Therapy Pre-Evaluation Packet

Thank you for taking the time to fill out this packet. The information you provide will help us plan your child's evaluation to meet his/her needs!

Child's Name:____ Date of Birth:_________________________

Age: _____________________ Gender: ❑ Male ❑ Female

Today's Date: _________________________

Person completing this form:_____________________________ Relationship to Child:__________________________

Reason for Evaluation (primary concerns):____

____

Primary Pediatrician: ____

Clinic/Location/Phone Number:____

What services are you interested in receiving? (check all that apply)

❑ ABA Therapy ❑ Speech-Language Therapy ❑ Occupational Therapy ❑ Feeding Therapy

CURRENT LIVING SITUATION

Address:____

Phone Number(s): Home:______________________ Work: ______________________ Cell:______________________

Who lives with your child at home?:

Name Relationship to your child (please include age if sibling)

____

____

____

____

____

Have there been any recent changes in your living situation (divorce, moving, new sibling, etc)? ❑ Yes ❑ No

If yes, please explain: ____

What is the primary language spoken in your home?____

Additional languages spoken in the home: ____

PREVIOUS & CURRENT SERVICES

Please list all services that your child currently receives or has received in the past.

Service Type	**Name**	**Date Started**	**Date Ended & Reason for Ending** (if your child currently receives this service, please write "current")
School (check all that apply) ❑ Traditional Classroom ❑ Special Education ❑ IEP ❑ Full-Time ❑ Part-time Schedule:_____________			
Daycare			
ABA Therapy			
Speech-Language Therapy			
Occupational Therapy			
Feeding Therapy			
Other:______________________			
Other:______________________			
Other:______________________			

MEDICAL HISTORY

Were there any complications during birth or pregnancy? ❑ Yes ❑ No

If yes, please explain:____

Has your child's hearing been tested? ❑ Yes ❑ No

Results:____

Do you have any concerns about your child's hearing? ❑ Yes ❑ No

If yes, please explain:____

Has your child had any significant illnesses or conditions (currently or in the past)? ❑ Yes ❑ No

If yes, please explain:____

Please list all diagnoses that your child has had or currently has (medical, developmental, mental health, etc):

____

Please list all known allergies (food, medications, environmental, etc):

____

Other important things we should know about your child (prior hospitalizations, trauma, etc):

____

Medications/Supplements: *Please list all of your child's current medications & nutritional supplements*

Medication/Supplement	Reason	Dosage	Start Date

Physicians/Specialists: *Please list any physicians or specialists that are involved in your child's care besides your primary physician listed above.*

Physician Name	Facility/Contact Number	Specialty	Date of last appointment/ Frequency of appointments

Does your child utilize any specific equipment (braces, splints, wheelchair, augmentative communication device, hearing aids, etc)? ❑ Yes ❑ No

If yes, please explain:____

COMMUNICATION SKILLS

What are the primary methods your child uses for letting you know what he/she wants? (check all that apply):

- ❑ Looking at objects
- ❑ Crying
- ❑ Vocalizing/Grunting
- ❑ Pointing at Objects
- ❑ Physical Manipulation
- ❑ Gestures
- ❑ Pulling someone over to a desired item
- ❑ Single Words
- ❑ 2-3 word combinations
- ❑ Sentences
- ❑ Sign Language (ASL or modified signs)
- ❑ Picture Communication
- ❑ Speech-Generating Device
- ❑ Other:_____________________

Which of the following do you think your child understands? (check all that apply):

- ❑ His/her own name
- ❑ Names of family members
- ❑ Names of common objects
- ❑ Names of body parts
- ❑ Simple directions
- ❑ Simple questions
- ❑ Complex directions
- ❑ Conversational speech

Which of the following best describes your child's speech?

- ❑ Easy to understand
- ❑ Difficult for parents to understand
- ❑ Difficult for others to understand
- ❑ Almost never understood by others

Which of the following statements best describes your child's reactions to his/her speech?

