Engaging Minds
Autism Services
614 East Boulevard
Kokomo, IN 46902
(765) 461-1245

New Client Parent Questionnaire

CLIENT DEMOGRAPHICS

Learner's name: _____ _____ _____ (Last) (First) (MI)	
Date of birth: _____ / _____ / _____	Gender: _____ M _____ F
Age: _____ years, _____ months	
Current diagnosis (es): ☐ Autism Spectrum Disorder (ASD) ☐ Asperger's syndrome ☐ PDD-NOS ☐ Other: _____ ☐ Other: _____	Date of diagnosis: _____ / _____ / _____ Age of diagnosis: _____ years, _____ months Diagnosed by: _____

PARENTS AND/OR GUARDIANS

Father's name: _____	Mother's name: _____
Date of birth: _____ / _____ / _____	Date of birth: _____ / _____ / _____
Occupation: _____	Occupation: _____
Employer: _____	Employer: _____
Home phone number: _____	Home phone number: _____
Work phone number: _____	Work phone number: _____
Cell phone number: _____	Cell phone number: _____
Best number to reach: Home / Work / Cell	Best number to reach: Home / Work / Cell
Email address: _____	Email address: _____

INSURANCE

Primary:

Subscriber's name:	DOB of subscriber:
Subscriber's employer:	
Carrier:	Case manager:
Group #:	ID #:
Phone #:	Fax #:
Claims address:	

Secondary:

Subscriber's name:	DOB of subscriber:
Subscriber's employer:	
Carrier:	Case manager:
Group #:	ID #:
Phone #:	Fax #:
Claims address:	

Medicaid:

ID #:	Type:
Name of service coordinator:	
County:	Region:
State:	Phone #:

Other payment source:

FAMILY BACKGROUND

Parents are: _____ Married _____ Divorced _____ Separated _____ Never married

If divorced or never married, who has custody of minor? _____

Please list name of step-parents: _____

Was the child adopted? _____ Yes _____ No

Siblings

Name:	Age:	Biological? Y N	Neurotypical? Y N
Name:	Age:	Biological? Y N	Neurotypical? Y N
Name:	Age:	Biological? Y N	Neurotypical? Y N
Name:	Age:	Biological? Y N	Neurotypical? Y N
Name:	Age:	Biological? Y N	Neurotypical? Y N

Please indicate any special needs or concerns regarding the other children living in your home, including any sibling relationship concerns:

_____

_____

Please list any other people who currently live in your home:

Name	Age	Relationship to child	Years living in home
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

Is there a history in your immediate or extended family with the following conditions?

	Yes	No	Who
Autism Spectrum Disorders	_____	_____	_____
Learning difficulties/delays	_____	_____	_____
ADHD/ADD/Other attention problems	_____	_____	_____
Behavior issues in school	_____	_____	_____
Anxiety disorders (OCD, phobias)	_____	_____	_____
Substance abuse or dependence	_____	_____	_____
Other mental health conditions	_____	_____	_____

CURRENT MEDICAL CONDITIONS

Please mark any medical diagnoses:

_____ Autism Spectrum Disorder

_____ PDD-NOS

_____ Asperger's syndrome (AS)

_____ Speech delay

_____ Other: _____

_____ Oppositional Defiance Disorder (ODD)

_____ Attention Deficit & Hyperactivity Disorder (ADHD)

_____ Attention Deficit Disorder (ADD)

_____ Intellectual Disability (ID)

List any allergies your child has:

_____

_____

List any special nutritional needs your child has:

_____

_____

MEDICATION

Please list any medications that your child is currently taking.			
Medication Name	Dosage	Length of Time	To treatment symptoms for:
Please list any supplements, vitamins, etc. that your child is currently taking.			

Name of child's primary care physician(s):

_____

Practice name: _____

Address: _____

Phone number: _____ Fax number: _____

Are immunizations up to date: _____ Yes _____ No _____ Does not receive

Current height: _____ ft. _____ in. Weight: _____ lbs.

