THE CENTER FOR AUTISM
a PHMC affiliate

4601 Market Street
Philadelphia, PA 19139

215.878.3400 PHONE
215.878.2082 FAX
THECENTERFORAUTISM.ORG

INTAKE FORM

FORM COMPLETED BY: _____ TODAYS DATE: ____/____/____

RELATIONSHIP TO CLIENT: _____

CLIENT INFORMATION

First Name: _____ Last Name: _____

Date of Birth: ____/____/____ Social Security #: _____

Preferred Language: _____ Gender: _____

Is an interpreter needed? [ ] Yes [ ] No Gender Identity: _____

Biological Parent(s) Name(s) _____ & _____
(*if client is under 18 years old)*

Address:

_____

City: _____
State: _____ Zip Code: _____
Primary Phone: _____
Secondary Phone: _____
Email Address: _____

2nd Address (*if applicable*):

_____

City: _____
State: _____ Zip Code: _____
Primary Phone: _____
Secondary Phone: _____
Email Address: _____

If biological parent is not legal guardian:
Name(s): _____

If applicable:
Are there legal custody documents? [ ] Yes [ ] No
Court Order? [ ] Yes [ ] No
Is custody shared with DHS [ ] Yes [ ] No
Are the biological parent(s) involved in the child's life? [ ] Yes [ ] No

Race/Ethnicity (check all that apply)

[ ] American Indian or Alaska Native [ ] Asian [ ] African American [ ] Hispanic/Latino [ ] Caucasian

[ ] Other: _____ [ ] Decline to provide

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INSURANCE INFORMATION

Insurance Company Name: _____

Member ID: _____

2nd Insurance Name (*if applicable):*

Member ID: _____

REASON FOR VISIT (Check all that apply)

[ ] First Autism Evaluation [ ] Autism Re-evaluation/Second Opinion [ ] CORE [ ] STEP

[ ] CAPS [ ] SOCIAL COMPETENCY [ ] Outpatient [ ] Psychiatry

Current Concerns/Reason for an Evaluation (in your own words):

_____

_____

_____

DEVELOPMENTAL HISTORY PAST/PRESENT:

Reviewing infant/toddler milestone books or past reports may be helpful when completing the following questions. If you are uncertain, estimate as best as you can. Leave blank if the skill is not yet developed. Please record the ages in months when you or your child first:

1. Smiled in response to others: _____ months [ ] Unknown
2. Sat without support: _____ months [ ] Unknown
3. Walked independently w/o support: _____ months [ ] Unknown
4. Bladder control (day): _____ months [ ] Unknown
5. Bladder control (night): _____ months [ ] Unknown
6. Bowel control: _____ months [ ] Unknown
7. First words (other than mama, dada): _____ months [ ] Unknown
8. Spoke in 3-word phrases: _____ months [ ] Unknown
9. Spoke in full sentences (at least 4 words): _____ months [ ] Unknown

At what age, if any, did you first notice developmental delays or differences? _____

Has there been any significant LOSS of a previously acquired skill or skills (not just a delay)? For example, the individual was speaking in full sentences for many months and then stopped speaking altogether or began using only single words occasionally (leave blank if not applicable):

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Age:_____

Describe loss of skill: _____

PAST/PRESENT TRAUMA

Has the client experienced anything traumatic or scary? [ ] Yes [ ] No
If yes, when?: _____
Brief description (if comfortable to share): _____

Client Preferences/Likes:

_____

_____

COMPREHENSIVE BEHAVIORAL AND COMMUNICATION PROFILE PAST/PRESENT

COMMUNICATION METHODS (Check all that apply):

[ ] Verbal [ ] Talks about a variety of topics [ ] Extremely limited speech [ ] Non-verbal [ ] Sign Language
[ ] PECS (Picture Exchange Communication System) [ ] Initiates a conversation [ ] Other: _____

SOCIAL SKILLS (Check all that apply):

[ ] Interest in peers their age [ ] Preference to interact with younger/older children or adults
[ ] Prefers to be alone rather than with others [ ] Other: _____

SENSORY SENSITIVITIES (Check all that apply):
[ ] Loud/certain sounds [ ] Lighting (too bright/dark) [ ] Water [ ] Temperature (too hot/cold) [ ] Tactile (clothing/materials on hands) [ ] Crowds [ ] Other:_____

BEHAVIORAL CONCERNS (Check all that apply):
[ ] Bangs head [ ] Bites self [ ] Pinches self [ ] Scratches self [ ] Hits others [ ] Elopes/Runs away
[ ] Bites others [ ] Scratches others [ ] Pinches others [ ] Tantrums longer than 5 minutes
[ ] Unable to self-regulate [ ] Depression [ ] History of self-harm [ ] Other: _____

MENTAL HEALTH SERVICES (PAST/PRESET)

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MENTAL HEALTH SERVICES RECEIVED: _____
DATE(S): _____
AGENCY NAME & NUMBER/EMAIL: _____
LEAD CLINICIAN NAME: _____
CASE MANAGER NAME (if applicable): _____
CASE MANAGER CONTACT INFO: Phone: _____ Email: _____

Any formal mental health diagnoses (such as Autism, ADHD, Anxiety, Depression, etc.)? [ ] Yes [ ] No
If yes, please see attached RTOI form to obtain copy of diagnosis/treatment history

If yes, please list diagnos(es): _____
by: Agency/Doctor: _____ Date of evaluation(s): _____
[ ] School/Educational Evaluation [ ] Self-diagnosed [ ] Other: _____

The parent/guardian/client reported the evaluation will be provided as follows:

[ ] Emailed or faxed prior to intake

[ ] Release of information needed at intake to request copy of evaluation from external provider

HOUSEHOLD INFORMATION

Name	Age	Relationship to Client

Do any family members of the client see those who do not live in the home?

Name	Relationship to Client

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CLIENT MEDICAL HISTORY

ALLERGIES?

[ ] Yes [ ] No If yes, list allergy and reaction: _____

Are Immunizations Up to Date:

[ ] Yes [ ] No [ ] Decline to answer

Any past hospitalizations? [ ] Yes [ ] No If yes, date: _____

Does the client take medication? [ ] Yes [ ] No

If yes, please list below:

Name of Medication	Dosage	Prescribing Doctor

**IF SOMEONE IN YOUR HOUSEHOLD HAS BEEN EXPOSED TO A COMMUNICABLE DISEASE 10 DAYS OR LESS PRIOR TO YOUR ONSITE APPOINTMENT, PLEASE CALL 215-878-3400 TO RESCHEDULE*

EARLY INTERVENTION (PAST/PRESENT)

Name of Agency: _____ Address & Phone Number _____

SCHOOL INFORMATION

School/College Name: _____ Address & Number: _____

Special Education [ ] Yes [ ] No Individualized Education Plan (IEP)/504 Plan [ ] Yes [ ] No

Appointment Preference: [ ] In-person [ ] Telehealth (Virtual)

"The Center for Autism solely completes a diagnostic/treatment evaluation to determine if individuals meet the criteria for Autism Spectrum Disorder. (ASD) If interested in confirming or denying additional diagnoses, clients must identify a different agency or be referred out by CFA".

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