THE CENTER FOR AUTISM
a PHMC affiliate

4601 Market Street
Philadelphia, PA 19139

215.878.3400 PHONE
215.878.2082 FAX
THECENTERFORAUTISM.ORG

INTAKE FORM

FORM COMPLETED BY: _____
RELATIONSHIP TO CLIENT: _____
TODAY'S DATE: ____ / ____ / _____

CLIENT INFORMATION

First Name: _____	Last Name: _____
Date of Birth: _____/_____/_____ Preferred Language: _____ Is an interpreter needed? [ ] Yes [ ] No	Social Security #: _____ Gender: _____ Gender identity: _____ Pronouns: _____
Biological Parent's Name (if client is under 17 years old): _____	Biological Parent's Name 2 (if client is under 17 years old): _____
Address: _____ City: _____ State: _____ Zip Code: _____ Primary Phone: _____ Secondary Phone: _____ Email Address: _____	Address: _____ City: _____ State: _____ Zip Code: _____ Primary Phone: _____ Secondary Phone: _____ Email Address: _____
Legal Guardian Name (if applicable): _____ Legal Guardian Name 2 (if applicable): _____	RACE/ETHNICITY (Check all that apply): [] American Indian or Alaska Native [ ] Asian [ ] African American [ ] Hispanic/Latino [ ] Caucasian [ ] Decline to Provide [ ] Other: _____

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INSURANCE INFORMATION

Insurance Company Name: _____ Member ID: _____	Insurance Company Name 2 (If Applicable): _____ Member ID: _____
Policy ID: _____ Group #: _____ Member Services: _____ Phone Number: _____ Specialty Co-Pay: _____	Policy ID: _____ Group #: _____ Member Services: _____ Phone Number: _____ Specialty Co-Pay: _____

CUSTODY ARRANGEMENTS (If Applicable)

Who has legal custody? _____	Are there legal custody documents? [ ] Yes [ ] No
Who has legal signing rights? _____	Is custody shared with DHS? [ ] Yes [ ] No
Court Order? [ ] Yes [ ] No	Reason: _____
Is the biological parent involved in the child's life? [ ] Yes [ ] No	Is the biological parent 2 involved in the child's life? [ ] Yes [ ] No

REASON FOR VISIT (Check all that apply)

[ ] First Autism Evaluation	[ ] Social Competency
[ ] Autism Re-evaluation/Second Opinion	[ ] Outpatient
[ ] CORE	[ ] STEP

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HOUSEHOLD INFORMATION

Name	Age	Relationship to Client

Do any family members of the client see those who do not live in the home?

Name	Relationship to Client

CLIENT MEDICAL HISTORY

PRIMARY CARE PHYSICIAN: _____

PHONE NUMBER: _____

ALLERGIES?
[ ] Yes [ ] No | If yes, list allergy and reaction: _____

Are Immunizations Up to Date:
[ ] Yes [ ] No [ ] Decline to answer

Any past hospitalizations? [ ] Yes [ ] No

If yes, date: _____

Name of Agency: _____

Does the client take medication? [ ] Yes [ ] No
If yes, please list below:

Name of Medication	Dosage	Prescribing Doctor

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EARLY INTERVENTION (PAST/PRESENT)

NAME OF AGENCY: _____	ADDRESS: _____
GRADE LEVEL: _____	PHONE NUMBER: _____
SPECIAL EDUCATION: [ ] Yes [ ] No	IEP (Individualized Education Plan): [ ] Yes [ ] No 504 Plan: [ ] Yes [ ] No

SCHOOL INFORMATION

SCHOOL/COLLEGE NAME: _____	ADDRESS: _____
GRADE LEVEL: _____	PHONE NUMBER: _____
SPECIAL EDUCATION: [ ] Yes [ ] No	IEP (Individualized Education Plan): [ ] Yes [ ] No 504 Plan: [ ] Yes [ ] No

Has the client ever received mental health services? [ ] Yes [ ] No
If yes, please complete below section

MENTAL HEALTH SERVICES (PAST)

MENTAL HEALTH SERVICES RECEIVED: _____
AGENCY NAME: _____
LEAD CLINICIAN NAME: _____

LEAD CLINICIAN CONTACT INFO: Phone: _____ Email: _____

CASE MANAGER NAME (if applicable): _____

CASE MANAGER CONTACT INFO: Phone: _____ Email: _____

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MENTAL HEALTH SERVICES (PRESENT)

MENTAL HEALTH SERVICES RECEIVED: _____

AGENCY NAME: _____

LEAD CLINICIAN NAME: _____

LEAD CLINICIAN CONTACT INFO: Phone: _____ Email: _____

CASE MANAGER NAME (if applicable): _____

CASE MANAGER CONTACT INFO: Phone: _____ Email: _____

Any formal mental health diagnoses (such as Autism, ADHD, Anxiety, Depression, etc.)?

