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| Intake Questionnaire |

Please complete this questionnaire about the potential client. It is written as if you are the client’s parent/guardian; but can also be completed by teachers, related professionals, service coordinators, friends, or the client him/herself. Your insight is valuable to us and will help us to better prepare for evaluations and services.

You can complete this form electronically by tabbing from one response field to the next and by skipping any fields that do not apply. Please save the completed form and then e-mail it to us at Trendlineadm1@gmail.com . If you would rather complete this form by hand, you can print it, write in the response fields, and then mail it to us at the address above. Please call us at (573) 605-1600 or e-mail us at Trendlineadm1@gmail.com with any questions or comments about this questionnaire or process.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| DEMOGRAPHICS | Client’s Name |  |  | Client’s Date of Birth |  |
|  | Parent/Guardian 1 |  |  | Street Address |  |
|  | Parent/Guardian 2 |  |  | City |  |
|  | Phone Number |  |  | Zip Code |  |
|  | Cell Phone |  |  | E-Mail |  |

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| SUPPORT COORDINATOR | This is information about the person who is responsible for coordinating or authorizing services for the client. This could be a Support or Service Coordinator within the DMH system, the client’s lead IEP team member within the school system, the client’s Vocational Rehabilitation Counselor, etc. | | | | |
| Name of Coordinator |  |  | Company/Agency |  |
| Phone Number |  |  | Street Address |  |
| Cell Phone |  |  | City |  |
|  |  |  | Zip Code |  |
|  |  |  | E-Mail |  |

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| DIAGNOSES | Please list all medical, psychological, and/or educational diagnoses that the client has received and the approximate dates (month/year) that these occurred. | | | | |
| Diagnosis |  |  | Approximate Date |  |
| Diagnosis |  |  | Approximate Date |  |
| Diagnosis |  |  | Approximate Date |  |
| Diagnosis |  |  | Approximate Date |  |
| Diagnosis |  |  | Approximate Date |  |

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| SERVICES THAT INTEREST YOU | Trendline Consulting staff offer a number of services, and most of our consumers receive more than one service at-a-time. Please place an “X” in front of any services that you feel might be beneficial. | | | | |
|  | Camp Curiosity | | Ages 5-12 | Staff support students who have special needs in the Perryville Public Schools summer camp program. |
|  | Tutoring Services | | Ages 5-80 | Staff teach consumers critical academic life skills such as reading, math, money skills, and telling/using time. |
|  | SASS  (Kids Social Skills Group) | | Ages 5-14 | Staff and group members meet twice weekly to target social skills. One day each week includes swimming, while two days each month are used for outings that the group members brainstorm and decide. |
|  | YASS  (Youth Social Skills Group) | | Ages 15-25 | Staff and group members meet twice weekly to target skills across 13 domains that are critical for successfully transitioning to adulthood. Group members brainstorm, vote for, and then go on two outings per month. |
|  | Personal Assistance | | Ages 3-70 | This service can be provided in almost any home or community setting and is used to ensure safety and to teach basic daily living skills. |
|  | Community Integration | | Ages 18+ | Staff and the consumers go to community settings that offer high degrees of interaction, and staff actively teach skills that increase independence in these settings. |
|  | Behavioral Services | | Ages 3-70 | Staff analyze negative behavior and/or skills deficits, develop behavior support plans and instructional protocols, and then train team and family members to implement the plans. |
|  | Independent Living Training | | Ages 18-70 | Staff help individuals transition to living on their own by targeting budgeting, taking care of a home, meal-planning, paying bills, shopping, cooking, etc. |
|  | Life Skills University | | Ages 16-70 | Staff offer 3-month classes for adults that focus on new leisure skills, social skills, employment-related skills, cooking, driver’s education, etc. There are classes for individuals of all skill levels. |
|  | Employment Services |  | Ages 16-70 | Staff work with consumers to discover their interests and employment skills, search for employment, gain employment-related “people skills”, and navigate the job search and interview processes. Once employed, staff can help consumers learn on-the-job skills and network. |
|  | CISE (Career Interest & Skills Evaluation |  | Ages 16-70 | This is a specific employment service where consumers can try out as many as 16 different occupations to discover their strengths and their interests. |
| More information can be found about each of these services at our website (TrendlineConsulting.org) by clicking on the “Our Services” tab. | | | | |

