Building BLOCS
Client Intake Form

Please fill out this form as completely as possible. If you need more space, write on the back or add a sheet.
Please call 512-827-7011 if you have additional questions.

Date: _____

Person filling out this form: _____

Relationship to child: _____

Identifying Information

*Child's name: _____*Birth date: _____

Age:_____ Gender:_____ Home Phone: _____

Address: _____ City/Zip:_____

	Parent 1	Parent 2
Name		
Child's name for this person, e.g., Mom, Amma, Papa, etc.		
Email address		
Mobile Phone Number		
Occupation		
Employer		

Who are the most important people in your child's life?

Name	Age	Gender	Lives with Child? Y/N	Relationship

Current Concerns

What is the purpose for seeking an assessment at this time?

_____

_____

What questions about your child would you like answered?

_____

_____

When did you first have concerns about your child's development or speech?

_____

_____

What are your greatest hopes for your child?

_____

_____

What are your greatest fears for your child?

_____

_____

Were you referred for this assessment? Yes☐No ☐
If yes, by whom?

_____

Previous Evaluations and Current Services

****Please include copies of any previous assessments or evaluations****

Has your child had any previous assessments/evaluations? ☐Yes ☐No
If yes, please provide more information below

Type of Assessment/Evaluation	Location and Assessor	Date	Results

Does your child have a current IFSP/IEP? ☐Yes ☐No ☐I don't know
If yes, where?

_____

Current program/school: _____

Past/Current services being provided

Type	When	Therapist	Where
Physical Therapy			
Occupational Therapy			
Speech Therapy			
ABA Therapy			
Other: _____			

Health History

Birth History

Tests during pregnancy: _____ Triple Test _____Amniocentesis _____CVS
Results of tests:

_____

_____

Select if any of the following present during the pregnancy, labor, or delivery

Preterm labor		Alcohol exposure	
Excessive bleeding		Smoking	
Illicit/street drugs		Prescription drugs	
Illness/fever		High blood pressure	
Rash		Poor weight gain	
Toxemia		Too much weight gain	
Diabetes		Other	

Please explain any "yes" answers:

_____

_____

Please describe any other aspects of the pregnancy and/or birth that were unusual or exceptional:

_____

_____

The baby was born ☐ on time ☐ early ☐ late

What was the length of the pregnancy? _____

Length of labor: _____

The baby was born: (select one) ☐ feet first ☐ head first ☐ breech ☐ C-section

Birth weight: _____pounds _____ounces

Did your baby pass a newborn hearing test? ☐ Yes ☐ No ☐ I don't know

Select if your child have any of the following during the first month of life

Jaundice		Infection	
Fever		Severe irritability	
Feeding difficulties		Emergency room visit	

Please explain any "yes" answers:

_____

Feeding

Breast fed for _____ months Formula fed for _____ months

Do/did you have any concerns regarding your child's eating? ☐ Yes ☐ No

What were/are your concerns?

____Number of meals eaten ____Amount eaten ____Time it takes to feed
____What is/was eaten ____Avoidance of foods ____How to feed

Please explain:

_____

_____

Sleeping

Do/did you have any concerns regarding your child's sleeping? ☐ Yes ☐ No

If yes, what were/are your concerns?

____No or short naps ____Difficulty going to bed ____Length of night sleep

____Length of bedtime routine ____Where the child sleeps/slept ____Staying asleep at night

Please explain:

_____

_____

Behavior

Do/did you have any concerns about your child's behavior? ☐ Yes ☐ No

If yes, what are they?

_____

_____

Medical History

Please list any surgeries, hospitalizations, accidents or injuries your child has had:

	What	Where	When
Surgeries			
Hospitalizations			
Accidents/Injuries			

Select if your child had a history of or been treated for any of the following

Abdominal pain		Hearing problems	
Abuse		Heart problems	
Allergies/asthma		Hormone problems	
Behavioral concerns		Ingested poisons	
Blood disorder		Joint or bone problems	
Cancer		Metabolic problems	
Concussion/Head injury		Muscle problems	
Dental problems		Seizures/epilepsy	
Ear infections		Significant accidents	
Eating issues		Skin problems	
Excessive drooling		Repetitive movements	
Genetic syndromes		Urinary problems	
Growth problems		Vision problems	

Please explain any "yes" answers:

_____

_____

Current Health/Medical Information

Child's Primary Diagnosis: _____ Date of Diagnosis: _____ Age: _____

Diagnosing Physician_____ Most recent date of diagnosis_____

Secondary Diagnosis: _____ Date of Diagnosis: _____ Age: ____

Other Diagnoses: _____ Date of Diagnosis: _____ Age:_____

Referring Physician/PCP: _____ Phone: (____)_____

Has your child had a vision test? Yes No If yes: Pass Fail
Has your child had a hearing test? Yes No If yes: Pass Fail
Are your child's immunizations current? Yes No
Is your child allergic to anything? Yes No
If yes, what is he/she allergic to and what is the reaction?

