



Behavior Intake Questionnaire (ABA program)

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? _____

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

- | | |
|--|---|
| <input type="checkbox"/> communication | <input type="checkbox"/> self injurious behaviors |
| <input type="checkbox"/> dressing | <input type="checkbox"/> physical aggression |
| <input type="checkbox"/> feeding/eating | <input type="checkbox"/> verbal aggression |
| <input type="checkbox"/> toilet training | <input type="checkbox"/> non compliance |
| <input type="checkbox"/> social skills | <input type="checkbox"/> PICA |
| <input type="checkbox"/> coping skills | <input type="checkbox"/> flopping/dropping |
| <input type="checkbox"/> safety skills | <input type="checkbox"/> elopement |
| <input type="checkbox"/> independence skills | <input type="checkbox"/> tantrum |
| | <input type="checkbox"/> 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

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?

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

6) How does your child communicate?

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? (ie. Look both ways, don't run in the parking lots, stay with mom/dad, etc.)	Y	or	N
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? (If NO then you can skip to number 25)	Y	or	N

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	_____
bread/pastas:	Y	N	_____
sweets/candy:	Y	N	_____

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) _____



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