"Dedicated to helping each child reach their full potential...."

Initial Assessment

CHILDREN Making Strides

Parent Packet

Please complete this packet prior to meeting with BCBA for your assessment

CHILDREN Making Strides

Child Information (parent please fill out this section)

Name: **Sex: M F**

Age: **DOB:**

Primary Diagnosis: **Age diagnosed:**

Physician: ***Please attach Diagnostic Report***

Secondary Diagnosis **Age diagnosed:**

Physician: ***Please attach Diagnostic Report***

Other Diagnosis: **Age diagnosed:**

Physician: ***Please attach Diagnostic Report***

Parent/Primary Caregiver and Family History Information (parent please fill out this section)

Parent/Guardian 1

Name: **Relationship to child**

Address:

City:

State: **Home Phone Number: ( )**

Zip code: **Contact Number: ( )**

County:

Marital Status (Circle One): Married Single Divorced

Parent Guardian 2

Name: **Relationship to child**

Address:

City:

State: **Home Phone Number: ( )**

Zip code: **Contact Number: ( )**

County:

Marital Status (Circle One): Married Single Divorced

Sibling Name(s): **DOB:**

_____ _____

_____ _____

_____ _____

_____ _____

Child Currently Lives (Circle One): Home Residential Facility Other:_____

With whom does the child legally reside?_____

Are there any current legal issues regarding patient/family? (Circle One): Yes No

If yes, please list and explain:_____

_____

Are there any spiritual, vocational, cultural, educational, legal or other circumstances that would affect treatment for your child? (Circle One) Yes No

If yes, please explain:_____

Please list why you are seeking treatment for your child:_____

_____

_____

Has anyone in the family had:	**Yes**	**No**	**Parents or sibling of your child (please specify whom)**	**Grandparents, aunts, uncles, cousins of your child (please specify whom)**
Autism Spectrum Disorder				
Mental Retardation				
Impaired Language or Language Disorder				
Severe Communication Problems				
Severe Social Problems (specify)				
Mental Health Problems (specify)				
Emotional Health Problems (specify)				
Substance Abuse/Alcohol Problems (specify)				
Behavioral Problems				

Child's Medical History (parent please fill out this section)

Primary Care Physician:_____

Address:_____

_____

_____

Please list any medications your child is currently taking:

Medication	Dosage	Reason medication prescribed

Medical History

Has your child had any of the following? If yes, check and explain

Starring Spells		
Seizures		
Head Trauma		
Speech Problems		
Tics or repeated movements		
Weight loss		
Rapid weight gain		
Trouble with appetite		
Unexplained fevers		
Vision problems		
Hearing problems		
Lung problems		
Heart problems		
Stomach or bowel problems such as diarrhea or constipation		
Urinary tract infections		
Kidney problems		
Broken bones/joint problems		
Skin problems		
Endocrine problems		
Anemia		
Immunization reactions		
Pre-natal/Perinatal events		
Allergies to medications, food etc.		
Problems Swallowing		
Infectious Disease		

Any substance abuse problems such nicotine, drugs or alcohol (for children 12 or over)		

Has your child had any of the following tests or evaluations?	**Yes**	**Date**	**No**	**Where was it done? What were the results?**
Psychology or neuro-psychology evaluation **(Please Include Copies)**				
Brain wave test, EEG, electroencephalogram				
CT or MRI of the Head				
Blood Chromosome Test				
Blood Test for Fragile X Syndrome				
Former Evaluation(s) for Autism **(Please Include Copies)**				

School Information (parent please fill out this section)

Does your child currently attend school? Yes No

If so, where does your child currently attend?

What grade level?

What days and times?

Please describe the teaching goals and objectives for your child's current school year or please provide a copy of your child's current IEP.

Therapy Program(s) History: Current/Previous Therapy Provider Information (Outpatient)

Please provide copies of any recent evaluations and/or progress notes

Speech Therapy

Day	Time	Therapist	Facility
Please describe if any progress has been made			

Occupational Therapy

Day	Time	Therapist	Facility
Please describe if any progress has been made			

Physical Therapy

Day	Time	Therapist	Facility
Please describe if any progress has been made			

School Based Related Therapies

Occupational Therapy frequency:	Speech Therapy frequency:	Physical Therapy frequency:	Other Frequency:

Behavioral Health/ABA Therapy

Is your child currently receiving ABA therapy or has your child received ABA therapy in the past? Yes No

If so, please describe the past or current program goals and objectives and how specific goals are taught:

Day	Time	Therapist	Facility
Please describe if any progress has been made			

Please list any other community resources you currently use for your child?_____

Child's Developmental History

By what age did your child sit alone quietly for several minutes?	Age in months:			Not Yet
By what age did your child walk alone?	Age in months:			Not Yet
By what age did your child emit his or her first 5-6 words?	Age in months:			Not Yet
How old was your child when he or she first said something that involved putting words together meaningfully (two-or three-word phrases including a verb)? What did he or she say?	Age in months:			Not Yet
By what age did your child first begin playing with toys appropriately?	Age in months:			Not Yet
By what age did your child gain consistent during control during the day?	Age in months:			Not Yet
By what age did your child gain consistent bowel control over accidents and soiling?	Age in months:			Not Yet

Please list any concerns you have about your child's development not already mentioned above:
Briefly describe your child's infancy (for example, sleeping, crying habits, sleeping, eating…etc.):

Briefly describe your child's toddler years (for example, language use, play with other children, temper tantrums, sleep problems…etc.):
Briefly describe your child's preschool years (for example, behavior problems, activity preferences, playing well with other children, language skills…etc.):
Briefly describe the time of your initial concerns about your child, what those were, and who you took your child to see about them:

How would you describe your child and things you would like us to know about your child? – strengths, personality, etc.

What current communication skills does your child have? (vocal, sign language, PECS, augmentative communication device, etc.) Please explain what degree of functional communication your child has.

Child Reinforcer Preferences

Please list your child's favorite items, activities, and foods:

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

Functional Assessment Interview of Possible Functions of Problem Behavior

Does your child engage in any self-injurious behavior(s) (Circle One)? Yes No

If yes, please list:_____

Does your child engage in any aggressive behavior(s) (Circle One)? Yes No

If yes, please list:_____

Does your child elope from buildings and/or outdoor areas (Circle One)? Yes No

If yes, please explain:_____

Please list any other problem behaviors your child exhibits:

1.
2.
3.
4.
5.

Please explain how these behaviors interfere with daily activities throughout the day:

*The following questions address **each** individual problem behavior addressed above.*

1. Does the problem behavior occur during specific times? Yes No

2. Does the problem behavior occur in specific settings, activities or events? Yes No

3. Does the problem behavior occur around specific people? Yes No

4. How often does the problem behavior occur?

5. Please identify what appears to cause the behavior:
   1. Demands are being placed
   2. Preferred items or activities are removed
   3. Attention is removed
   4. Sensory Stimulation
   5. Medical condition
   6. Other:_____

6. What typically happens immediately following the behavior?

7. What steps have been taken to address the problem? Please describe:

8. Have you noticed any results from the above steps? Yes No
   If so, please describe:

Goals and Expectations

Please describe your goals or expectations you hold for your child in his/her environment:

School	Home	Community

Please describe any other concerns or expectations regarding your child's current behavior, communication, and social skills:

Who will be involved in your child's treatment? Please list all family members and care agents_____

_____

Are family members or additional care agents available for training in order to ensure appropriate support and services at home? (Please circle) Yes No