Client Name: _____

Hope Delivery Systems, Inc.

Intake Application

Date of Intake: _____

Child's Name: _____ Date of Birth: _____

Parent & Guardian Information:

Mother/ Guardian Name: _____

Address: _____

Mother's Phone: Cell _____ Home _____ email _____

Father's Name: _____

Address: _____

Father's Phone: Cell _____ Home _____ email _____

Alternate Emergency Contact Information--please list one alternative emergency contact:

Name of contact: _____ Relationship to child: _____

Phone number: _____

Child Information:

1. Does your child have a current IEP (Individualized Education Program? ❑ No ❑ Yes

If yes, what is (are) your child's educational diagnosis as listed on his/her IEP?

Primary diagnosis_____ Secondary diagnosis (if applicable) _____

2. In what type of setting is your child currently receiving educational services? (Please mark on the appropriate line).

Name of School: _____(I think it would be interesting to see which schools our clients are coming from and also use this info for recruitment/marketing purposes)

___In regular education classroom for over 60% of school day with support

___In regular education classroom for less than 60% of school day with support

____Cross categorical self-contained classroom

____Self-contained classroom for children with autism

____Therapeutic day school program

____Other: _____

3. What type of therapy services does your child currently receive (in or outside of the school setting)? (would you want to know the frequency/ minutes for each or only ABA?)

____Speech

____OT

____Social Work

____Counseling

____Behavior

____ABA (in-home) Hours per week _____

4, Is your child currently taking medication(s)? ❑ No ❑ Yes If yes, please describe below:

_____

5. Does your child have seizures? ❑ No ❑ Yes If yes, please describe below:

_____

6. Does your child have allergies? ❑ No ❑ Yes If yes, please describe below:

_____

7. Does your child have any dietary restrictions? ❑ No ❑ Yes If yes, please describe below:

_____

8. What is your child's primary mode of communication?

Verbal _____ Pictures_____ Sign_____ Augmentative Communication System_____

Does your child exhibit any of the following behaviors?

____Hitting

____Biting

____Head banging

____Pinching

____Self- Injurious Behavior

____Elopement

10. What are some of your child's most challenging social skills deficits?

11. What are some of your child's areas of strength?

12. What are the three main goals that you would like for Hope Delivery Systems to target during the social skills group?

1. _____

2. _____

3. _____