



# Client Information Questionnaire

## General Information

### CLIENT

Name of Child: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Male

Female

Current Age: \_\_\_\_\_

Current Diagnosis: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_

Diagnosed by: \_\_\_\_\_

Age at Diagnosis: \_\_\_\_\_

Affiliation: \_\_\_\_\_

Primary Address: \_\_\_\_\_

Secondary Address: \_\_\_\_\_  
(if any) \_\_\_\_\_

### PARENTS AND/OR GUARDIANS

Mother's Name: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Occupation: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Mobile Phone Number: \_\_\_\_\_

Mobile Phone Number: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_

Best Number to Reach: \_\_\_\_\_ Home \_\_\_\_\_ Mobile \_\_\_\_\_ Work

Best Number to Reach: \_\_\_\_\_ Home \_\_\_\_\_ Mobile \_\_\_\_\_ Work

Email Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

Are parents \_\_\_\_\_ married \_\_\_\_\_ divorced \_\_\_\_\_ separated?

If divorced, who has custody of minor? \_\_\_\_\_

### SIBLINGS

Sibling Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Sibling Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Sibling Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Sibling Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### SCHOOL AND REGIONAL CENTER

School District: \_\_\_\_\_

Regional Center: \_\_\_\_\_

School Name: \_\_\_\_\_

Case Worker: \_\_\_\_\_

Case Worker Phone

School Phone Number: \_\_\_\_\_

Number: \_\_\_\_\_

School Address: \_\_\_\_\_

Branch Address: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Client Name: \_\_\_\_\_

## Medical Information

### PREGNANCY, DELIVERY AND FIRST YEAR

Were there any complications with your pregnancy or delivery? If so, please explain.

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Did your child experience any illnesses during his or her first year? If so, please list the illnesses and how each was treated.

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### MEDICATIONS

Please list any medications that your child has previously taken:

Medication Name	Dosage	Length of Time Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any medications that your child is currently taking:

Medication Name	Dosage	Start Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any supplements, vitamins, etc. that your child is currently taking:

Medication Name	Dosage	Start Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

### MEDICAL TESTING

Please list any medical testing that your child has completed:

Test Name	Month/Year	Results
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Today's Date: \_\_\_\_\_

Client Name: \_\_\_\_\_

## Medical Information (continued)

### CURRENT MEDICAL CONDITIONS

Please list any current allergies that your child may have:

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Please list any infectious, contagious or communicable conditions:

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Please list any special nutritional needs:

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I have attached a copy of my child's immunization records.

### CURRENT TREATING PHYSICIANS

Doctor's Name:

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Specialty:

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Address:

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Phone Number:

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Doctor's Name:

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Specialty:

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Address:

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Phone Number:

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### INSURANCE INFORMATION

Name of Insurance:

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Group Number:

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Certificate Number:

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Today's Date: \_\_\_\_\_

Client Name: \_\_\_\_\_

## Skills Assessment

### LANGUAGE

Does your child...

			<u>Comments</u>
Match objects or pictures?	<input type="radio"/> yes	<input type="radio"/> no	_____
Imitate actions of others?	<input type="radio"/> yes	<input type="radio"/> no	_____
Follow directions without visual cues?	<input type="radio"/> yes	<input type="radio"/> no	_____
Indicate his/her needs or wants?	<input type="radio"/> yes	<input type="radio"/> no	Circle one: words pictures gestures
Imitate sounds or words when modeled?	<input type="radio"/> yes	<input type="radio"/> no	_____
Use words to ask for things?	<input type="radio"/> yes	<input type="radio"/> no	_____
Label items he or she sees or hears?	<input type="radio"/> yes	<input type="radio"/> no	_____
Answer questions?	<input type="radio"/> yes	<input type="radio"/> no	_____
Speak in sentences? (if no, skip remaining questions)	<input type="radio"/> yes	<input type="radio"/> no	If yes, average length? 3 5 8+ words
Participate in conversations?	<input type="radio"/> yes	<input type="radio"/> no	_____

What are your principal concerns regarding your child's language?

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### PLAY SKILLS

Does your child...