With which hand does the child primarily write? _____

Does the child have vision problems? _____ Y _____ N

Date of last vision screening: _____

Does the child have hearing problems? _____ Y _____ N

Date of last hearing screening: _____

Please indicate if your child is experiencing any of the following:

Problems with eating _____

Isolated socially from peers _____

Problems making friends _____

Problems keeping friends _____

Problems getting to sleep _____

Problems controlling temper _____

Problems sleeping through the night _____

Trouble waking up _____

Fatigue/tiredness during the day _____

Nightmares _____

Bed wetting _____

Soiling _____

Problems with authority _____

Anxiety _____

Unmotivated _____

Stress from parental conflict _____

Legal situation (anyone in the family) _____

History of abuse _____

Alcohol/drug use/abuse _____

School concentration difficulties _____

Grades dropping or consistently low _____

Sadness or depression _____

Is your child currently enrolled in school? _____ Y _____ N

If yes, where? _____

Teacher(s) name: _____

Does your child's teacher have concerns? _____ Y _____ N

If yes, list:

_____

_____

What is your child's favorite subject/class? _____

What is your child's least favorite subject/class? _____

Has your child ever repeated a grade? _____ Y _____ N

If yes, what grade(s)? _____

If your child has received Special Education services, did he/she have: (mark all that apply)

_____ 504 Plan

_____ IEP

_____ Psychological Evaluation

_____ Speech Evaluation

_____ Functional Behavior Assessment

_____ OT Evaluation

_____ Behavior Intervention Plan

_____ PT evaluation

_____ Other: _____

If your child has been in Special Education, how was he/she served?

_____ Resource classroom

_____ Collaborative

_____ Team Taught

_____ Pull-out

_____ Self-Contained Classroom

_____ Special Program

_____ Other: _____

Child's extracurricular activities, including sports, club, hobbies, etc.

_____

_____

List any special abilities, skills and strengths your child has:

_____

_____

DISCIPLINE INFORMATION

Below is a wide range of disciple strategies that are frequently used. Please rate how likely you are to use each of the strategies listed.

Intervention	Very unlikely Very likely	Effectiveness
Let situation go	1 2 3 4 5	_____
Take away a privilege	1 2 3 4 5	_____
Assign an additional chore	1 2 3 4 5	_____
Take away something material	1 2 3 4 5	_____
Send to room	1 2 3 4 5	_____
Physical punishment	1 2 3 4 5	_____
Reason with child	1 2 3 4 5	_____
Ground child	1 2 3 4 5	_____
Yell at child	1 2 3 4 5	_____
Send to time out	1 2 3 4 5	_____
_____	1 2 3 4 5	_____
_____	1 2 3 4 5	_____
_____	1 2 3 4 5	_____
_____	1 2 3 4 5	_____

Rate the THREE most effective strategies. In the effective column, place a 1 by the most effective, a 2 by the next most effective, and a 3 by the third most effective. Place a CHECKMARK next to the LEAST effective strategy.

Please rate what percentage of discipline is handle by each of the following:

Father: _____% Mother: _____% Other: _____% (specify) _____

Comments:

_____

_____

_____

Please list the five things you would like for your child to do more and less of in order of priority. For example, instead of saying, "I want my child to be more responsible," translate that into actual behaviors, such as "do household chores."

	Like child to do more of:	Like child to do less of:
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

PERTINENT INFORMATION

Please state your child's behaviors of concern:

_____

_____

_____

Please state the expectations and goals that you have for your child while in a behavioral program:

_____

_____

Please list any additional information that may be helpful while assessing and/or conducting therapy with your child:

_____

_____

Please list items and activities your child likes:

Food items:

_____

Toys and objects:

_____

Activities at home:

_____

Activities in the community:

_____

Other:

_____

SKILL ASSESSMENT

Language

Does your child:	Mark one	Comments
Imitate actions of others?	O Yes O No O Unsure	
Match objects or pictures?	O Yes O No O Unsure	
Follow directions without visual cues?	O Yes O No O Unsure	
Indicate his/her wants and needs?	O Yes O No O Unsure	Circle all that apply: Words Pictures Gestures
Imitate sounds or words?	O Yes O No O Unsure	
Use words to ask for things:	O Yes O No O Unsure	
Label items he/she sees or hears?	O Yes O No O Unsure	
Answer questions?	O Yes O No O Unsure	
Speak in sentences?	O Yes O No O Unsure	
Participate in conversations?	O Yes O No O Unsure	
What are your principal concerns regarding your child's language?		

Play skills

Does your child:	Mark one	Comments
Look at books?	O Yes O No O Unsure	
Play with cause & effect toys?	O Yes O No O Unsure	
Complete task completion toys? (i.e.: puzzles)	O Yes O No O Unsure	
Play with toys by using them like real items? (i.e.: uses a play spoon to pretend to eat)	O Yes O No O Unsure	
Play simple games, like ring around the rosy?	O Yes O No O Unsure	
Construct items using blocks, Legos, or other items?	O Yes O No O Unsure	
Play games with rules (i.e.: Memory)	O Yes O No O Unsure	
Engages in dress up or role play?	O Yes O No O Unsure	
Play appropriately on own for up to 5 minutes?	O Yes O No O Unsure	
What are your principal concerns regarding your child's play skills?		

