes to schedule		
waiting , sharing, turn taking		
being told "no" or "not now" or "later"		
limit access to preferred item(s)		
transitions		
trips to stores, barber, dentist, etc		
other:		

Does your child exhibit any self-injurious (towards themselves) or aggressive (towards others) behaviors? Yes No If yes, please describe: type, frequency, and triggers of those behaviors:

_____

_____

_____

In what circumstances do these behaviors occur the least? (i.e, at Grandma's house, at home, on weekends)

_____

_____

_____

In what circumstances do these behaviors occur the most? (i.e. when iPad is taken away, when forced to complete a task, at bedtime)

_____

_____

_____

If your child engages in difficult/negative behaviors or meltdowns at home, what adjustments do you make to stop them?

_____

_____

_____

Life/functional skills

Please list your child's favorite activities, toys, and/or games that are highly reinforcing and they enjoy:

_____
_____
_____

Describe strengths AND areas of need in daily living skills to include: chores, hygiene, making meals, etc:

_____
_____
_____

Sensory

Does your child seek: swinging jumping rocking deep pressure/weighted blankets chewies

Please describe:_____
_____
_____

Does your child have any aversions to odors, textures, sounds, eye contact, taste? Yes No

Please describe:_____
_____
_____

What soothing techniques, appropriate or otherwise, does your child utilize to calm himself/herself?

_____
_____
_____

Family

Are you, the family, willing to work collaboratively with our team and actively participate in your child's education? Yes No

***Beyond* Autism is a non-profit organization that requires participation from our families to ensure we can continue to provide a comprehensive program for all of our students. Are you able and willing to assist with our annual fundraiser in some capacity? Yes No**

_____

Name of person completing the form ***Relationship*** ***Date***

Contact Phone Number ***Email address***