CRYSTAL KIDS
Development Center

INTAKE FORM

CHILD INFORMATION						
Last Name:			Age:			
First Name:			Date of Birth:			
Home Phone:			Gender:			
Home Address:			Child Adopted: ___Yes ___No			
City:	State:		Zip Code:		Country:	
Primary Diagnosis or Concern:			Date of Diagnosis:			
Other Condition:			Date of Diagnosis:			
Describe child main concern/reason for referral:						
Type of Service interested: ____ ABA ____ Speech ____ OT			____ Home ____ School ____ Center			
Availability:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Hours:						

FAMILY INFORMATION: Mother or legal Guardian			
Full Name:		Relationship to child:	
Address: (if different from Applicant)			
City:	State:	Zip Code:	Country:
Home Phone: (if different from Applicant)		Cell Phone:	
Occupation:		Employer's Name:	
Employer's Phone:		Education Completed:	
Marital Status: __ Married __ Divorced __ Single		Overall Health: ___Excellent ___ Good ___ Poor	

FAMILY INFORMATION: Father or legal Guardian			
Full Name:		Relationship to child:	
Address: (if different from Applicant)			
City:	State:	Zip Code:	Country:
Home Phone: (if different from Applicant)		Cell Phone:	
Occupation:		Employer's Name:	
Employer's Phone:		Education Completed:	
Marital Status: __ Married __ Divorced __ Single		Overall Health: ___Excellent ___ Good ___ Poor	

FAMILY INFORMATION: Child's Siblings			
Name:	Age:	Gender:	Living at home: __ Yes __ No
Name:	Age:	Gender:	Living at home: __ Yes __ No

Name:	Age:	Gender:	Living at home: __ Yes __ No
Name:	Age:	Gender:	Living at home: __ Yes __ No

FAMILY INFORMATION: additional info	
Any history of developmental disability or mental illness in the family? ___ Yes ___ No, *if yes explain:*	
Other family relevant information:	

SCHOOL INFORMATION	
Name of School or Daycare:	Grade:
Address:	
Teacher's name:	Teacher's Phone number:
IEP curriculum: ___ Yes ___ No	Class arrangement:
Day of Attendance: ___Monday ___Tuesday ___Wednesday ___Thursday ___Friday	
Time of Attendance: ___ Morning ___ Afternoon	___Full Time ___Part time

MEDICAL & INSURANCE INFORMATION	
Primary Pediatrician:	Phone:
Address:	
Primary Insurance:	Phone:
Insured Name:	DOB:
Member ID#:	Group #:
Secondary Insurance: (if applicable)	Phone:
Insured Name:	DOB:
ID#:	Group #:

MEDICAL INFORMATION			
Is your Child on any Medication? ___ Yes ___No			
If yes, List medication, administration times, usage:			
Type of Medication	**Dosage**	**Administration Times**	**Used for**
Contraindication/Precautions: ___None ___Allergies ___Seizure Condition ___Other			
Describe Allergies or others contraindication:			
Any complication with child's pregnancy? __Yes __ No		Type of Delivery: ___ C-Section ___ Vaginal	
if so, please explain:			
Any Concerns about Child's hearing? ___ Yes ___No		Hearing Assessment conducted: ___Yes ___No	
Any Childhood illnesses?			

RELATED SERVICES Current and/or Past	(E.g. ABA services, OT, ST, PT)
Service/Therapy:	___School ___ Home ___ Center
Agency or Provider name:	Date of services: FROM_____ TO _____
Agency Address:	
Phone:	Contact Person/Therapist:
May we contact? ___ Yes ___No	Services Hours Per week:
Progress Observed:	
Please attached other related services	

DEVELOPMENTAL HISTORY	What age did your child? (if applicable)
Roll Over Consistently: _____	Eat Solids: _____
Sat Up Unsupported: _____	Began babbling: _____
Stood: _____	Sleep through the night: _____
Crawled: _____	Toilet trained during day: _____
Walked Unassisted: _____	Dry through the night: _____
Said 1st words: _____	Begin dress self: _____
At what age did you suspect problems about your child's development?	
Has your child exhibited any loss of skills in any area? ___Yes ___No, if so, explain:	

SOCIAL AND PLAY SKILLS	
Describe how your child plays:	
Does your child play independently? ___Yes ___No	If so, for how long?
What type of Toys/Items does he prefer?	
Does your child play with toys appropriately? ___ Yes ___No	Explain:
Does your child attempt to involve others? ___ Yes ___No	Explain:
Does your child engage in interactive play with others? ___ Yes ___No	Explain:
Does your child play engage in pretend play? ___ Yes ___No	Explain:
Which are your child prefer activities, toys or game?	