_____

What medications, herbs, or homeopathic remedies does your child take currently?

_____

Has your child had any negative reactions to medications?

_____

Developmental History

Do you feel that your child developed ☐ quickly ☐ typically ☐ slowly
Why?

_____

Age when child: (If you can't remember specific time, please indicate if it occurred at the expected time or was delayed)

began babbling _____ said first word _____ combined two words_____

sat up alone _____ crawled _____ walked _____ toilet trained _____

dressed self _____ fed self independently _____

What things does your child do best?

_____

_____

Has your child lost any developmental skills, or does he/she seem to not be progressing in any areas? Yes ☐ No ☐

If yes, please explain:

_____

_____

Language Development

What language(s) is/are spoken in home:

_____

What was your child's first word(s)? _____

How long are your child's sentences? _____

Does your child have any difficulty understanding you? ☐ Yes ☐ No

If yes, please explain:

_____

_____

How does your child get his needs met if he/she is not understood?

_____

_____

Does your child have difficulty following directions? ☐ Yes ☐ No

If yes, please explain:

_____

_____

How well is your child understood by: (i.e., what percentage of the time)

(Mom: _____ Dad: _____ Younger siblings: _____ Older siblings:_____

Other children: _____ Unfamiliar adults: _____

What is it like to have a conversation with your child? _____

Family History

The following questions are about your child's family, which includes parents, siblings, aunts, uncles, cousins, and grandparents.

Has anyone in the family been diagnosed with a language or developmental delay? ☐ Yes ☐ No

If yes, please explain:

_____

_____

*Any behavioral health or mental health conditions in the immediate or extended family (explain)?

☐ Yes ☐ No

If yes, please explain:

_____

_____

Social Development

Names and ages of siblings: _____

_____

_____

Has your child attended day care? ☐ Yes ☐ No

If so, where, when (what years), and how frequently (days and times)

_____

_____

How does your child handle

frustration: _____

_____

Conflict: _____

_____

Separation: _____

_____

What are your child's favorite

places: _____

people: _____

toys: _____

snacks: _____

activities: _____

What motivates your child most?

_____

_____

What does your child dislike most or find the most frustrating?

_____

_____

Are there any religious, spiritual, or cultural variables that you would like for us to know, or that might impact your child's treatment?

_____

_____

Is there anything else you would like us to know about your child or family?

_____

_____

_____

_____

_____

_____

_____

_____

Assessment of Daily Routines

Routine	Good time	Ok	Hard time	How stressful or hard is this time for you? Low High 1 2 3 4 5	How stressful or hard is this time for your child? Low High 1 2 3 4 5	What happens during this time of the day? You may explain your ratings here
				Please enter # 1-5 for all activities		
Diapering/toileting	☐	☐	☐			
Feeding/eating	☐	☐	☐			
Bathing/washing	☐	☐	☐			
Dressing	☐	☐	☐			
Combing/brushing hair	☐	☐	☐			
Child playing alone	☐	☐	☐			
Playing with family	☐	☐	☐			
Playing with other kids	☐	☐	☐			
Sharing books	☐	☐	☐			
Napping	☐	☐	☐			

Going to bed/waking up	☐	☐	☐			
Calming after being upset	☐	☐	☐			
Indoor play	☐	☐	☐			
Outdoor play	☐	☐	☐			
Going out to the car/stroller	☐	☐	☐			
Visiting grocery store	☐	☐	☐			
Visiting friends	☐	☐	☐			
Religious activities	☐	☐	☐			
Family celebrations	☐	☐	☐			
Going to the doctor	☐	☐	☐			
Haircuts	☐	☐	☐			
Going to the park	☐	☐	☐			
Other:	☐	☐	☐			
Other:	☐	☐	☐			
Other:	☐	☐	☐			

Which of the routines that you indicated are of concern for you or your child would you like to address first?

1._____

2._____

What would you like your child to develop in the next six months:
More independence in:

_____

More control:

_____

Better:

_____

Increased ability to

_____

Permission to Release Information

I, _____, give the professionals at Building BLOCS permission to share assessment and treatment information about my child, _____, with the professionals/agencies listed below for the purpose of assessment, planning treatment, and coordinating services. I understand that I may revoke this authorization at any time, but this revocation will not apply to information that has already been shared. This consent will expire one year from the date of signature.

