

Intake Form

Date:

Time:

Person Completing the questionnaire:

Child's Name:

Best Contact Number/Email:

1. What city do you live in?
2. What language is primarily spoken around your child?
3. Who has legal custody of your child?
4. Does your child have a diagnosis? If so, what is the diagnosis?
5. If your child has a diagnosis, who was the child diagnosed by?
6. If your child has a diagnosis, what was the date he/she was diagnosed?
7. If your child has a diagnosis, how old was the child when diagnosed?
8. Who is your primary medical doctor?
9. What is the name of your child's school?
10. What is your child's teacher's name?
11. Is your child in a regular education class, special education, inclusion, or other setting?
12. Does your child have a one-to-one aide at school?
13. Does your child receive any special education services at school?
14. Does your child receive any additional services? OT, Speech, physical therapy, other? If so, please provide the name of the therapist or clinic
15. Has your child received any ABA therapy before? If so, from who?

16. Please provide an explanation of requested services (e.g., help my child communicate with others, decrease aggressive behaviors, etc.)

17. Name of insurance company.

18. Please list the person or facility that referred you to Golden Triangle Autism Center.

19. What is your child's date of birth?

20. Which of the following would you consider your child:

- ☐ nonverbal
- ☐ limited speech
- ☐ some words/sentences
- ☐ very verbal