



CREATIVE HANDS ABA
HELPING CHILDREN EXCEL

New Client Intake Questionnaire

The following questionnaire is to be completed by the individual's parent or guardian. This form has been designed to provide essential information before your initial appointment in order to make the most productive and efficient use of our time together. Please feel free to add any additional information which you think may be helpful in understanding your child. Creative Hands ABA will hold information provided by you as strictly confidential and will only be released in accordance with HIPAA guidelines and as mandated by law.

Personal Information				
Child First Name		Child Last Name		
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB (dd/mm/yyyy)		Age
Address				
Mother's Name		Mother Cell #		
Employer		Typical Work Hours		
Father's Name		Father Cell #		
Employer		Typical Work Hours		
Who should be the first point of contact?	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other	If other, please specify:		
Parents living together?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, who does the child live with?		
Other people living in the home? (e.g., siblings, relatives, roommates, etc)				
Please indicate any concerns you have regarding your child and his/her siblings.				
Languages that are spoken in the home, other than English				



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Are there any pets in the home? If so, please specify	
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Military (for military families only to complete)			
Branch Served		Enrolled in the Exceptional Family Member Program (EFMP)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Highest Rank			
How long are you stationed in the area?		Registered for Extended Health Care Option (ECHO)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
PCS Date		Is either parent anticipating or currently deployed?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Medical Information			
Primary Diagnosis		Age at Diagnosis	
Diagnostic Provider		Hospital or Agency	
Other Diagnosis		Age at Diagnosis	
Diagnostic Provider		Hospital or Agency	
History of seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any other health problems?	
Current Medications: include over-the-counter medication given regularly (e.g., Miralax, melatonin, Benadryl, etc.)			
Medication Name	Dosage/Day or as Needed	Date Began	Reason for Medication



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Are there medication or supplements that CREATIVE HANDS ABA staff will need to administer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies (please indicate severity)	

Diet Information			
Have you ever consulted with a nutritionist?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are there significant eating/feeding/food issues?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please describe:			
What are the typical things that your child eats?			
Are there any foods that you have to hide from your child?			
What do you wish your child would eat that they won't?			
Is your child on a special diet?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what is it?	

Toileting Information			
Does your child use the toilet without accidents?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do they have accidents during the night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do they ask to use the toilet (vs you taking them)?	<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never		
Has toilet training been unsuccessful in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is toilet training a current goal of yours?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please add comments regarding toilet training, that you think would be helpful to share.			



Sleep Information			
Does your child sleep through the night?	<input type="checkbox"/> Yes <input type="checkbox"/> No	When do they go to bed and wake up?	
Does your child take naps during the day?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when and for how long?	
Are there any other sleep concerns that you have (e.g., the child has difficulty going to sleep, doesn't stay asleep, wakes during the night, etc.)?			

Potential Reinforcers	
Are there toys, snacks, activities that your child whines/cries/try to gain access to?	
If your child could do whatever they wanted, what would they do?	
What are their special interests (e.g., ABCs, Mickey Mouse, music, cars, etc.)?	
Does your child enjoy tickles, smiles, high 5s?	
Are there things your child likes, but if you require them to do something to gain access to the items, they no longer seem interested in them? If so, please specify.	

Things your child doesn't like	
Are there noises, people, activities, things, etc., that your child doesn't like? If so, please specify	
How do you know they don't like it? What do they do?	
Is your child bothered by loud or busy environments?	
Is there anything else that your child doesn't like? If so,	



please specify.	
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Challenging Behavior Please describe your child's behavior(s) that are of concern for you.
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Type of Behavior	
How often does this occur (# of times per day or week)?	
How long has this been happening?	
How can you make it stop at the moment?	
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How often does this occur (# of times per day or week)?	
How long has this been happening?	
How can you make it stop in the moment?	

Has your child engaged in any of these behaviors? Please check all relevant boxes	<input type="checkbox"/> Pica (eating non-food items) <input type="checkbox"/> Headbanging <input type="checkbox"/> Biting others (attempts to bite) <input type="checkbox"/> Spitting <input type="checkbox"/> Throwing objects at others <input type="checkbox"/> Hair pulling <input type="checkbox"/> Self-injurious behavior (hitting self) <input type="checkbox"/> Pinching or scratching others <input type="checkbox"/> Other (please specify below)	
Please list any <u>other</u> challenging behaviors that are not on the list above.		
Does your child regularly have challenging behavior <i>when you tell them no?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe
Does your child regularly have challenging behavior <i>when you make them wait?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe
Does your child regularly have challenging behavior <i>when you take things away?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe
Does your child regularly have challenging behavior <i>when you end an activity?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe
Does your child regularly have challenging behavior <i>when you tell them to do something (instruction or adult demand)?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe
Does your child regularly have challenging behavior <i>when you don't provide them with attention?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe



Please share any other concerns you have about challenging behaviors that you would like help with.	
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Safety Concerns	
Does your child <u>always</u> respond to his or her name across <u>all</u> settings?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child only respond to his or her name when you have his/her attention?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child stop engaging in the behavior when told 'stop' 'wait' or 'no'?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child have difficulty following single-step instructions given by any caregivers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child have environmental awareness or stranger danger awareness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your child aware of his/her immediate surroundings when in the community?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do adults have to be extra cautious about their child's safety when in public?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child elope or wander off?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have to keep your windows and doors locked to prevent your child from wandering off?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child handle sharp or hot objects, without realizing their danger?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child climb furniture, surfaces, etc without a sense of danger?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If there are any other safety concerns you have regarding your child's behavior, please specify.	



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Developmental Milestones

When did you first become concerned about your child's development and why?

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Approximate age at which your child (as much as you can remember). If your child is not yet doing performing these milestones, please indicate 'Not yet'

Sat Up		Crawled		Walked Alone	
Started responding to name		Use single words		Use two-word phrases	
Understood simple instructions		Was able to have a back-forth conversation		Use sentences (3-5 words)	
Played social games (peek a boo)		Use gestures to communicate		Was toilet trained	

Has your child ever lost or regressed in any of these skills? If yes, please describe what happened

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Does your child have sensory sensitivities (either loves or hates) - including certain sounds, sights, textures, taste, touch? If yes, please describe below.

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Did your child (or still they have) problems in learning to speak or understand language? If yes, please describe below.
How does your child let you know what she or he wants? Please describe below.

Primary Goals
What are the three most immediate goals you have for your child?
1.
2.
3.
What changes would improve your family's home life?
1.
2.
3.