Initial Intake Form

Thank you for your interest in behavior-analytic services at the Shabani Institute! Please fill out the following Initial Intake Form to the best of your ability with the most current accurate information. For additional questions, please contact jkorba@shabani-institute.org.

General Information	
Client Name:	
Date:	
Referred By:	
Form Filled Out By:	
Relationship to Client:	
If adult, are they conserved?	• Yes • No • N/A If "*Yes*," name of conservator: _____
Email Address:	
Phone Number:	

Client Specific Information	
Age:	
Date of Birth:	
Primary Diagnosis:	• Autism Spectrum Disorder (ASD) • Down's syndrome • Developmental Disability (DD) • Intellectual Disability (ID) • Other: _____
Address:	
Who Lives in Home:	

If Sibling:	• Age:
	• Diagnosis
	  ○ Yes: _____
	  ○ No
	
	• Age:
	• Diagnosis
	  ○ Yes: _____
	  ○ No

Primary Language:	• English • Spanish • Other: _____
Ethnicity:	• Caucasian

	• Hispanic/Latinx • African-American • Asian • Indian • Indigenous • Other: _____ • Prefer not to disclose
Please Describe Important Cultural Considerations:	
Allergies:	
Medication & Dosages:	
Potential for Out of Home Placement:	• Yes • No If "*Yes*," explain: _____
Recent Hospitalizations or ER Visits:	Date & Duration of Stay: Description: _____ Date & Duration of Stay: Description: _____

Client Services & Education Information	
School:	
Grade:	
Class:	• General Education • Special Day Class • NPS
School Services:	• 1:1 Paraprofessional • Speech and Language Therapy • Occupational Therapy • Physical Therapy • Other: _____
Outside Services:	• Speech and Language Therapy • Occupational Therapy • Physical Therapy • Other: _____
Previous ABA Services:	• Agency: _____ • Length of service: _____ • Average hours/week: _____ • Reason for termination: _____

Client Logistics	
Funding Source:	• Regional Center: _____ • Insurance: _____
Child's Availability:	• Morning • Afternoon • Evening • Other:_____
Sessions in Home?:	• Yes • No
Sessions in Clinic:	• Yes • No
Will you be able to be present for a minimum of 90% of sessions?	• Yes • No

Client General Concerns	
Reason for Inquiring about ABA Services:	
Expectations for ABA Services:	
Goals for ABA Services:	
Areas of Strength:	
Areas of Concern:	

Communication & Social Skills	
Verbal:	• Yes • No • Emerging (e.g., repeats words spoken by others, 1-word phrases)
Mode:	• Vocal • Picture Exchange (e.g., PECS) • AAC Device (e.g., iPad, Tablet) • Gestures • ASL/Signs • Other: _____
Communication Skills:	• Requests basic wants and needs • Echoes speech sounds or words • Identifies/labels simple objects and pictures • Responds to WH questions

	• Responds to "Yes/No" questions • Initiates and maintains conversations • Follows 1-step and basic instructions
Social Skills:	• Plays and interacts well with others • Maintains positive friendships with peers • Plays parallel to peers • Imitates the actions of others • Prefers independent play • Engages in repetitive, restricted, play • Stranger & basic safety awareness

Functional Daily Living Skills	
Recent Hearing Check:	**Date:** **Concerns:** • Yes • No If "*Yes*", explain: _____
Recent Vision Check:	**Date:** **Concerns:** • Yes • No If "*Yes*", explain: _____
Recent Physical Check:	**Date:** **Concerns:** • Yes • No If "*Yes*", explain: _____
Physical Limitations:	• Ambulatory • Ambulatory with support • Non-ambulatory • Other: _____
Sleep:	• Sleep schedule:___:___PM - ___:___AM • Sleeps throughout the night • Difficulty falling asleep • Difficulty staying asleep • Frequent night-wakings
Toileting:	• Independently urinates and defecates in the toilet

	• Urinates and defecates in the toilet with support or help • Wears underwear throughout the day • Only urinates in the toilet • Only defecates in the toilet • Wears diapers • Urinates and defecates in diapers
Self-Care	• Brushes hair • Brushes teeth • Dresses independently • Washes hands • Wipes after using the toilet • Menstrual cycle care (if applicable)
Feeding:	• Self-feeds using utensils • Self-feeds using fingers • Self-feeds with support or help • Requires full support to be fed • Utilizes medical device to be fed (e.g., feeding tube): _____ • Food selectivity or restricted diet
Other	

Problem Behavior	**Description** *(written description)*	**Dangerous/ Severity***	**How Often** *(Hourly, Daily, Weekly, Monthly)*	**History**
Aggression:		1 2 3 4 5		
Self-Injury:		1 2 3 4 5		
Elopement:		1 2 3 4 5		
Yelling & Screaming:		1 2 3 4 5		
Non-Compliance & Vocal Protest:		1 2 3 4 5		
Pica:		1 2 3 4 5		

Inappropriate Sexual Behavior:		1 2 3 4 5		
Property Destruction:		1 2 3 4 5		
Stereotypy:		1 2 3 4 5		
Other:		1 2 3 4 5		

Dangerous/Severity Likert Scale: (*1) behavior easily blocked and redirected, (2) behavior sometimes blocked and redirected, (3) behavior causes injury or harm to self or others, (4) behavior often causes injury or harm to self or others (e.g., bruising), (5) behavior leads to extreme injury to self or others resulting in need for outside care (e.g., hospitalizations, emergency service call (911), etc).*

Additional Comments:	

Consent & Approval Statement

By signing the form below, you consent to sharing the above information with the Shabani Institute Clinical Director team for the purpose of determining the appropriateness of assessment services. This information will be kept confidential in a secure location, to uphold the requirements delineated by the Health Information Privacy and Protection Act (HIPPA).

_____

Name

_____

Signature

_____

Date

Please submit the completed form to: jkorba@shabani-institute.org