The Doris Duan-Young Autism Center

Pre-Intake Form

Please complete all answers according to your child's current skills.

Indicate YES/NO and provide further explanation with examples.

Date of Completion:				
Person Completing:			Relation:	
Child's Name:				
Father's Name:				
Mother's Name:				
Child's Date of Birth:				
Diagnosis:				
Primary language spoken at home:				
What language does child speak:	English	Arabic	Other:	
Reason for referral:				

Please indicate any services your child is currently enrolled in:

Current Services	YES/NO	Name/Location	Dates Attended:	Hours per Week:
School				
ABA				
Speech				
OT				
Other				

Medical Information	YES/NO	Describe:
Allergies		
Medication		
Diets/Restrictions		
Sleep Issues		
Other		

Communication – Expressive Skills	YES/NO	Examples:
Vocalizations? (sounds/babbles/words/sentences)		
How do they communicate what they want? (e.g. cry, grab, point, pull hands, words)		
What happens if they can't have what they want?		

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History of speech and language problems in your family?		

Communication – Receptive Skills	YES/NO	Examples:
Follow simple instructions? (e.g. clap hands, come here, sit down)		
Respond when name is called? (e.g. turns head, answers, go to person)		
Comply with requests?		
Copy actions if you do the action and say "copy me"? (e.g. clapping hands)		

Play Skills	YES/NO	Examples:
What does your child play with?		
Play with toys the right way (e.g. rolling a train across the tracks)?		
Engage in imaginary play? (e.g. pretending to cook or be a superhero)		

Social Skills	YES/NO	Examples:
Make eye contact with others?		
Tolerate being around other children?		
Play with other children?		
Share their toys and take turns playing with other children?		

Self-Help/Daily Living Skills	YES/NO	Examples:
Dress Independently? (i.e. shorts, shirt, shoes, socks)		
Eat independently? (i.e. finger food, spoon, fork, knife)		
Brush teeth independently?		
Tolerate having nails and hair cut?		
Use the toilet independently without help?		

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Independently tell you when they need the toilet?		

Sensory	YES/NO	Examples:
Any food selectivity?		
Any feeding problems? (e.g. drooling, choking, etc.)		
Any sensitivity to different sounds, textures, light?		
Does your child engage in self-stimulatory behavior?		
• Vocal stims (random sounds, repeating words/sounds, etc.)		
• Motor stims (hand flapping, jumping, spinning, etc.)		

Behavior	YES/NO	Examples:
Does your child engage in any dangerous behaviors?		
• Hitting/kicking/biting others		
• hitting/biting self		
• Breaking items		
• Running away		
Does your child engage in any disruptive behaviors?		
• Screaming/shouting		
• Crying excessively		
• Throwing items		
Any other behavior concerns?		

Goals
What are your top 3 goals for your child's development?
1.
2.
3.