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| --- | --- | --- | --- | --- | --- |
| MEDICATIONS AND DOCTOR | Please list all medications that the person takes and the perceived reasons or aims of each. | | | | |
| Medication |  |  | Reason |  |
| Medication |  |  | Reason |  |
| Medication |  |  | Reason |  |
| Medication |  |  | Reason |  |
| Medication |  |  | Reason |  |
| Medication |  |  | Reason |  |
| Medication |  |  | Reason |  |
|  | |  |  |  |
| Who is the individual’s personal doctor or person most directly responsible for his/her care? | |  | Name of Doctor |  |
|  | Agency/Location |  |
|  | Phone # |  |

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| RELEVENT ENVIRONMENTS | Does the client currently attend school? | | | | | | | | | | Yes | No |
|  | Attends on |  | | days each week for | | | |  | | hrs/day |
|  | Contact’s Name |  | | Contact’s Phone # | | |  | | | | |
|  | Contact's E-Mail |  | | # of Years Attending | | |  | | | | |
|  | | | | | | | | | | | |
| Does the client currently attend a day habilitation program? | | | | | | | | | | Yes | No |
|  | Attends on |  | | days each week for | | | |  | | hrs/day |
|  | Contact's Name |  | | Contact's Phone # | | |  | | | | |
|  | Contact's E-Mail |  | | # of Years Attending | | |  | | | | |
|  | | | | | | | | | | | |
| Is the client currently employed? | | | | | | | | | | Yes | No |
|  | Works at | *(name of company or workshop)* | | | | | | | | | |
|  | Works on |  | | days each week for | | | | |  | hrs/day | |
|  | Contact's Name |  | | Contact's Phone # | | | | |  | | |
|  | Contact’s E-Mail |  | | # of Years Working | | | | |  | | |
|  | | | | | | | | | | | |
| Where does the client live? | | | w/family | | in own home | group home | | | | in ISL | other |
|  | Contact’s Name |  | | Contact’s Phone # | | |  | | | | |
|  | Contact's E-Mail |  | | # of Years Living Here | | |  | | | | |

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| CURRENT SERVICES | Does the client currently receive personal assistance (PA) services? | | | | | | Yes | No |
|  | Receives on |  | days each week for |  | | hrs. per week | |
|  | Company/Agency |  | Contact Phone # |  | | | |
|  | Main PA’s Name |  | Main PA’s Phone # |  | | | |
|  | | | | | | | |
| Does the client currently receive speech/language therapy services? | | | | | | Yes | No |
|  | Receives |  | sessions weekly for |  | | min. per session | |
|  | Therapist's Name |  | Therapist's Phone # |  | | | |
|  | Therapist's E-Mail |  | # of Years Receiving |  | | | |
|  | | | | | | | |
| Does the client currently receive occupational or physical therapy services? | | | | | | Yes | No |
|  | Receives |  | sessions weekly for | |  | min. per session | |
|  | Therapist's Name |  | Therapist's Phone # | |  | | |
|  | Therapist's E-Mail |  | # of Years Receiving | |  | | |
|  | | | | | | | |
| Does the client currently receive music therapy services? | | | | | | Yes | No |
|  | Receives |  | sessions weekly for | |  | min. per session | |
|  | Therapist's Name |  | Therapist's Phone # | |  | | |
|  | Therapist's E-Mail |  | # of Years Receiving | |  | | |
|  | | | | | | | |
| Does the client currently receive behavior or developmental therapy services? | | | | | | Yes | No |
|  | Receives on |  | days each week for | |  | hrs. per week | |
|  | Therapist's Name |  | Therapist's Phone # | |  | | |
|  | Therapist's E-Mail |  | # of Years Receiving | |  | | |

