A BLOCK ABOVE
BEHAVIORAL CONSULTING

Under 6 Child Intake Form

North Vancouver BC - 604-351-7842 - info@ablockabove.com

Personal

Child's Full Name: _____

D.O.B.:_____

Full Address: _____

Parent's Name #1: _____

Parent's Name #2: _____

Primary Telephone: _____

Primary E-mail: _____

Does child have siblings, if so ages of siblings: _____

Does child split their time between multiple homes, if so describe living arrangements or current custody details: _____

_____

_____

Primary Language spoken at home: _____

Medical

Primary Diagnosis:_____

Secondary Diagnosis:_____

Age at Diagnosis: _____

Diagnosis Received by (professional's name and agency):_____

_____

Other Upcoming Assessments / Appointments:_____

Other (if your child is not currently diagnosed, please specify why you are seeking services):

_____

_____

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Medical Cont.

Confirmed Allergies: _____

Special Diet:_____

Food Intolerances:_____

Other Biological Interventions:_____

Current Medication / Supplements: _____

_____

Other / Concurrent Medical Conditions:

_____

Learning History

Has your child received intervention prior to our services? _____

List other professionals your child has received treatment from:

Name: _____ Specialty:_____ Location: _____

Name: _____ Specialty:_____ Location: _____

Name: _____ Specialty:_____ Location: _____

Name: _____ Specialty:_____ Location: _____

What assessment(s) have been implemented?

_____

_____

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Documentation

Do you have documentation you can share with our team, please circle all that apply:

- Diagnostic Report
- Letter from Paediatrician
- Genetic Information
- Speech and Language Pathologist Assessments / Notes
- Occupational Therapist Assessments / Notes
- Social Worker Report
- Behaviour Analyst Assessments / Plans / Progress Reports
- School / Daycare / Pre-School Documentation such as: Individual Education Plan; Safety Plan
- Assessment Summaries such as: VB-MAPPS; ABLLS-R; AFFLS; TOPS-E; SLDT-3; other:_____
- Child Development /IDP Forms

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For children attending Daycare / Preschool

N / A

Name of Facility**:** _____

Circle Current Weekly Schedule of Attendance:

Preschool

Monday	Tuesday	Wednesday	Thursday	Friday
AM	AM	AM	AM	AM
PM	PM	PM	PM	PM

Daycare / Pre-school Hours

Part-time hours:_____

Full-time hours:_____

Describe extra assistance child receives in classroom:_____

_____

Behavioural challenges in classroom: _____

_____

_____

_____

Current behavioural plan in place to address challenges:_____

_____

_____

Social functioning with peers:

_____

_____

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For Children Receiving Home or School Based Behaviour Intervention

N / A

Current Home Based Program

Current Consultant(s):_____

Previous Consultant(s):_____

Dates services provided:_____

Type of home-based ABA program instruction:_____

Your / family member's experience with past treatment plan(s):_____

_____

_____

_____

_____

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General Information About Child

Your child's preferred leisure activities and interests (what does he / she like to do in their down time?):

_____

_____

Tell us what your child's strengths are:

_____

_____

Family Goals

Please indicate your family's biggest goals for your child:

_____

_____

_____

_____

_____

_____

_____

_____

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Communication

How does your child communicate their needs with others (does he / she use words, how many word per utterance, picture exchange, augmentative communication device, gestures, approach person, reach or take items?):

_____

_____

_____

_____

Does your child imitate sounds, words or phrases he / she hears? (give examples)

_____

Does your child label what he / she sees independently? (give example of what your child says)

_____

Following Instructions and Imitation Skills

How does your child respond to instructions:

_____

_____

How does your child imitate others? (such as clapping or waving when you clap or wave)

_____

_____

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Social Skills

Does your child have a close friend? Describe their friendship.

_____

_____

If your child is verbal, does he/she maintain conversations with their peers? Does he/she stay on topic? Does your child initiate conversations?

_____

_____

General Behaviour Challenges

Tell us about your child's biggest behavioural challenges:

_____

_____

_____

_____

What strategies have you tried, and what have you found to help with behavioural challenges, if any:

_____

_____

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Sleep

Describe your child's sleep routine:

_____

_____

_____

Does your child have significant sleep disturbances, please describe:

_____

_____

Eating

Does your child have significant eating issues?

_____Y / N_____

Describe what your child will eat, and how:

_____

_____

_____

Describe what your child will not eat, and behaviours when introduced to new foods:

_____

_____

_____

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Toiletting

Is your child toilet trained?

_____Y / N_____

If your child is toilet trained, do you use a pull up or diaper during any portion of the day (i.e. outings, bedtime etc.)

_____

Does your child initiate toilet use or require reminders or being brought to the toilet?

_____Y / N_____

Does your child have bowel movements in the toilet?

_____Y / N_____

Please provide copies of any relevant supporting documents, such as the diagnostic report, specialist assessments or notes. Providing as much information as possible will assist our team with understanding your child's learning profile, and assist us with the initial intake meeting. We ensure complete confidentiality with the information you decide to share with our team for this intake process.