_____ _____

Signature of Parent/caregiver Date

_____

Print Child's Name

Please list the professionals for us to contact here:

name	**type of therapy/organization**	**phone or email**

Patient Bill of Rights and Responsibilities

Building BLOCS is dedicated to helping children with autism spectrum disorders (ASD) and other developmental disabilities achieve their potential in family, community and school life. We care about the dignity and welfare of all who receive services from us. Although these rights are written for the patient, in most cases they also apply to the patient's parents or legal guardians. The center expects staff, patients, families and visitors to act in a reasonable and responsible way at all times.

If you have a concern about any of these rights or responsibilities, you may discuss it with the staff involved, their supervisor or your physician or social worker. If you are still concerned, you may also speak with the directors' office at 512-827-7011.

A Child's Rights

While you are at Building BLOCS, you have the right:

- To always be politely treated by a staff member who knows you.
- To keep your health information private from strangers.
- To have safe care that is not needlessly hurtful.
- To have your care told to you in a way you understand.
- To use a translator to tell you about your care in a language you understand.
- To understand your options to make the best choices for your care.

A Parent's Rights

As a parent of a child at Building BLOCS, you have the right:

- To receive a complete copy of your child's information, including diagnosis (identified medical condition), treatments and prognosis (predicted chance of recovery).
- To stop, ignore or refuse treatment for your child to the extent it is allowed by law. If you do this, Building BLOCS may stop treating your child.
- To receive a description of all the services and charges listed on your child's bill—no matter how you are paying for it.
- To expect that the Building BLOCS staff talk with you regularly to understand your family's needs; recognize developmental goals; and understand when a treatment is right for your child's age.
- To be involved in your child's care and use the Building BLOCS resources to understand your child's condition.
- To discuss concerns with your child's medical staff. If you still have concerns, you can request a meeting with the directors to discuss them.

Responsibilities

As a parent who is dedicated and motivated to assist your child, you have a responsibility:

- To give the staff your child's complete, correct medical history and to update this information with any changes.
- To follow the treatment plans developed by the Building BLOCS staff.
- To be responsible for your actions and any effect it may have on your child, if you refuse treatment or do not follow the staff's directions.
- To pay for services as soon as possible.
- To be respectful of other children, families and the Building BLOCS staff.

ABA Parent Contract

Your child is enrolled in a Building BLOCS ABA Program. This program is designed to be a joint therapist and family program that allows each child to meet their full potential.

This will involve learning and following through with family components of the ABA therapy including, but not limited to: following through with behavior plans, parent homework, behavior and data tracking, parent training sessions, and potty training, if appropriate.

Please read and initial, stating your understand of and agreement to follow through with each family component:

____Communication with Therapists

Please inform your child's supervisor of any significant changes that may affect therapy, progress towards goals, prevalence of challenging behavior, or overall well-being, e.g., changes in medications, new treatments, significant changes to home life. Information that you share regarding your child and therapy will be disclosed to relevant members of your child's team at Building BLOCS.

____Following Through with Behavior Plans

Your child will have a behavior plan that will address how challenging behavior should be addressed in the home and in the community. Once the behavior plan is reviewed with you and the correct behavioral responses taught, it is expected that you follow through with the plan for all instances of the behavior.

___Parent Homework

You will be asked to follow through with some activities at home. These could involve a fun routine, potty training schedule, or a different daily or weekly activity. These activities are designed to promote generalization and learning across environments.

___Behavior and Data Tracking

You will be asked from time to time to track a behavior at home. This might involve tallying each time a behavior happens, or tracking their language during an activity, writing down what happens right before and after a tantrum, or another individualized item. This information is needed to help monitor home behaviors and progress.

___Parent Training Sessions

You may receive parent training sessions as part of your child's ABA therapy. These sessions could be at the Building BLOCS center, the community, or, most often, in the home. The parent training sessions will involve the therapist coaching you though and role-playing different play, home routines, language activities, and challenging behaviors. The therapist might also have lessons prepared to show you different activities that your child has been working on in therapy that could be added to home routines. During this time, you will also be able to problem solve with the therapist on any problems that you are having at home or in the community. Please let your therapist know if there are behaviors or routines that you would like to have addressed during your parent training sessions.

___ Potty Training

Potty training is a skill that is frequently addressed in our program. When you and your child are ready for potty training we will be more than happy to assess and then create a potty training protocol. It is essential that parents follow through with the potty training protocol at home as this is a skill that is primarily taught by parents and overseen by the therapist at Building BLOCS.

I have read and understand each portion of the parent contract. I understand that the family components are an essential portion of the Building program and that the program is not as effective without these components. Because of this, if I fail to follow through with these agreed upon components, I know that I will receive one warning and a date for conference. It may be necessary, if the family component is not appropriate for my family, that our spot in the Early Intervention Program will be forfeit, and that other therapies that might be a better fit for my family will be recommended.

_____ _____

Parent/Guardian Signature(s) Date

_____ _____

Building BLOCS Representative Reviewing Contract Date