			<u>Comments</u>
Look at books?	<input type="radio"/> yes	<input type="radio"/> no	_____
Play with cause/effect toys (i.e.: Jack in the Box)?	<input type="radio"/> yes	<input type="radio"/> no	_____
Complete task completion toys (i.e.: puzzles, beads)?	<input type="radio"/> yes	<input type="radio"/> no	_____
Play with toys by using them like real items (i.e. uses a play spoon to pretend to eat)?	<input type="radio"/> yes	<input type="radio"/> no	_____
Play simple games like "ring around the rosy"?	<input type="radio"/> yes	<input type="radio"/> no	_____
Construct items using blocks, legos, or other items?	<input type="radio"/> yes	<input type="radio"/> no	_____
Play games with rules (i.e.; memory)?	<input type="radio"/> yes	<input type="radio"/> no	_____
Engage in dress up or role play (i.e.; pretending to be a barber)?	<input type="radio"/> yes	<input type="radio"/> no	_____
Play appropriately on his or her own for up to 5 minutes?	<input type="radio"/> yes	<input type="radio"/> no	If no, how long?

What are your principal concerns regarding your child's play skills?

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Today's Date: \_\_\_\_\_

Client Name: \_\_\_\_\_

## Skills Assessment (continued)

### SOCIAL SKILLS

Does your child...

			<u>Comments</u>
Respond to his or her name by looking at you?	<input type="radio"/> yes	<input type="radio"/> no	_____
Make eye contact when speaking to you?	<input type="radio"/> yes	<input type="radio"/> no	_____
Greet you when you arrive home?	<input type="radio"/> yes	<input type="radio"/> no	_____
Respond to others' emotions?	<input type="radio"/> yes	<input type="radio"/> no	_____
Attempt to involve you in something that he/she is doing to share interest (not b/c he or she needs your help)?	<input type="radio"/> yes	<input type="radio"/> no	_____
Observe other children playing?	<input type="radio"/> yes	<input type="radio"/> no	_____
Join in with other children when they are playing?	<input type="radio"/> yes	<input type="radio"/> no	_____
Take turns in games?	<input type="radio"/> yes	<input type="radio"/> no	_____
Verbally interact with peers?	<input type="radio"/> yes	<input type="radio"/> no	_____

What are your principal concerns regarding your child's social skills?

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### SELF HELP SKILLS

Does your child...

			<u>Comments</u>
Sleep through the night?	<input type="radio"/> yes	<input type="radio"/> no	_____
Sleep in his/her own bed without supervision?	<input type="radio"/> yes	<input type="radio"/> no	_____
Drink from a cup?	<input type="radio"/> yes	<input type="radio"/> no	_____
Eat a variety of foods (i.e. fruits, veggies, meats, grains)?	<input type="radio"/> yes	<input type="radio"/> no	_____
Use a spoon and a fork to feed himself or herself?	<input type="radio"/> yes	<input type="radio"/> no	_____
Remove pull-down garments independently?	<input type="radio"/> yes	<input type="radio"/> no	_____
Remove socks and shoes independently?	<input type="radio"/> yes	<input type="radio"/> no	_____
Remove shirts independently?	<input type="radio"/> yes	<input type="radio"/> no	_____
Put on pull-up garments independently?	<input type="radio"/> yes	<input type="radio"/> no	_____
Put on socks and shoes independently?	<input type="radio"/> yes	<input type="radio"/> no	_____
Put on shirts independently?	<input type="radio"/> yes	<input type="radio"/> no	_____
Use the toilet independently?	<input type="radio"/> yes	<input type="radio"/> no	_____

What are your principal concerns regarding your child's self help skills?

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Today's Date: \_\_\_\_\_

Client Name: \_\_\_\_\_

### Skills Assessment (continued)

#### FINE MOTOR

Does your child...

			<u>Comments</u>
Unwrap presents?	<input type="radio"/> yes	<input type="radio"/> no	_____
Pour water or sand from one object to another?	<input type="radio"/> yes	<input type="radio"/> no	_____
Turn doorknobs to open doors?	<input type="radio"/> yes	<input type="radio"/> no	_____
Use one hand consistently?	<input type="radio"/> yes	<input type="radio"/> no	circle one:    right hand    left hand
Use a crayon with hand NOT fist?	<input type="radio"/> yes	<input type="radio"/> no	_____
Copy lines and simple shapes?	<input type="radio"/> yes	<input type="radio"/> no	_____
Write his or her own name?	<input type="radio"/> yes	<input type="radio"/> no	_____
Use scissors?	<input type="radio"/> yes	<input type="radio"/> no	_____

What are your principal concerns regarding your child's fine motor skills?

\_\_\_\_\_  
\_\_\_\_\_

#### GROSS MOTOR

Does your child...