[ ] Yes [ ] No | If yes, please list name of diagnoses: _____

Agency/Doctor: _____ Diagnoses: _____

Date of evaluation(s): _____ Date of most recent evaluation: _____

[ ] School/Educational Evaluation [ ] Self-diagnosed

[ ] No current diagnosis [ ] Other: _____

COPY OF DOCUMENTATION EVALUATION:

The parent/guardian/client reported the evaluation will be provided as follows:
[ ] Emailed or faxed prior to intake
[ ] Release of information needed at intake to request copy of evaluation from external provider

* *If client has a current diagnosis please explain where the diagnosis was given and who gave the diagnosis. Please see attached RTOI form to obtain copy of diagnosis/treatment history*

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DEVELOPMENTAL HISTORY PAST/PRESENT:

Reviewing infant/toddler milestone books or past reports may be helpful when completing the following questions. If you are uncertain, estimate as best as you can. Leave blank if the skill is not yet developed. Please record the ages in months when you or your child first:

1. Smiled in response to others: _____ months [ ] Unknown
2. Sat without support: _____ months [ ] Unknown
3. Walked independently w/o support: _____ months [ ] Unknown
4. Bladder control (day): _____ months [ ] Unknown
5. Bladder control (night): _____ months [ ] Unknown
6. Bowel control: _____ months [ ] Unknown
7. First words (other than mama, dada): _____ months [ ] Unknown
8. Spoke in 3-word phrases: _____ months [ ] Unknown
9. Spoke in full sentences (at least 4 words): _____ months [ ] Unknown

At what age, if any, did you first notice developmental delays or differences?
_____

Has there been any significant LOSS of a previously acquired skill or skills (not just a delay)?
For example, the child (or individual) was engaging in pretend play with other children for at least 4 to 6 months and then stopped or the child (or individual) was speaking in full sentences for many months and then stopped speaking altogether or began using only single words occasionally (leave blank if not applicable):

What did you notice and at what age did you notice this? _____

PAST/PRESENT TRAUMA

Has the client experienced anything traumatic or scary?
[ ] Yes [ ] No
If yes, when? _____
Brief description (if comfortable to share): _____

Current Concerns/Reason for an Evaluation (in your own words)?

_____

Client Preferences/Likes:

_____

_____

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COMPREHENSIVE BEHAVIORAL AND COMMUNICATION PROFILE PAST/PRESENT

COMMUNICATION METHODS (Check all that apply):
[ ] Verbal
[ ] Initiates a conversation
[ ] Talks about a variety of topics
[ ] PECS (Picture Exchange Communication System)
[ ] Sign Language
[ ] Extremely limited speech
[ ] Non-verbal
[ ] Other: _____

SOCIAL SKILLS (Check all that apply):
[ ] Interest in peers their age
[ ] Preference to interact with younger/older children or adults
[ ] Prefers to be alone rather than with others
[ ] Other: _____

SENSORY SENSITIVITIES (Check all that apply):
[ ] Loud/certain sounds
[ ] Lighting (too bright/dark)
[ ] Water
[ ] Temperature (too hot/cold)
[ ] Tactile (clothing/materials on hands)
[ ] Large Groups
[ ] Other: _____

BEHAVIORAL CONCERNS (Check all that apply):

[ ] Bangs head	[ ] Scratches others
[ ] Bites self	[ ] Pinches others
[ ] Pinches self	[ ] Tantrums for longer than 5 minutes
[ ] Scratches self	[ ] Unable to self-regulate
[ ] Hits others	[ ] History of self-harm
[ ] Elopes/runs away	[ ] Depression
[ ] Bites others	[ ] Other: _____

Appointment Preference: [ ] In-person [ ] Telehealth (Virtual)