- ❑ Is easily frustrated when not understood
- ❑ Does not seem aware of speech/communication problem
- ❑ Tries to say sounds or words more clearly when asked
- ❑ Will attempt to use an alternative form of communication if the original method fails (e.g., child reverts to using a picture to communicate when you don't understand what he/she says)

How have your child's communication skills changed over the past few months?

____
____

What are your primary concerns regarding your child's communication skills?

____
____
____

PLAY & SOCIAL SKILLS

How does your child play? (check all that apply):

- ❑ Mouths objects
- ❑ Shakes/bangs objects
- ❑ Uses 2 or more objects at the same time
- ❑ Typically uses toys functionally
- ❑ Prefers to play alone
- ❑ Engages in pretend play
- ❑ Plays simple games
- ❑ Plays interactively with caregivers
- ❑ Plays interactively with other children
- ❑ Makes appropriate eye contact while playing

Do you have any concerns regarding your child's play and/or social skills? ❑ Yes ❑ No

If yes, please explain: ____

____

____

FEEDING SKILLS

Please indicate if your child demonstrates difficulties with any of the following (check all that apply):

- ❑ Excessive length of time to eat
- ❑ Food or liquid coming out of the nose
- ❑ Biting off pieces of food
- ❑ Chewing or swallowing any foods
- ❑ Drooling
- ❑ Teeth grinding
- ❑ Lip control (keeping mouth closed)
- ❑ Coughing while or immediately after eating
- ❑ Gagging
- ❑ Choking
- ❑ Vomiting/regurgitation
- ❑ Tongue control (tongue thrust, poor mobility)
- ❑ Aversion to certain textures or types of foods
- ❑ Other:_________________________________

Please indicate if your child demonstrates any of the following behaviors during mealtime (check all that apply):

- ❑ Refuses food
- ❑ Spits out food
- ❑ Throws food
- ❑ Excessively messy eater
- ❑ Cries/screams
- ❑ Leaves table before meal is over
- ❑ Only eats certain foods
- ❑ Takes food from others
- ❑ Overeats/stuffs mouth
- ❑ Holds food in mouth
- ❑ Falls asleep or fatigues during meals
- ❑ Other:_________________________________

Does your child feed him/herself? ❑ Yes ❑ No

Does your child have any dietary constraints? ❑ Yes ❑ No

If yes, please explain:____

Do you have any concerns regarding your child's feeding skills? ❑ Yes ❑ No

If yes, please explain: ____
____
____

DAILY LIVING SKILLS

How much help do you give your child to complete each of the following tasks? Please use the following scale:

100% I do all of the task for my child *75% I do almost everything, and my child helps a little*
50% We each do about half of the work *25% My child needs a little help (physical or verbal) to get the task done*
0% I do nothing; my child is able to do this independently

Wash Hands		Take a bath/shower	
Dress/undress (pull-on clothing)		Comb/brush hair	
Zip (including starting)		Use toilet/toilet paper	
Tie shoes		Use a fork/spoon	
Buttons		Drink from a cup	
Snaps		Fall asleep within 30 minutes	
Brush teeth		Stay asleep at night	

MOTOR SKILLS

Do you have any concerns regarding your child's gross motor skills (climbing, coordination, ball skills, balance, jumping, running, etc)? ❑ Yes ❑ No

If yes, please explain: ____
____
____

Do you have any concerns regarding your child's fine motor skills (using hands for functional tasks such as cutting, holding a pencil, hand coordination and/or strength, picking up small items, etc)? ❑ Yes ❑ No

If yes, please explain: ____
____
____

Do you feel you child is meeting all of his/her appropriate motor milestones? ❑ Yes ❑ No

If no, please explain: ____
____
____

SENSORY PREFERENCES

Please describe your child's sensory preferences by selecting the box that is most similar to your child's behaviors when responding to input from each sensory system or area. The behaviors listed are examples and not all inclusive. If you are unsure, please select "My Child Seems to Be In the Middle in this Area."

Sensory System/Area	My Child Needs More Input to Respond in This Area	My Child Seems to Be In the Middle in This Area	My Child Needs Less Input to Respond in This Area
Auditory	❑ Examples: Misses certain sounds/names being called, makes unusual sounds/noises, confused by direction of sounds	❑ Examples: Orients to name being called, able to focus in noisy environment	❑ Examples: Doesn’t like loud noises, covers ears with hands, has trouble in loud/noisy environments
Visual	❑ Examples: Examines pictures/objects closely and carefully, seems oblivious to people entering/moving in the room	❑ Examples: Able to move between focus on small objects and his/her environment without difficulty, adequate reading abilities	❑ Examples: Squints, often bothered by bright lights, frustrated by visual clutter/ unable to find things in his/her environment
Oral/Smell	❑ Examples: Chews on non-food items/clothes inappropriately for age, smells objects/foods frequently, overstuffs mouth when eating	❑ Examples: Eats a varied diet, completes tooth brushing without difficulty	❑ Examples: Very restricted diet (craves or avoids certain foods), over-active gag reflex, expresses discomfort or distress to tooth brushing or dental care
Touch	❑ Examples: Enjoys messy play, pinches, bites or otherwise hurts self, seems to constantly touch something/fidget, seems less sensitive to pain than other children	❑ Examples: Accepts hugs/kisses (age appropriately), able to accept non-preferred textures to complete an activity and then wash hands	❑ Examples: Avoids messy play, expresses distress/discomfort during grooming (nail care, face washing, hair care), needs to be in control of touch, seems more sensitive to pain than other children
Movement	❑ Examples: Always moving/fidgeting, loves spinning/rides, takes extra risks during play	❑ Examples: Able to balance active play with quiet play, enjoys movement, but does not crave it	❑ Examples: Becomes anxious when upside down or feet leave ground, strongly prefers sit down/quiet activities to active play
Body Awareness	❑ Examples: Trips/falls often, described as clumsy, changes body position often during sit down tasks	❑ Examples: Good body awareness, fair coordination when compared to other children	❑ Examples: May have tight muscles, rigid body posture, locks joints
Self-Regulation	❑ Examples: Slow to respond, appears bored, low energy, passive	❑ Examples: able to adjust attention and effort to the activity and between activities easily	❑ Examples: Very active, even when activity is quiet, difficulty falling asleep, has difficulty maintaining the appropriate amount of energy for the activity, described as excitable

BEHAVIORAL HISTORY

How often does your child follow directions without complaining?

❑ Never ❑ Rarely ❑ Sometimes ❑ Usually ❑ Always

How does your child behave when he/she is upset or unhappy about something? (check all that apply):

- ❑ Calmly uses words to express feelings
- ❑ Uses words but speaks disrespectfully
- ❑ Uses curse words
- ❑ Yells or screams
- ❑ Cries
- ❑ Spits
- ❑ Throws him/herself to the floor
- ❑ Flails arms and/or legs
- ❑ Runs away
- ❑ Becomes unresponsive or ignores you
- ❑ Attempts to harm others
- ❑ Attempts to harm him/herself
- ❑ Attempts to damage property
- ❑ Other:____

Does your child engage in behaviors that cause harm to others (hitting, kicking, scratching, biting, hair pulling, etc)?

❑ Yes ❑ No ❑ Previously (does not anymore)

If yes or previously, please list specific behaviors: ____

____

____

Does your child engage in behaviors that cause harm to him/herself (hitting self, scratching self, biting self, etc)?

❑ Yes ❑ No ❑ Previously (does not anymore)

If yes or previously, please list specific behaviors: ____

____

____

Does your child engage in behaviors that cause destruction of property (breaking toys, throwing items, etc)?