Social skills

Does your child:	Mark one	Comments
Respond to his or her name by looking at you?	O Yes O No O Unsure	
Make eye contact when speaking you?	O Yes O No O Unsure	
Greet you when you arrive home?	O Yes O No O Unsure	
Respond to others emotions?	O Yes O No O Unsure	
Attempt to involve you in something that he/she is doing to share interest (not because he/she needs help)?	O Yes O No O Unsure	
Observe other children playing?	O Yes O No O Unsure	
Join in with other children when they are playing?	O Yes O No O Unsure	
Take turns in games?	O Yes O No O Unsure	
Verbally interact with peers?	O Yes O No O Unsure	
What are your principal concerns regarding your child's social skills?		

Self-help skills

Does your child:	Mark one	Comments
Sleep through the night?	O Yes O No O Unsure	
Sleep in his/her own bed without supervision?	O Yes O No O Unsure	
Drink from a cup?	O Yes O No O Unsure	
Eat a variety of food?	O Yes O No O Unsure	
Use a spoon and fork to feed self?	O Yes O No O Unsure	
Remove pull-down garments independently?	O Yes O No O Unsure	
Remove shoes and socks independently?	O Yes O No O Unsure	
Removes shirt independently?	O Yes O No O Unsure	
Put on pull-up garments independently?	O Yes O No O Unsure	
Put on shoes and socks independently?	O Yes O No O Unsure	
Put on shirt independently?	O Yes O No O Unsure	
Use the toilet independently?	O Yes O No O Unsure	
What are your principal concerns regarding your child's self-help skills?		

Fine motor

Does your child:	Mark one	Comments
Unwrap presents?	O Yes O No O Unsure	
Pour water or sand from one object to another?	O Yes O No O Unsure	
Turn doorknobs to open doors?	O Yes O No O Unsure	
Use one hand consistently?	O Yes O No O Unsure	
Use a crayon with hand NOT fisted?	O Yes O No O Unsure	
Copy lines and simple shapes?	O Yes O No O Unsure	
Write his or her own name?	O Yes O No O Unsure	
Use scissors?	O Yes O No O Unsure	
What are your principal concerns regarding your child's fine motor skills?		

Gross motor

Does your child:	Mark one	Comments
Walk up and down stairs with alternating feet?	O Yes O No O Unsure	
Walk around or step over items on the floor?	O Yes O No O Unsure	
Jump off the ground with both feet?	O Yes O No O Unsure	
Kick playground ball to you?	O Yes O No O Unsure	
Throw a playground ball to you?	O Yes O No O Unsure	
Catch a ball when thrown to?	O Yes O No O Unsure	
Show interest in sports?	O Yes O No O Unsure	
What are your principal concerns regarding your child's gross motor skills?		

Academic skills

Does your child:	Mark one	Comments
Identify shapes, colors, numbers and letters?	O Yes O No O Unsure	
Identify locations, occupations and functions of objects (i.e.: the refrigerator keeps things cold)?	O Yes O No O Unsure	
Use pronouns, plurals and prepositions appropriately?	O Yes O No O Unsure	
Identify cause and effect relationships?	O Yes O No O Unsure	
What are your principal concerns regarding your child's academic skills?		

Challenging behaviors

Type of behavior	Please describe the behavior.	Does anything seem to trigger the behavior?	How many times per day or week does this behavior occur?
Tantrums			
Aggression			
Running away/eloping			
Failing to follow instructions			
Self-injurious behaviors			
PICA (eating inedible objects)			
Other:			

Self-stimulatory behaviors

Type of behavior	Please describe the behavior.	Does anything seem to trigger the behavior?	How many times per day or week does this behavior occur?
Vocal (repeating vocalizations, words or phrases)			
Preoccupations with items, topics, etc.			
Repetitive motor mannerisms (flapping, spinning, lining up items)			
Routine behaviors (same cup, same route in the car)			

TREATMENT HISTORY

Type of treatment	Service provider & phone number	How many hours per week?	Dates of treatment:	Did you feel this treatment was beneficial?
Other ABA program				
Occupational therapy				
Speech therapy				
Physical therapy				
Other:				
Other:				

CURRENT TREATMENT AND SCHEDULE

Type of treatment	Service provider & phone number	How many hours per week?	Start date?	Did you feel this treatment is beneficial?
School -general education -special education -combination				
Occupational therapy				
Speech therapy				
Physical therapy				
Other ABA program				
Other:				
Other:				

Pleas complete the schedule to indicate your child's availability for ABA services.

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY