



Please check which service(s) you are interested in:

Social Skills Training ()

*Before a therapy assessment can take place, we need **written confirmation of a diagnosis as well as a diagnostic assessment and a prescription stating the diagnosis and referral for ABA / Social Skills Training.***

Question	Answer If Yes, please explain:
1. Does the client have any history of anxiety?	<input type="checkbox"/> Yes <input type="checkbox"/> No <hr/> <hr/> <hr/>
2. Does the client have any history of depression?	<input type="checkbox"/> Yes <input type="checkbox"/> No <hr/> <hr/> <hr/>
3. Does the client have any history of suicidal ideations or acts?	<input type="checkbox"/> Yes <input type="checkbox"/> No <hr/> <hr/> <hr/>
4. Does the client have any history of homicidal threats or acts?	<input type="checkbox"/> Yes <input type="checkbox"/> No <hr/> <hr/> <hr/>
5. Does the client have any experience of being physically or sexually abused?	<input type="checkbox"/> Yes <input type="checkbox"/> No <hr/> <hr/> <hr/>
6. Does the client have any experience with being the perpetrator of sexual or physical abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No <hr/> <hr/> <hr/>
7. Has the client sought treatment for their autism diagnosis in the past (including Early	<input type="checkbox"/> Yes <input type="checkbox"/> No <hr/> <hr/> <hr/>

Intervention)? Please list dates	
8. If yes, list any community based programs or assistance used:	1. 2. 3.
9. Who diagnosed your child and when?	_____ _____ _____
10. Has the client been or is being seen by another behavioral health clinician?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____ _____
11. Please list all medications and dosages.	1. 2. 3.
12. List the presenting problems and the reasons the client is entering The Family Center for Autism's program and the psychological/social conditions affecting their status:	1. 2. 3. 4.
13. List all family members or related providers involved in the client's treatment for this diagnosis (explain their capacity - including parents or guardians):	1. 2. 3.
14. Please name all family members living in the home and the relationship to your child.	1. 2. 3.
15. Does the client have any family member with a history of medical or behavioral health concerns?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____ _____

<p>16. List all sources of support, barriers and influence that may impact the client and family:</p>	<p>Vocational: _____ Spiritual: _____ Cultural: _____ Educational: _____</p>
<p>17. Relevant Legal Matters</p>	<p>Divorce: _____ Custody: _____ Records Subpoenaed: _____</p>
<p>18. Please describe your pregnancy: full term, complications, natural or C-section, medications during, complications after etc.</p>	<p><input type="checkbox"/> C-section <input type="checkbox"/> natural</p> <p>_____ _____ _____</p>
<p>19. Did your child reach developmental milestones? Please indicate when and what milestone.</p>	<p><input type="checkbox"/> on time <input type="checkbox"/> delayed</p> <p>_____ _____ _____</p>
<p>20. Does your child attend public school and what type of classroom are they in? Please indicate the ratio if your child is in a Self-Contained classroom.</p>	<p><input type="checkbox"/> Self-contained <input type="checkbox"/> Inclusion <input type="checkbox"/> Mainstream <input type="checkbox"/> Public <input type="checkbox"/> Private</p>
<p>21. Does your child receive related services (Speech, PT, OT, Counseling, Social Group etc.) and if so, how often?</p>	<p><input type="checkbox"/> Speech <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Counseling <input type="checkbox"/> Social Group</p> <p>Other: _____</p>
<p>22. How does your child communicate their wants and needs? (For example, gestures, one word requests, full sentences)</p>	<p><input type="checkbox"/> Full Sentences <input type="checkbox"/> 2-3 word requests <input type="checkbox"/> 1 word requests <input type="checkbox"/> Gestures <input type="checkbox"/> PECS/Augmentative Device</p>
<p>23. Can your child engage in a conversation (at least 5 volleys) with information that is relevant to the conversation?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>_____ _____ _____</p>

24. Please list likes and dislikes. For example, likes the iPad, dislikes loud noises.	<hr/> <hr/> <hr/> <hr/>
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For clients over the age of 12 ONLY: If Yes, please explain:

Does the client drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes list amount/type:
Has the client ever felt he/she ought to cut down on drinking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the client use drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes list amount/type:
Has the client ever felt he/she ought to cut down on the use of drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No <hr/>
Has the client ever felt bad or guilty about drinking or drug use?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the client ever had a drink or used drugs first thing in the morning to steady their nerves, to start their day or to get rid of a hangover (eye-opener)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <hr/>