859.224.0834 Office
859.224.0882 Fax
2520 Regency Rd, Ste 150
Lexington, KY 40503
www.OnTheMovePeds.com

Behavior Intake Questionnaire

Child's Name: ______________________ **Date of Birth:** ______________ **Date of Questionnaire**: ______________
Name of Person Completing Questionnaire: ____________________**Relationship to the Child**: _______________

Child Diagnosis(es) when diagnosed (month/year) and doctor who gave diagnosis:

Diagnosis: ____ Date: ______________ Doctor: ___________________
Diagnosis: ____ Date: ______________ Doctor: ___________________
Diagnosis: ____ Date: ______________ Doctor: ___________________
Diagnosis: ____ Date: ______________ Doctor: ___________________
Diagnosis: ____ Date: ______________ Doctor: ___________________

Medications: *(Additional medications please list on back page under contact information)*

Medication:___________________ Dosage: _________ Purpose: _____________ Prescribed By: ________________
Medication:___________________ Dosage: _________ Purpose: _____________ Prescribed By: ________________
Medication:___________________ Dosage: _________ Purpose: _____________ Prescribed By: ________________
Medication:___________________ Dosage: _________ Purpose: _____________ Prescribed By: ________________
Medication:___________________ Dosage: _________ Purpose: _____________ Prescribed By: ________________
Medication:___________________ Dosage: _________ Purpose: _____________ Prescribed By: ________________
Medication:___________________ Dosage: _________ Purpose: _____________ Prescribed By: ________________

Other Therapies:
Does your child attend other therapies at this time? Y N
If Y, please list below: (if your child receives another therapy through OTM, please list therapist as well)
Therapy: ____________________________ Location: ____________________ Therapist: ________________________
Therapy: ____________________________ Location: ____________________ Therapist: ________________________
Therapy: ____________________________ Location: ____________________ Therapist: ________________________
Therapy: ____________________________ Location: ____________________ Therapist: ________________________

1) Does your child have any medical conditions (asthma, allergies, seizures, etc.)? If so, please describe:
____
____

2) Does your child have any medication allergies? ____

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3) What are your current concerns? (Check categories)

___ communication
___ dressing
___ feeding/eating
___toilet training
___ social skills
___ coping skills
___ safety skills
___ independence skills

___ self injurious behaviors
___ physical aggression
___ verbal aggression
___ non compliance
___ PICA
___ flopping/dropping
___ elopement
___ tantrum
___ other

4) Describe behaviors of concern below: *(behaviors you would like to decrease/eliminate)*

Behavior	What does it look like?	How often does it happen?	How long does it last?	Why do you think it happens?	What happens after?
Example: hitting	**Smacking on the arm with an open hand**	**Every night at homework time**	**About 2 minutes**	**Doesn't want to do the work**	**Didn't finish homework, went to watch tv**

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5) List your child's most preferred things (food, people, movies, shows, games, etc) that can/may be used **IN SESSIONS** as rewards/reinforcers

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

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6) How does your child communication?

VERBALLY PICTURES PULLING SIGN iPAD/DEVICE

7) Can they communicate wants and needs **without** behaviors? Y or N
8) Can they accept no/redirect without behaviors? Y or N
9) Can they follow directions with 2 or less verbal prompts? Y or N
10) Can they imitate physical models (ie. Do this… watch me….) Y or N
11) Can they complete age appropriate hygienic tasks independently? Y or N
12) Can they dress themselves independently? Y or N
13) Does your child have age appropriate chores/responsibilities at home? Y or N
14) Does your child understand and follow basic safety rules? Y or N
(ie. Look both ways, don't run in the parking lots, stay with mom/dad, etc.)
15) Does your child make eye contact? Y or N
16) Can your child share preferred items? Y or N

17) Is your child a picky eater? Y or N
(If NO then you can skip to number 25)

18) If so, name 3 foods your child **WILLINGLY** eats:

____
____
____

19) If so name 3 foods you **WANT** your child to eat:

____
____
____

20) Will your child eat: *(If YES please list 1 or 2 items)*

fruits:	Y	N	_______________
vegetables:	Y	N	_______________
meats:	Y	N	_______________
dairy:	Y	N	_______________
breads/pastas:	Y	N	_______________
sweets/candy:	Y	N	_______________

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21) Will your child drink: (*If YES please list the type)*

water:	Y	N	____
juice:	Y	N	____
milk:	Y	N	____
soda:	Y	N	____
other:	Y	N	____

22) Does your child have any food allergies? Y N ____

23) Does child sit and eat dinner? Y N

24) Does your child graze throughout the day? Y N

25) Does your child sleep through the night? Y N

If NO, please describe your child's sleep habits:

____

____

____

26) Is your child toilet trained? Y N

27) Is your child able to sit **WITHOUT** engaging in behaviors for:

a. eating

__ less than 2 min __ 2 min __ 5 min __ 10 min __ 15 min __ 20 min __ 20 min +

b. working/task activity (ie. Homework) (please give example: ________________________________)

__ less than 2 min __ 2 min __ 5 min __ 10 min __ 15 min __ 20 min __ 20 min +

c. preferred activity (ie, game, tablet) (please give example: _________________________________)

__ less than 2 min __ 2 min __ 5 min __ 10 min __ 15 min __ 20 min __ 20 min +

28) What things would you most like to see **increased or improved**? (ie. Sharing, requesting, toilet training, waiting, dressing self, etc.) Please list a few below:

1) ________________________________ 6) ______________________________

2) ________________________________ 7) ______________________________

3) ________________________________ 8) ______________________________

4) ________________________________ 9) ______________________________

5) ________________________________ 10) ______________________________

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29) Are there any other topics that you would like to discuss or address that was not on this form? If so, please describe below:

____

____

____

Thank you for taking the time to complete this questionnaire! This will be reviewed and further questions will be asked if necessary to determine the most appropriate service path for your child. Please leave contact information below :

Name: ____

Phone Number: ____

Email address: ____

Preferred form of contact: CALL TEXT EMAIL