			<u>Comments</u>
Walk up and down stairs with alternating feet?	<input type="radio"/> yes	<input type="radio"/> no	_____
Walk around or step over items that are on the floor?	<input type="radio"/> yes	<input type="radio"/> no	_____
Jump off the ground with both feet?	<input type="radio"/> yes	<input type="radio"/> no	_____
Kick a playground ball to you?	<input type="radio"/> yes	<input type="radio"/> no	_____
Throw a playground ball to you?	<input type="radio"/> yes	<input type="radio"/> no	_____
Catch a ball when thrown?	<input type="radio"/> yes	<input type="radio"/> no	_____
Show interest in sports?	<input type="radio"/> yes	<input type="radio"/> no	_____

What are your principal concerns regarding your child's gross motor skills?

\_\_\_\_\_  
\_\_\_\_\_

#### ACADEMIC SKILLS

Does your child...

			<u>Comments</u>
Identify shapes, colors, numbers and letters?	<input type="radio"/> yes	<input type="radio"/> no	_____
Identify locations, occupations, and functions of objects (i.e.; the refrigerator keeps things cold)	<input type="radio"/> yes	<input type="radio"/> no	_____
Use pronouns, plurals and prepositions appropriately?	<input type="radio"/> yes	<input type="radio"/> no	_____
Identify cause/effect relationships?	<input type="radio"/> yes	<input type="radio"/> no	_____

What are your principal concerns regarding your child's academic skills?

\_\_\_\_\_  
\_\_\_\_\_

Today's Date: \_\_\_\_\_

Client Name: \_\_\_\_\_

## Behaviors

### CHALLENGING BEHAVIORS

Please list any challenging behaviors that your child may exhibit and complete the table accordingly.

Type of Behavior	Please describe the behavior.	What typically happens immediately before, or "triggers" the behavior?	How many times per day or week does this behavior occur? If the behavior lasts for more than 10 seconds, list the average duration of the behavior as well.	What typically happens after the behavior, or, what do you do when this behavior occurs?
Tantrums				
Failing to Follow Instructions				
Aggression				
Running Away/Eloping				
Self Injurious Behaviors				
Eating Inedible Objects (Pica)				
Other:				
Other:				

Today's Date: \_\_\_\_\_

Client Name: \_\_\_\_\_

## Behaviors

### SELF STIMULATORY BEHAVIORS

Please list any self stimulatory / repetitive behaviors that your child may exhibit and complete the table accordingly.

Type of Behavior	Please describe the behavior.	What typically happens immediately before, or "triggers" the behavior?	How many times per day or week does this behavior occur? If the behavior lasts for more than 10 seconds, list the average duration of the behavior as well.	What typically happens after the behavior, or, what do you do when this behavior occurs?
Vocal (repeating vocalizations, words or phrases)				
Preoccupations with items, topics, etc.				
Repetitive motor mannerisms (hand flapping, spinning items, lining up objects, etc.)				
Routine behaviors (insisting on the same cup, same route in the car)				
Other:				
Other:				
Other:				

Today's Date: \_\_\_\_\_

Client Name: \_\_\_\_\_

## Treatment History

Please list any treatments that your child has received in the past and complete the table accordingly.

Type of Treatment	Service Provider or Clinician And Contact Information	How many hours per week was this treatment provided?	Dates of Treatment	Did you feel that this treatment was beneficial? Please explain.
Special Education Classroom			Start Date: End Date:	
Speech Therapy			Start Date: End Date:	
Occupational Therapy			Start Date: End Date:	
Physical Therapy			Start Date: End Date:	
Other ABA Program			Start Date: End Date:	
Other:			Start Date: End Date:	
Other:			Start Date: End Date:	
Other:			Start Date: End Date:	

Today's Date: \_\_\_\_\_

Client Name: \_\_\_\_\_

### Current Treatment and Schedule

Please list any treatments that your child is currently receiving and complete the table accordingly.

Type of Treatment	Service Provider or Clinician And Contact Information	How many hours per week is this treatment provided?	Start Date of Treatment	Do you feel that this treatment is beneficial? Please explain.
Regular Education Classroom			Start Date:	
Special Education Placement	<u>Circle One:</u> Mixed Special Ed. Autism Classroom Partial Inclusion		Start Date:	
Speech Therapy			Start Date:	
Occupational Therapy			Start Date:	
Physical Therapy			Start Date:	
Other ABA Program			Start Date:	
Other:			Start Date:	
Other:			Start Date:	

Please complete the schedule to indicate your child's availability beginning in 4 weeks.

Mon	Tues	Wed	Thru	Fri	Sat	Sun