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| CURRENT SERVICES | Does the client currently receive any social skills or social group services? | | | | | | Yes | No |
|  | Receives |  | Sessions weekly for |  | | min. per session | |
|  | Contact’s Name |  | Contact's Phone # |  | | | |
|  | Contact's E-Mail |  | # of Years Receiving |  | | | |
|  | | | | | | | |
| Does the client currently receive employment services? | | | | | | Yes | No |
|  | Receives on |  | days each week for |  | | hrs. per week | |
|  | Contact’s Name |  | Contact's Phone # |  | | | |
|  | Contact's E-Mail |  | # of Years Receiving |  | | | |
|  | | | | | | | |
| Does the client currently receive any other service? | | | | | | Yes | No |
|  | Type of Service |  |  | |  |  | |
|  | Receives |  | sessions weekly for | |  | min. per session | |
|  | Contact’s Name |  | Contact's Phone # | |  | | |
|  | Contact's E-Mail |  | # of Years Receiving | |  | | |
|  | | | | | | | |
| Does the client currently receive any other service? | | | | | | Yes | No |
|  | Type of Service |  |  | |  |  | |
|  | Receives |  | sessions weekly for | |  | min. per session | |
|  | Contact’s Name |  | Contact's Phone # | |  | | |
|  | Contact's E-Mail |  | # of Years Receiving | |  | | |

Additional Services or Notes About Services:

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| BIRTH AND DEVELOPMENT | Please describe any pre-natal difficulties in the space below. | | | | | | | | |
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|  |  | | | | | | | | |
|  | Was the client carried full-term? | Yes | No |  | If no, for how many weeks? | | | |  |
|  | Was the delivery without complications? | Yes | No |  | If no, please describe below. | | | | |
|  |  | | | | | | | | |
|  |  | | | | | | | | |
|  | Did the infant suffer from serious illness? | Yes | No |  | If yes, please describe below. | | | | |
|  |  | | | | | | | | |
|  |  | | | | | | | | |
|  | Did the infant/toddler require surgery? | Yes | No |  | If yes, please describe below. | | | | |
|  |  |  |  |  |  | | | | |
|  |  |  |  |  |  | | | | |
|  | Did the infant/toddler engage in unusual or particularly difficult behavior? | Yes | No |  | If yes, please describe below. | | | | |
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|  |  | | | | | | | | |
|  | How old was the client when he/she first…  (please type the approximate age that the client was when he/she attained the milestone or check the box to indicate that he/she has not yet attained it) | ate finger foods | | | |  | yrs. | not yet | |
|  |  | drank from cups | | | |  | yrs. | not yet | |
|  |  | crawled | | | |  | yrs. | not yet | |
|  |  | walked | | | |  | yrs. | not yet | |
|  |  | used 1st word | | | |  | yrs. | not yet | |
|  |  | used at least 5 spoken words with meaning | | | |  | yrs. | not yet | |
|  |  | used a fork and spoon | | | |  | yrs. | not yet | |
|  |  | jumped | | | |  | yrs. | not yet | |
|  |  | spoke in sentences at least 2 words long | | | |  | yrs. | not yet | |

Additional Notes about Early Development:

