



Children's Autism Treatment Specialists, LLC.

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18070 S. Tamiami Trail, Unit 16
Fort Myers, FL 33908

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INTAKE QUESTIONNAIRE

Thank you for answering this questionnaire. Respond to only those questions relevant to your child's treatment. This information will better help us determine your child's strengths and areas of concern prior to the evaluation. Call 239-985-2287 with questions.

Date _____

Name of Child _____
Last First M.I.

Nickname _____ D.O.B. _____

Child's Diagnosis _____

Name of person completing this form _____

Relationship to the child _____

Name and address of school or daycare _____

Is your child attending PT (physical therapy)/OT (occupational therapy)/ST (speech therapy)? (Yes/No) If yes, indicate which ones, number of hours per week, and name(s) and address(es) of the provider(s). _____

Any other special services received? _____

Does your child have an IEP? _____

Please list the names and ages of all siblings

What are your child's favorite toys? _____
games? _____
books? _____

Additional Interests _____

Do you own pets? _____ If so, number, names, and kinds of pets _____

Does your child have any particular fears (dogs, sirens, etc.)? _____

What are your child's strengths? _____

How does your child react to anxiety or stressful situations (cry, withdraw, tantrums)? _____

Does your child have any previous behavioral treatment experience? If so, please specify what type, where obtained, when obtained, and whether successful. _____

How does your child react to other people? _____

What is your usual mode of reassuring your child? _____

What is your usual mode of reinforcing your child? _____

What is your usual mode of punishing your child? _____

If there are any other circumstances regarding your child's emotional or physical health, please inform us of them. _____

Does your child enjoy eating? _____ Favorite Foods? _____

Food Aversions? _____

Does your child have any allergies (food or otherwise)? _____

Is your child on a special diet? (Yes/No) If yes, give details. _____

Is your child toilet trained? _____

Does your child sleep well at night? Typically, how long? _____

Does your child nap? _____ How long? _____ When? _____

Please indicate if your child has a history of any of the following?

Medical History	Yes	No	Please list current/regular Medications:		
Ear Infections					
Ear Tubes					
Needs hearing aids			Birth History	Yes	No
Hearing evaluation completed? When?			Was pregnancy full term?		
Serious illness or injury (If yes, give details in Comments section)			Any medications taken during pregnancy?		
Frequent colds or sinus problems			Any complications with delivery?		
Need for eye glasses			Any special care required at birth (i.e. oxygen, intubation)		
Allergies (If yes, specify types)			Comments:		
Upper respiratory infections					
History of car sickness					
Asthma					
Genetic disorder					

Please circle any concerns you have about your child’s development

- | | | |
|--------------------------|--|---------------------------------------|
| Understanding directions | Overall Coordination | Social Skills/Interaction with others |
| Understanding others | Attention | Play Skills |
| Ability to express self | Independence/Self-care | Fine motor skills |
| Stuttering | Feeding/Picky Eater | Oral Motor Skills |
| Not Talking | Sensory Issues | Behaviors |
| Understanding your child | Echolalia (repeating words without regard for meaning) | |

Please circle any behaviors that your child may exhibit

- | | | |
|-------------------------------|------------------------------------|--------------------|
| Refusal to do difficult tasks | Hitting or throwing items | Refusal to imitate |
| Tantrums | Difficulty separating from parents | |
| Short attention | Shutdowns | Others: _____ |

Ability Questions

Self Care skills:

1. Does your child need help with dressing? Yes/No
2. Can your child complete snaps, zippers, and buttons? Yes/No
3. Can your child pick out his/her own clothing? Yes/No
4. Does your child take showers or baths? Indicate which: _____
5. Does your child know and follow morning or evening routines with few reminders? Yes/No
6. Is your child rigid about his/her routine? Yes/No

Sensory:

1. How does your child respond to changes in environments such as going to school, or visiting friends or relatives? _____

2. Does your child respond negatively to busy environments such as the grocery store or mall? Yes/No
3. Does your child have trouble with transitions to new places or new activities? Yes/No
If yes, explain _____

4. Are there certain textures that bother your child (clothing, tags, toothpaste, foods, grass, sand)? Yes/No
5. Are there any other sensory issues that might affect your child's behavior and/or ability to learn?
(visual, auditory, smells, touch, taste)

Attention:

1. Does your child understand simple, routine directions (sit down, come here)? Yes/No
2. Can your child follow multiple-step directions (pick up your toys and put them away)? Yes/No
3. When looking at a book or pictures, does your child show interest or interaction with story characters in the book? Yes/No
4. How long will your child sit for a story? 5 min 10 min 15 min _____ min

Speech and Language Questions

Speech:

Does your child use words to communicate? If not, move on to Receptive Language.

How much of the time do you understand your child's speech?

0-25% 25-50% 50-75% 75-100%

Do you understand more or less as sentence length increases? _____

Receptive Language:

- Does your child look at the person who is talking to him or her? Yes/No
- Does your child understand simple routine directions (sit down, come here)? Yes/No
- Does your child respond to words like "stop" or "wait"? Yes/ No

Expressive Language:

Does your child try to gain your attention to show you things? Yes/ No
Does your child use more words or more gestures to let you know what he or she wants?
A. Words B. Gestures

Does your child use words to:
Ask for something he/ she wants to do or for a desired object? Yes/ No
Ask for help? Yes/ No

Social Skills:

Is your child able to easily:
a. Make friends? Yes/ No b. Keep friends? Yes/ No
Does your child participate in pretend play? Yes/ No
Does your child play with peers? Yes/ No
Does your child make eye contact? Yes/No

Feeding/Oral Motor:

- 1. Does your child cough when drinking or eating? Yes/No
- 2. Does your child put toys/objects in his or her mouth? Yes/No
- 3. Does your child drool? Yes/No
- 4. Is your child a picky eater? Yes/No
- 5. Does your child use a spoon or fork independently? Yes/No

List 3 meats that your child will eat: _____

List 3 breads/starches that your child will eat: _____

List 3 vegetables/ fruits that your child will eat: _____

Anything else about your child’s communication, skills or development? Please state in detail.

We thank you for the opportunity to work with your child and you at CATS, LLC.

****Please return these forms to:**

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