

INTAKE APPLICATION FORM

IDENTIFYING INFORMATION

CHILD'S NAME:		
DATE OF BIRTH:	CURRENT AGE:	GENDER:
ADDRESS:		
PARENT/GUARDIAN'S NAME 1:		
ADDRESS (IF DIFFERENT FROM ABOVE)		
BEST CONTACT NUMBER:		E-MAIL:
PLACE OF EMPLOYMENT:		PHONE NUMBER:
PARENT/GUARDIAN'S NAME 2:		
ADDRESS (IF DIFFERENT FROM ABOVE)		
BEST CONTACT NUMBER:		E-MAIL:
PLACE OF EMPLOYMENT:		PHONE NUMBER:
EMERGENCY CONTACT NAME AND NUMBER (other than parent/guardian)		
SIBLINGS NAME(S)		

1.	AGE:
2.	AGE:
3.	AGE:
4.	AGE:
DO ANY SIBLINGS HAVE A DISABILITY?	___ YES ___ NO
IF SO, PLEASE EXPLAIN	

MEDICAL INFORMATION OF STUDENT

NAME OF PRIMARY INSURANCE CARRIER:		
NAME OF BENEFICIARY OR SPONSOR:		DATE OF BIRTH OF BENEFICIARY
NAME OF SECONDARY INSURANCE CARRIER:		
NAME OF BENEFICIARY OR SPONSOR		
CURRENT PRIMARY CARE PHYSICIAN (PCP):		
ADDRESS:		PHONE NUMBER:
OTHER HEALTH CARE PROVIDERS NAME	PHONE NUMBER	ADDRESS
CURRENT PRESCRIPTIONS:	DOSAGE	SYMPTOMS TREATING
OVER THE COUNTER MEDICATIONS:	DOSAGE	SYMPTOMS TREATING

PRIMARY DIAGNOSIS:	DIAGNOSED BY:	
OTHER DIAGNOSES:	DIAGNOSED BY:	
ALLERGIES	DESCRIBE TYPICAL REACTION	

HEALTH HISTORY

IS THERE ANY FAMILY HISTORY OF MEDICAL OR MENTAL HEALTH DIAGNOSES?		
MOTHER'S HEALTH DURING PREGNANCY:		LENGTH OF PREGNANCY
ILLNESSES/COMPLICATIONS DURING PREGNANCY:		
DELIVERY WAS:		
<input type="checkbox"/> FULL TERM	<input type="checkbox"/> PREMATURE	<input type="checkbox"/> INDUCED
<input type="checkbox"/> NATURAL	<input type="checkbox"/> CESAREAN	<input type="checkbox"/> OTHER _____
<input type="checkbox"/> FETAL DISTRESS	<input type="checkbox"/> BREECH	BIRTH WEIGHT ___ LBS ___ _ OZ
HEALTH OF BABY AT BIRTH:		
<input type="checkbox"/> JAUNDICED	<input type="checkbox"/> OXYGEN NEEDED HOW LONG: _____	<input type="checkbox"/> NICU HOW LONG: _____
LENGTH OF HOSPITAL STAY:		

	INFANT: _____	MOTHER: _____
--	---------------	---------------

PAST/CURRENT HISTORY AND/OR TREATMENT OF

__ PE (EAR) TUBES	__ HEAD INJURY	__ SURGERIES
__ HOSPITALIZATION	__ EAR, NOSE, THROAT PROBLEMS	__ DIGESTIVE DISORDER
__ HIGH FEVERS	__ SEIZURES	__ ASTHMA
__ STROKE	__ CANCER	__ MIGRAINES
__ UTI	__ ANEMIA	__ DIABETES
__ MENINGITIS	OTHER:	

DOES YOUR STUDENT COMPLAIN OF OR DISPLAY SIGNS OF

__ INDIGESTION	__ CONSTIPATION	__ DIFFICULTY SLEEPING
__ DIFFICULTY CHEWING	__ DIFFICULTY SWALLOWING	__ DIFFICULTY EATING
__ NERVOUS HABITS/TICS	__ NIGHTMARES	__ BED WETTING
__ SINUS TROUBLE	__ HEADACHES	__ DAYTIME INCONTINENCE

OTHER PHYSICAL FACTORS

DATE/RESULT OF LAST PHYSICAL EXAM	
DATE/ RESULT OF LAST DENTAL EXAM	
DATE/RESULT OF LAST HEARING EXAM	
DATE/RESULT OF LAST VISION EXAM	
ADDITIONAL SERVICES	
PSYCHIATRIST NAME/PHONE NUMBER/FAX/E-MAIL	
OCCUPATIONAL THERAPIST NAME/PHONE NUMBER/ FAX/E-MAIL	
SPEECH THERAPIST NAME/PHONE NUMBER/ FAX/E-MAIL	
ABA COMPANY/BCBA NAME/PHONE NUMBER/FAX	