COMMUNICATION SKILLS	
Describe how your child communicates what she/he wants:	
Does your child Follow simple direction? ___ Yes ___No	Explain:
Does your child make eye-contact? ___ Yes ___No	Explain:
Does your child label items/events/actions? ___ Yes ___No	Explain:
Does your child answer WH questions? ___ Yes ___No	Explain:

Does your child engage in verbal exchanges with others? ___ Yes ___No	
Other Communication concerns:	
MOTOR SKILLS	Can your child perform any of the following?
Can your child imitate simple gestures (e.g., clapping, waving)? ____ Yes ____ No	
Can your child imitate simple gestures using objects (e.g., banging or drum)? ____ Yes ____ No	
Can your child imitate fine motor gestures (e.g., cut, write)? ____ Yes ____ No	
Can your child imitate gross motor abilities? ____ Yes ____ No	
Describe the child's general fine motor abilities:	

OTHER SKILLS	Can your child perform any of the following?
Identify Numbers: ____ Yes ____ No	Identify Letters: ____ Yes ____No
Complete Puzzle: ____ Yes ____No	Sort colors and shapes: ____ Yes ____ No
Match Items: ____ Yes ____ No	Write numbers and letters: ____ Yes ____No
Stack blocks: ____ Yes ____No	Identify people: ____ Yes ____No
Draw: ____ Yes ____No	Paint and color: ____ Yes ____No

SELF HELP SKILLS	
Is your child toilet trained? ___ Yes ___No	
Is your child feeding him/herself? ___ Yes ___No	
Does your child dress him/herself independently? ___ Yes ___No	
Does your child clean up after him/herself independently? ___ Yes ___No	

BEHAVIOR CONCERNS		Circle what describe best child's behavior			
Screams/Tantrums	N/A	Never	Rarely	Sometimes	Frequently
Flaps arms	N/A	Never	Rarely	Sometimes	Frequently
Runs from you	N/A	Never	Rarely	Sometimes	Frequently
Hits or Bites Others	N/A	Never	Rarely	Sometimes	Frequently
Interrupts others	N/A	Never	Rarely	Sometimes	Frequently
Difficulty pronouncing words	N/A	Never	Rarely	Sometimes	Frequently
Shy/Avoidant/Withdrawn	N/A	Never	Rarely	Sometimes	Frequently
Easily distracted	N/A	Never	Rarely	Sometimes	Frequently
Does not listen when spoken to	N/A	Never	Rarely	Sometimes	Frequently
Fidgety/Squirmy	N/A	Never	Rarely	Sometimes	Frequently
Difficulty remaining seated	N/A	Never	Rarely	Sometimes	Frequently
Runs around excessively	N/A	Never	Rarely	Sometimes	Frequently
Difficulty playing quietly	N/A	Never	Rarely	Sometimes	Frequently
Hyperactive	N/A	Never	Rarely	Sometimes	Frequently

Difficulty awaiting turn	N/A	Never	Rarely	Sometimes	Frequently
Difficulty organizing tasks	N/A	Never	Rarely	Sometimes	Frequently
Anxious/Nervous	N/A	Never	Rarely	Sometimes	Frequently
Sleep disturbances	N/A	Never	Rarely	Sometimes	Frequently
Doesn't pay attention to details	N/A	Never	Rarely	Sometimes	Frequently
Does not complete work	N/A	Never	Rarely	Sometimes	Frequently
Refuses adult's requests	N/A	Never	Rarely	Sometimes	Frequently
Loses temper easily	N/A	Never	Rarely	Sometimes	Frequently
Deliberately annoys others	N/A	Never	Rarely	Sometimes	Frequently
Easily annoyed by others	N/A	Never	Rarely	Sometimes	Frequently
Bullies/teases others	N/A	Never	Rarely	Sometimes	Frequently
Is angry/resentful	N/A	Never	Rarely	Sometimes	Frequently
Manipulates others	N/A	Never	Rarely	Sometimes	Frequently
Expelled from school	N/A	Never	Rarely	Sometimes	Frequently
Physically aggressive to others	N/A	Never	Rarely	Sometimes	Frequently
Physically aggressive to animals	N/A	Never	Rarely	Sometimes	Frequently

ADDITIONAL PROBLEM BEHAVIOR INFORMATION

What situations are these behaviors MOST likely to occur? (Days/times/activities/persons present)

_____

_____

_____

What situations are these behaviors LEAST likely to occur? (Days/times/activities/persons present)

_____

_____

_____

What typically happens right **BEFORE** problem behavior occurs?

_____

_____

_____

What typically happens right **AFTER** problem behavior occurs?

_____

_____

_____

What current treatments are being implemented?

_____
_____
_____

What treatments have been implemented in the past?

_____
_____
_____

What motivates/interests your child?

_____
_____
_____

Please list any other important information you would like us to know about your child.

_____
_____
_____
_____