Helping Hands
Behaviour Consulting

Client Intake Form

Please complete the information required in this form prior to first program meeting with Behaviour Consultant. If you have any questions or require further clarification during the completion of this form, please contact Lorraine De Souza at: 604-572-1126.

Intake Meeting Date: _____
Child's Birthdate: _____

Demographics:

Mother's Name: _____

Mother's Daytime Contact Number: _____ (home/work/cellular)

Mother's Evening Contact Number: ___ _____(home/work/cellular)

Mother's Email Address: _____

Father's Name: _____

Father's Daytime Contact Number: _____ (home/work/cellular)

Father's Evening Contact Number: _____ (home/work/cellular)

Father's Email Address: _____

Primary Address: _____
Apt. # Street Address

_____
City Province Postal Code

Siblings:

	Name	Age
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Services/Agencies Involved:

1. Name of School: _____

Address: _____
Street Name/Number City Postal Code

Phone Number: _____

Principal's Name: _____

Teacher's Name: _____

Assistant's Name: _____

Resource Teacher's Name: _____

2. Social Skills Group: _____

Name of Agency/Service Provider: _____

Address: _____
Street Name/Number City Postal Code

Phone Number: _____

Contact Person: _____

4. Respite Provider: _____

Address: _____
Street Name/Number City Postal Code

Caregiver's Name: _____

Respite Days/Hours: _____

5. Behavioural Interventionist Agency: _____

Address: _____
Street Name/Number City Postal Code

Phone Number: _____

Interventionist's Name: _____

Hours of Intervention per Day/Week: _____

Professional Team Members Involved:

Social Worker: _____

Address: _____
Street Name/Number City Postal Code

Phone Number: _____
Fax Number: _____

Occupational Therapist: _____

Address: _____
Street Name/Number City Postal Code

Phone Number: _____

Email Address: _____

Fax Number: _____

Speech Therapist: _____

Address: _____
Street Name/Number City Postal Code

Phone Number: _____

Email Address: _____

Fax Number: _____

Family Doctor:_____

Address: _____
Street Name/Number City Postal Code

Phone Number: _____

Other: _____

Address: _____
Street Name/Number City Postal Code

Phone Number: _____

Email Address: _____

Fax Number: _____

Medical History:

Diagnoses (i.e. Autism, ADHD, Anxiety Disorder, etc.)	**Source of Diagnosis (**i.e. Pediatrician; Family Doctor; Psychologist, etc.)	**Contact Number**

Current Medications:

Name	**Health Condition**	**Prescribing Physician**

Strengths/Skills in Child's Repertoire:
Below, please list what your child CAN DO in each of the sections listed. Please be as specific as possible.

Communication: (what are his strengths? i.e.: makes 2-way conversation, make eye contact, ends conversations, speaks in sentences, expresses anger in what way, expresses pleasure in what way…etc.)

1. _____

2. _____

3. _____

4. _____

Socialization: (what are his strengths? i.e. has friends, asks friends to join him/her in activity; attends social outings with friends, etc.)

1. _____

2. _____

3. _____

4. _____

Behaviour Management (i.e. performs relaxation exercises, follows instructions, how does he/she learner, compliance, accepts changes in routine, etc.):

1. _____

2. _____

3. _____

4. _____

Activities of Daily Living (i.e. how independent is he in the following: dressing, eating, toileting, bathing, teeth brushing):

1. _____

2. _____

3. _____

4. _____

Behavioural Priorities:

In the space below, please list the **three main concerns** you have regarding your child's behaviour, in order of priority. These priorities can reflect skills deficits such as "cannot initiate conversations" or problem/disruptive behaviour such as, aggression, or repetitive questioning. Prior to listing your priorities, you may wish to complete the attached standardized assessments. These assessments will help trigger ideas about other areas of concern that may also require intervention.

1. _____

_____

2. _____

_____

3. _____

Barriers Checklist:

As behavioural consultation is designed to help you bring about positive changes in your child's behaviour, we also recognize that there will be demands placed on you during this process. Please check any of the following barriers that **may prevent you from participating fully in the development and implementation of your child's program**. We will work together to try to overcome or minimize the effects of these barriers in order that your child's program is successful in bringing about a positive change in his/her behaviour.

- ❑ Limited financial resources
- ❑ Demanding work schedule
- ❑ Involvement in outside activities
- ❑ Health Issues
- ❑ Language Barrier
- ❑ Mental Health Issues
- ❑ Time constraints
- ❑ Limited social support network
- ❑ Single parent family
- ❑ Caring for extended family members
- ❑ Other children in family with special needs
- ❑ Limited child care support
- ❑ No respite care
- ❑ School/Training Program