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| CURRENT FUNCTIONING: SENSES | What do your observations as well as formal screenings suggest about the client’s ability to see? | | | | |
|  | Very Poor | Poor | Average or Above | Average w/ Glasses/Contacts |
|  | | | | |
| What do your observations as well as formal screenings suggest about the client’s ability to hear? | | | | |
|  | Very Poor | Poor | Average or Above | Average w/ Hearing Aids |
|  | | | | |
| What do your observations suggest about the client’s ability to process touch/temperature/pain? | | | | |
|  | Very Poor | Poor | Average or Above |  |
|  | | | | |
| What do your observations suggest about the client’s ability to move around his/her environment? | | | | |
|  | Very Poor | Poor | Average or Above | Uses Wheelchair or Walker |
|  | | | | |
| Please include any other notes/comments about the client’s sensory processing in the space below. | | | | |
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| CURRENT FUNCTIONING: LANGUAGE COMPREHENSION | How would you characterize the client’s ability to understand language? | | | | | | |
|  | Very Delayed | Delayed | Slightly Delayed | Average | Above Average | |
|  | | | | | | |
| Can the client… | | Point to a wide variety of body parts on request? | | | Yes | No |
|  | | Follow 20 different simple one-step instructions? | | | Yes | No |
| (these items refer to the ability to follow verbal directions without being shown what to do and without instructions being repeated) | | Walk to specific locations in the home/school on request? | | | Yes | No |
| Retrieve specific items from other parts of the room? | | | Yes | No |
| Follow lengthy or multi-step verbal instructions? | | | Yes | No |
| Read and follow written instructions? | | | Yes | No |
| Understand and follow “first…then…” instructions? | | | Yes | No |
| Follow group / classroom directions without being named? | | | Yes | No |
|  | | | | | | |
| Please include additional notes and comments about the client’s language comprehension in the space below. | | | | | | |
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| CURRENT FUNCTIONING: COMMUNICATION / LANGUAGE USE | What is the client’s most advanced form of communication? | | | | | | |
|  | Talking | Signing | Using Pictures, i-Pad, or Device | Pointing | None | |
|  | | | | | | |
| How would you rate the client’s ability to communicate with people? | | | | | | |
|  | Very Delayed | Delayed | Slightly Delayed | Average | Above Average | |
|  | | | | | | |
| Can the client… | | Name at least 5 familiar people? | | | Yes | No |
|  | | Name at least 5 body parts? | | | Yes | No |
| Does the client spontaneously…  (these items refer to things that the client does without being told or prompted) | | Name at least 20 common objects? | | | Yes | No |
| Name at least 5 shapes and/or colors? | | | Yes | No |
| Use sentences to describe pictures or events? | | | Yes | No |
| Respond to at least 10 questions about him/herself? | | | Yes | No |
|  | | |  |  |
| Greet familiar people at least once each day? | | | Yes | No |
| Request desired items and activities? | | | Yes | No |
| Make comments about things in the environment to draw your attention to them. | | | Yes | No |
| Take turns within conversations? | | | Yes | No |
| Encourage or try to comfort others? | | | Yes | No |
| Ask people questions about themselves? | | | Yes | No |
|  | |  | | |  |  |
| Please include any additional notes or comments about the client’s communication and/or language use in the space below. | | | | | | |
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| CURRENT FUNCTIONING: PLAY AND LEISURE SKILLS | How would you rate the client’s ability to appropriately occupy his/her free time? | | | | | | | |
|  |  | Dangerous | Very Poor | Poor | | Average | Above Average | |
|  |  | | | | | | | |
|  | In the space below, please list the 5-8 things that the client is most likely to do when left on his/her own for free time indoors. | | | | | | | |
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|  | In the space below, please list the 4-6 things that the client is most likely to do when left on his/her own for free time outdoors. | | | | | | | |
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|  |  |  | | | | | | |
|  | What are the client’s hobbies or favorite free-time activities? | | | | | | | |
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|  |  |  | | | | | | |
|  | Does the client… | | Use toys or objects in their intended manner? | | | | Yes | No |
|  |  | | Engage in imaginative play acting out scripts or scenes? | | | | Yes | No |
|  |  | | Engage in imaginative play with figures or stuffed animals? | | | | Yes | No |
|  |  | | Play cooperatively with peers? | | | | Yes | No |
|  |  | | | | | | | |
|  | Please include any additional notes or comments about the client’s leisure skills and interests in the space below. | | | | | | | |
|  |  | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| CURRENT FUNCTIONING: SOCIAL SKILLS | How would you rate the client’s social skills? | | | | | | |
|  | Very inappropriate | | Delayed | Average | Above Average | |
|  | | | | | | |
| Does the client… | | Tolerate being near other people? | | | Yes | No |
|  | | Acknowledge people who approach? | | | Yes | No |
|  | | Return greetings from others? | | | Yes | No |
|  | | Spontaneously greet others? | | | Yes | No |
|  | | Initiate interactions with familiar adults other than to request? | | | Yes | No |
| Initiate interactions with peers other than to request? | | | Yes | No |
|  | | Make comments about others’ actions other than to request? | | | Yes | No |
|  | | Ask questions toward others to find out about them? | | | Yes | No |
|  | | Produce inappropriate comments/questions that might offend people? | | | Yes | No |
|  | | Steer conversations toward areas of interest or fail to take turns or follow the other person’s lead in conversations? | | | Yes | No |
|  | | Use appropriate space and mannerisms during conversations and interactions? | | | Yes | No |
|  | | Show a desire to do things with and to spend time with peers? | | | Yes | No |
|  | | Have at least one true friend? | | | Yes | No |
|  | | Have two or more true friends? | | | Yes | No |
|  | | | | | | |
| Please include any additional notes or comments about the client’s social skills below. | | | | | | |
|  | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| CURRENT FUNCTIONING: ADAPTIVE SKILLS | How would you rate the client’s adaptive / self-care skills? | | | | | | |
|  | Very Delayed | | Delayed | Average | Above Average | |
|  | | | | | | |
| Does the client… | | Feed him/herself finger foods? | | | Yes | No |
|  | | Eat appropriate amounts and varieties of food? | | | Yes | No |
|  | | Use utensils while eating? | | | Yes | No |
|  | | Keep him/herself and eating area clean while eating? | | | Yes | No |
|  | | Prepare his/her own meals? | | | Yes | No |
|  | | Create appropriate menus, plan, and execute shopping? | | | Yes | No |
|  | |  | | |  |  |
| Remain dry when prompted to use the toilet? | | | Yes | No |
|  | | Complete entire toileting routine independently? | | | Yes | No |
|  | | Independently wipe self when necessary? | | | Yes | No |
|  | | Spontaneously initiate toileting and remain dry? | | | Yes | No |
|  | | Remain dry through the night? | | | Yes | No |
|  | | | | | | |
|  | | Undress independently? | | | Yes | No |
|  | | Dress independently? | | | Yes | No |
|  | | Tie shoes independently? | | | Yes | No |
|  | | Select appropriate clothing for weather and appearance? | | | Yes | No |
|  | | | | | | |
|  | | Wash his/her hands independently? | | | Yes | No |
|  | | Bathe/shower independently? | | | Yes | No |
|  | | Brush teeth independently? | | | Yes | No |
|  | | Maintain appropriate hygiene/appearance independently? | | | Yes | No |
|  | | Keep room/living area clean with prompts/reminders? | | | Yes | No |
|  | | Independently keep room/living area clean? | | | Yes | No |
|  | | | | | | |
|  | | Recognize health needs? | | | Yes | No |
|  | | Schedule and maintain appointments? | | | Yes | No |
|  | | Engage in appropriate phone conversations? | | | Yes | No |
|  | | Find community information? | | | Yes | No |
|  | | Plan and execute community outings? | | | Yes | No |
|  | | Have a driver’s license and drive him/herself places? | | | Yes | No |
|  | | Use public transport safely? | | | Yes | No |