DEVELOPMENTAL HISTORY

AT APPROXIMATELY WHAT AGE DID YOUR STUDENT BEGIN TO:	
SIT WITHOUT SUPPORT	CRAWL:

STAND WITHOUT SUPPORT:		WALK INDEPENDENTLY:	
SPEAK FIRST WORDS:		SPEAK USING 2 WORD PHRASES:	
SPEAK IN SENTENCES/PHRASES:		BEGIN TO TRY TO DRESS INDEPENDENTLY	
START TO TOILET TRAIN		COMPLETE TOILET TRAINING	
SLEEP ALONE			
DOES THE STUDENT HAVE ANY HISTORY OF THE FOLLOWING (CHECK ALL THAT APPLY)?			
<input type="checkbox"/>	CHILD ABUSE (PHYSICAL, SEXUAL, OR PSYCHOLOGICAL)	<input type="checkbox"/>	CHILD NEGLECT (PHYSICAL, PSYCHOLOGICAL, OR MEDICAL)
<input type="checkbox"/>	DOMESTIC VIOLENCE	<input type="checkbox"/>	SEXUAL ASSAULT
<input type="checkbox"/>	LOSS OF SIGNIFICANT RELATIONSHIP (IE: DEATH OR INCARCERATION)	<input type="checkbox"/>	VIOLENCE IN THE COMMUNITY
<input type="checkbox"/>	OTHER SOURCES OF VIOLENCE	<input type="checkbox"/>	OTHER

SOCIAL RELATIONS

DOES YOUR CHILD MAKE FRIENDS EASILY?		YES	NO
DOES YOUR STUDENT HAVE MANY FRIENDS IN			
<input type="checkbox"/> SCHOOL	<input type="checkbox"/> NEIGHBORHOOD	<input type="checkbox"/> ORGANIZED ACTIVITIES	
DOES YOUR STUDENT PREFER TO PLAY WITH OTHERS WHO ARE			
<input type="checkbox"/> SAME AGE	<input type="checkbox"/> YOUNGER	<input type="checkbox"/> OLDER	
DOES YOUR STUDENT TEND TO BE			
<input type="checkbox"/> DOMINANT	<input type="checkbox"/> EASILY LED	<input type="checkbox"/> WITHDRAWN	
<input type="checkbox"/> FIGHTS FREQUENTLY	OTHER:		
HOW DOES YOUR STUDENT GET ALONG WITH			
PARENTS:			
SIBLINGS			

TEACHERS:
OTHER ADULTS:
HOW DO YOU TYPICALLY RESPOND TO YOUR CHILD WHEN THEY ENGAGE IN INAPPROPRIATE BEHAVIOR?
HOW DO THEY REACT TO YOUR RESPONSE?
HOW DO YOU TYPICALLY RESPOND TO YOUR CHILD WHEN THEY DO SOMETHING WELL?

REFERRAL INFORMATION

HOW DID YOU HEAR ABOUT US?	HAS YOUR CHILD EVER RECEIVED ABA SERVICES BEFORE?
IF YES, PROVIDER AND DATES RECEIVED SERVICES?	
REASON FOR SEEKING SERVICES WITH MONARCH:	
TOP 3 LONG-TERM GOALS YOU WISH TO SEE YOUR CHILD ACHIEVE DURING THEIR TIME WITH MONARCH?	

ARE THERE ANY HOME, FAMILY, OR SOCIAL CONCERNS THAT WE SHOULD BE AWARE OF?

DOES YOUR FAMILY HAVE ANY CULTURAL OR RELIGIOUS PRACTICES THAT YOU WOULD LIKE FOR US TO KNOW?

WHAT DOES YOUR CHILD ENJOY DOING MOST IN THEIR LEISURE TIME?

WHAT DO YOU LIKE BEST ABOUT YOUR STUDENT?

WHAT ARE YOUR STUDENT'S STRENGTHS?

IS THERE ANYTHING MORE WE NEED TO KNOW TO BETTER UNDERSTAND YOUR STUDENT?

Thank you for taking the time to complete this form!

*****For this to be considered a complete application, at minimum, a copy of the diagnosis report and funding source MUST be submitted*****

For Office Use Only

Date of Receipt & Completion _____
(must include application, diagnosis, and funding source information)

Reviewed By: _____