Embrace Your Ability - Intake Form

Client's Name: _____ Date: _____

Client Information

DOB: _____ Age: _____ Grade: _____ Gender: _____ Primary Language: _____

School AND Therapy Centers the Client Attends: _____

Contact Information

Parent Name(s) or Emergency Contact: _____

Email: _____ Phone: _____ Preferred Contact Method: ☐ Call ☐ Text ☐ Email

Address: _____ City: _____ State: _____ Zip: _____

Availability Information

How often do you wish to receive services?

☐ 1 day per week ☐ 2 days per week ☐ 3 days per week ☐ 4 days per week ☐ Other: _____

What days work best for services?

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

What times work best for services?

☐ 5pm - 6pm ☐ 6pm - 7pm ☐ 7pm - 8pm

☐ Weekend: 9am - 10am ☐ Weekend: 10am - 11am ☐ Weekend: 11am - 12pm ☐ Other: _____

Health & Behavioral Information

Insurance Provider: _____

Health History (Diagnosis, Medications, Surgeries, etc.):

_____

_____

What areas of focus are most important to you? ☐ Recreational Therapy ☐ Education ☐ Play ☐ Socialization

Does your child suffer from anxiety? In what areas do you see the most heightened anxiety?

_____

How does your child do with outsiders/guests coming into your home?

_____

How does your child sleep?

☐ Sleeps through the night ☐ Wakes up 2-4 times per night ☐ Has a hard time falling asleep ☐ Wakes up very early

☐ Other: _____

What is your child's diet like?

_____

Does your child have any allergies?

_____

How does your child communicate?

☐ Verbally ☐ Nonverbal ☐ Sign language (ASL) ☐ Assistive device ☐ Other: _____

Please share your religious views / standpoints:

_____

Are you willing to participate and learn while we work with your child? ☐ Yes ☐ No

Health & Behavioral Information (cont.)

What technology is used at home? Are there any that are triggers or issues when using technology?

_____

What negative behaviors does your child have?

☐ Noncompliance ☐ Yelling ☐ Pacing ☐ Hitting ☐ Punching ☐ Kicking ☐ Biting ☐ Elopement ☐ Disrobing
☐ Property Destruction ☐ Other: _____

What are some antecedents (triggers) that are likely to cause negative behaviors?

_____

What is a list of rules that your child has in the home? (Please just list basic "must know" rules)

_____

Do you have pets? Please list.

_____

Please list name, age, and relationship to client for all members in your home.

_____

Does anyone smoke inside the home? ☐ Yes ☐ No

Where will we be working while we are in your home? Do you have an area that we could set up and use as a “home base” for sitting/learning purposes?

☐ Kitchen ☐ Living Room ☐ Office ☐ Play Area ☐ Basement ☐ Other: _____

Do we have permission to assist your child with toileting? ☐ Yes ☐ No

Final Notes

How did you hear about us?

☐ Word of mouth ☐ Social media ☐ Flyer / business card ☐ Church ☐ Other: _____

Please note any other significant information:

_____

_____

_____

_____

_____

_____

I give Embrace Your Ability permission to evaluate and provide services for my child.

Signature: _____ Date: _____

Printed Name: _____