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| --- | --- | --- | --- | --- |
| CURRENT FUNCTIONING: ADAPTIVE SKILLS (cont.) | Does the client… | Understand that money buys things? | Yes | No |
|  | Count money correctly? | Yes | No |
|  | Use money to make purchases independently? | Yes | No |
|  | Maintain finances, check account, bank account? | Yes | No |
|  | | | |
|  | Spontaneously transition from one step to the next within common or daily tasks/activities? | Yes | No |
|  | Learn schedules through repetition? | Yes | No |
|  | Manage time and tasks? | Yes | No |
|  | Monitor and evaluate own performance and skills? | Yes | No |
|  | Follow visual schedules? | Yes | No |
|  | Follow written schedules or task lists? | Yes | No |
|  | Tell time? | Yes | No |
|  | Use time to guide activities? | Yes | No |
|  | Complete written paper work and forms? | Yes | No |
|  | Navigate and use the internet? | Yes | No |
|  | Make notes and written lists to self? | Yes | No |
|  | | | |
|  | Recognize and verbalize his/her own emotional state? | Yes | No |
|  | Use appropriate strategies to calm him/herself? | Yes | No |
|  | | | |
| Please note any other aspects of the client’s adaptive or self-help skills below. | | | |
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| CURRENT FUNCTIONING: MOTIVATION | How would you rate the client’s motivation to learn and to gain new skills? | | | |
|  | Very difficult to motivate | | Motivation limited to a few specific areas |
|  | Responds well to reinforcement efforts | | Seems to have an internal drive to learn |
|  | | | |
| In the space below, please list the client’s 6-8 favorite toys/objects. | | | |
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|  |  |  | |
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|  | | | |
| In the space below, please list the client’s 6-8 favorite interactions/activities. | | | |
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|  | | | |
| In the space below, please list the client’s 6-8 favorite foods/beverages. | | | |
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|  | | | |
| In the space below, please list the client’s 6-8 favorite sensory experiences / activities / sights / sounds (if not already noted above) | | | |
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|  |  |  | |
|  | | | |
| Please describe the client’s optimum learning environment below. | | | |
|  | | | |
|  | | | |
| How does the client typically react to instances of structure or to purposeful instruction? | | | |
|  | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CURRENT FUNCTIONING: BEHAVIOR | How would you rate the client’s behavior? | | | | | | | | | | |
|  | Dangerous | | | | | Extremely difficult to handle | | | |
|  | Somewhat difficult to handle | | | | | Average for his/her age | | | |
| Please mark any of the following behaviors that occur by indicating that they occur at least “Daily” (D), at least “Weekly” (W), or at least “Monthly” (M). Use the last six spaces at the bottom of the list to type behaviors that are not listed. | | | | | | | | | | |
| Bites self | | D | W | M |  | Hits self | D | W | M | | |
| Bangs head | | D | W | M |  | Pinches/scratches self | D | W | M | | |
| Bites others | | D | W | M |  | Hits others | D | W | M | | |
| Kicks others | | D | W | M |  | Pinches/scratches others | D | W | M | | |
| Destroys things | | D | W | M |  | Rips things | D | W | M | | |
| Goes dangerous places | | D | W | M |  | Touches dangerous things | D | W | M | | |
| Runs away/flees | | D | W | M |  | Approaches strangers | D | W | M | | |
| Swallows air | | D | W | M |  | Gags or vomits | D | W | M | | |
| Frequently spits | | D | W | M |  | Makes odd noises | D | W | M | | |
| Makes loud noises | | D | W | M |  | Yells or screams | D | W | M | | |
| Interrupts people | | D | W | M |  | Repeats words/phrases | D | W | M | | |
| Makes rude comments or questions | | D | W | M |  | Makes inappropriate physical contact | D | W | M | | |
| Perseverates on topics during conversations | | D | W | M |  | Asks constant or repetitive questions | D | W | M | | |
| Is in frequent motion | | D | W | M |  | Jumps/runs at odd times | D | W | M | | |
| Climbs on furniture | | D | W | M |  | Rocks in place | D | W | M | | |
| Spins self | | D | W | M |  | Spins objects | D | W | M | | |
| Shakes hands/fingers | | D | W | M |  | Shakes objects | D | W | M | | |
| Avoids eye contact | | D | W | M |  | Stares at objects | D | W | M | | |
| Mouths fingers | | D | W | M |  | Mouth objects | D | W | M | | |
| Smells things | | D | W | M |  | Uses objects repetitively | D | W | M | | |
| Tantrums when taught | | D | W | M |  | Resists prompts/help | D | W | M | | |
|  | | D | W | M |  |  | D | W | M | | |
|  | | D | W | M |  |  | D | W | M | | |
|  | | D | W | M |  |  | D | W | M | | |