❑ Yes ❑ No ❑ Previously (does not anymore)

If yes or previously, please list specific behaviors: ____

____

____

ADDITIONAL INFORMATION

What are your child's biggest strengths?

____

____

What are your child's biggest struggles?

____
____

What is your top priority or goal for your child right now?

____
____

Do you have any safety concerns for your child (eloping, lack of stranger danger awareness, etc)? ❑ Yes ❑ No

If yes, please explain: ____
____
____

Has your child lost skills that they previously had (eye contact, pointing, waving, using words, etc)? ❑ Yes ❑ No

If yes, please explain: ____
____
____

What are strong motivators for your child (food, toys, activities, etc)?

____
____

Please tell us anything else you'd like us to know about your child.

____
____
____

ANNUAL CONSENT FOR RELEASE AND EXCHANGE OF INFORMATION

Name of Client: ____ **DOB:**_______________________

Name of Parent(s) or Guardian __________________________________ **Phone:** _____________________

If you are separated or divorced, please verify you are the party above and have full legal custody by initialing here _____

If you are separated or divorced, please verify you **share** legal custody by initialing here _____

If you are not separated or divorced to the child's biological parent initial here _____

Please indicate your relationship to child ____________________________________

Parent's Rights: I/we understand that:

- This consent for release of information is valid for one year once signed.
- Information shared will be used for the purpose of transporting, planning, training or providing either speech and language services, occupational therapy services or intensive behavioral intervention services.
- The information requested is classified as private data, as defined and governed by the Government Data Privacy Act. It cannot be released without written consent unless required by law.
- If you do not want information shared, your child will still be served but there may be a delay in services starting.
- You may change this authorization at any time with a written request.
- Information on file with any one of these parties may be shared with the other parties you authorize based only on their need to know. Documents, however, cannot be shared between two different parties outside Autism Matters when Autism Matters is the liaison and the intended recipient of that document.

❑ **I/we do not have any outside parties or organizations to release or share information at this time.**

I/we give permission for information to be shared among the following organizations (e.g., school, doctor's office, etc.):

1. Physician:______________________________
2. School:_________________________________
3. Speech-Language Therapy:__________________
4. Occupational Therapy: _____________________
5. Other Professional: ___________________________
6. Family Members: _____________________________
7. Transportation: ______________________________
8. ____

I/we give permission for requests for information as well as release and exchange of the following information:

❑ child and family identifying information ❑ child's developmental history ❑ service plan(s) (i.e. IEP, ITP)
❑ health and medical data ❑ educational data ❑ social
❑ mental health ❑ chemical ❑ video/picture
❑ other:

I/we wish to withhold information concerning: ____

____

Parent/Guardian Signature **Date**

Personal and Financial Information: *(Please Print)*

Child's name: ______________________ Date of Birth: ______________

Parent name(s): ____

Address______________ City: ____________ State: ______ Zip: __________

Day phone: __________________ Evening phone: __________________

Cell phone: __________________ Email address: __________________

Insurance Information: *(Please include a copy of your insurance card.)*

Primary Insurance: ______________	Secondary Insurance: ______________
Policy Holder and DOB: ______________	Policy Holder: ______________
Identification Number: ______________	Identification Number: ______________
Group Number: ______________	Group Number: ______________

Physician Information:

Referring Physician Name: ______________________________________

Clinic: __________________ Address: ______________ Phone: __________

I understand that I am financially responsible for payment of any services provided by Autism Matters, Inc., including co-pays, deductibles, and co-insurance.

I request that payment of authorized insurance benefits be made to Autism Matters, Inc. for any services furnished to my child.

I authorize Autism Matters, Inc. to release and/or exchange any information with other providers/organizations who are involved in my child's treatment.

I acknowledge that I have been given the opportunity to read and/or receive Autism Matters, Inc. Notice of Privacy Practices.

This authorization and assignment will remain in effect until revoked by me in writing.

______________________________ ______________________________
Parent Signature **Date**