INTAKE QUESTIONNAIRE

To better acquaint us with your child, please complete this form and return to info@beyond-autism.com. Please attach your child's current IEP, MET, BIP and the most recent diagnostic evaluation(s) that will assist our team in determining if placement is appropriate for your child.

Student's name: _____ Nickname:_____

Address:_____

Lives with: _____ DOB:_____ Age: _____

Please tell us about your child and describe where they are most successful:
_____
_____
_____
_____

Medical/health

Diagnosis(es): _____

Medications: _____

Dietary restrictions: _____

Allergies (food, medications): _____

History of seizures: Y N If yes, please describe:

_____

_____

Educational

Current school: _____ Grade:_____

What services is your child receiving: (please circle all that apply) ST PT OT Music ABA

Is your child able to sit at a desk and complete a task? Y N For how long? _____

Is your child able to work independently? Y N For how long? _____

Does your child participate in (circle all that apply) 1:1 sessions small group large groups

Does your child require a 1:1 aide during the school day? Y N

Is your child receiving or previously received ABA therapy? Dates: _____ to _____

Agency:_____ Phone: _____

Contact:_____ Permission to contact this agency? Y N

What supports does your child need to be successful in a school setting?

_____

_____

Communication

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

If your child does use AAC, what software does he/she use? _____

Does your child use a different communication system at home than at school? Y N

Does your child request desired items or activities spontaneously? Y N

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)? Y N

Safety

Does your child's exhibit safety awareness in parking lots, near water, in the community? Y N

If no, please explain: _____

Does your child exhibit safety while riding in vehicles? Y N

If no, please explain: _____

Does your child have a history of elopement? Y N

If yes, please explain: _____

Does your child react appropriately when asked to hold their hand/arm for safety purposes? Y N

Does your child: place inedible objects in his/her mouth? Y N Choking hazard? Y N

If yes, please explain: _____

Behavioral

Does your child have a current Behavior Intervention Plan? Y N

Does your child require a 1:1 aide to manage his/her behavioral needs? Y N

Does your child exhibit different behaviors at school than you see in the home? Y N

If yes, please explain:

_____
_____

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)

_____
_____

Does your child exhibit any self-injurious (towards self) or aggressive (towards others) behaviors? Y N

If yes, please describe (please include type, frequency, and triggers of those behaviors):

_____
_____
_____
_____
_____

If your child engages in disruptive/challenging behaviors at home, what strategies do you deploy that help?

_____
_____
_____

Does your child exhibit disruptive/challenging behaviors with any of the following:

	Y / N	Behavior(s) observed
noisy environments		
changes to schedule		
waiting		
taking turns		
during non preferred tasks		
being told "no" or "not now" or "later"		
limit access to preferred item(s)		
transitions		
trips to stores, barber, dentist, etc		
during mealtime		
completing the bathroom routine		

Sensory

Does your child seek out(circle all that apply):

swinging jumping rocking deep pressure weighted blankets chewies other:_____

Please describe:

_____
_____

Does your child have any aversions to odors, textures, sounds, eye contact, taste? Y N

Please describe:

_____
_____

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

_____
_____
_____

Life/functional skills

How would you describe your child's level of independence in the following areas:

eating/drinking	Indep	Some assist	Total assist
toileting	Indep	Some assist	Total assist
showering, bathing	Indep	Some assist	Total assist
brushing teeth, hair	Indep	Some assist	Total assist
dressing, undressing	Indep	Some assist	Total assist
getting in/out vehicle, seatbelt	Indep	Some assist	Total assist
handwashing	Indep	Some assist	Total assist
meal/snack prep	Indep	Some assist	Total assist

Play/leisure

Please list your child's favorite toys, games, activities and tv shows/videos that are highly reinforcing?

_____
_____

Does your child prefer to play alone or does he/she seek out others? _____

Goals

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

Social ___Life Skills ___ Community Involvement ___ Academic ___ Behavioral management___

We focus on teaching the skills that will have the greatest impact on the lives of our students and their families.

Please share those skills that you believe will improve the lives of your child and your family.

_____

_____

_____

Please share any long term goals that you hope to your child will achieve.

_____

_____

_____

Commitment

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

_____

Printed name *Signature* *Date*

_____

Phone *Email address*