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| CURRENT FUNCTIONING: BEHAVIOR (cont.) | Please think about the four negative or odd behaviors that you view as most important or concerning. Describe each of these behaviors in the spaces below. | |
|  | |
| Describe Behavior #1: |  |
| How often does this behavior occur? |  |
| Where is this behavior most likely to occur? |  |
| With whom or to whom is this behavior most likely? |  |
| When is this behavior most likely to occur? |  |
| What could we do to avoid this behavior? |  |
|  |  |
| Describe Behavior #2: |  |
| How often does this behavior occur? |  |
| Where is this behavior most likely to occur? |  |
| With whom or to whom is this behavior most likely? |  |
| When is this behavior most likely to occur? |  |
| What could we do to avoid this behavior? |  |
|  |  |
| Describe Behavior #3: |  |
| How often does this behavior occur? |  |
| Where is this behavior most likely to occur? |  |
| With whom or to whom is this behavior most likely? |  |
| When is this behavior most likely to occur? |  |
| What could we do to avoid this behavior? |  |
|  |  |
| Describe Behavior #4: |  |
| How often does this behavior occur? |  |
| Where is this behavior most likely to occur? |  |
| With whom or to whom is this behavior most likely? |  |
| When is this behavior most likely to occur? |  |
| What could we do to avoid this behavior? |  |

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| --- | --- |
| HOPES, FEARS, GOALS | Please describe your hopes and dreams for the potential client in the space below. |
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| Please describe your fears for the potential client in the space below. |
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| It is very important that we understand the goals that you have for treatment efforts. Please list 10 year-long goals in the space below. One way to think about this is to ask yourself, “to be happy with intervention efforts, what would the client be able to do one year from now that he/she cannot do today?” |
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Thank you for taking the time to complete this intake packet. Your insight about the potential client is very important to us. Please call or e-mail us at (573) 605-1600 or at Trendlineadm1@gmail.com with any questions, comments, or concerns that you have about this questionnaire or about the intake process.