UW AUTISM CENTER
UNIVERSITY of WASHINGTON
Center on Human Development & Disability

BEC Clinical Services Intervention Intake Form

Date Completed:
Site Requested: ☐ Seattle ☐ Tacoma

Person Completing this Form

Name: _____ Please indicate relationship to the client: ☐Parent ☐ Guardian ☐ Other:_____

Are you authorized to consent for this individual's healthcare? ☐ No ☐ Yes

Client Information

Client Name: _____, _____

Date of Birth:

Please answer the following questions about the child's living situation:

A. Are the child's parents Divorced/Separated? ☐ No ☐ Yes
   1) If Divorced/Separated:
      Who is responsible for making medical decisions for the child? ☐ Joint ☐ Sole
      If sole custody, please specify which parent: _____
      With whom does the child reside? _____

B. Household 1: _____% time
   Name of Parent or Guardian #1: _____
   Name of Parent or Guardian #2: _____
   Names, ages, and relation to child of all other individuals in the home:
   _____
   _____

C. Household 2**:** _____ % time
   Name of Parent or Guardian #1: _____
   Name of Parent or Guardian #2: _____
   Names, ages, and relation to child of all other individuals in the home:
   _____
   _____

D. Are both parents aware of services being sought at the Autism Center? ☐ No ☐ Yes
   Does your child have a Guardian Ad Litem? ☐ No ☐ Yes
   If Yes, please provide their name: _____

E. Names and ages of any other siblings:
   _____
   _____

F. Primary Language: ☐ English ☐ Other: specify _____
   Percent time child is exposed to non-English language(s): _____%

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Previous Evaluations/Assessments

Please list any school testing and/ or other evaluations of the client's skills.

1. Has the client ever been assessed/evaluated by an Occupational Therapist, Speech and Language Therapist, Psychiatrist, Psychologist, Special Educator, or other mental health counselor? ☐ No ☐ Yes ☐ Unknown

   If yes, please provide the following information:

   A. Name: _____ Type of Specialist_____ Date of evaluation: _____
   Purpose of Evaluation / Services: _____
   Results of Evaluation:
   _____
   _____

   B. Name: _____ Type of Specialist_____ Date of evaluation: _____
   Purpose of Evaluation / Services: _____
   Results of Evaluation:
   _____
   _____

   C. Name: _____ Type of Specialist_____ Date of evaluation: _____
   Purpose of Evaluation / Services: _____
   Results of Evaluation:
   _____
   _____

Educational History

Please list the schools attended from most recent.

1. Is the client currently enrolled in school or Birth-3 Services? ☐ No ☐ Yes ☐ N/A
   School Name: _____ School District: _____
   Program or Grade level: _____

2. Please list any other schools that the client has attended:
   A. School Name: _____ School District: _____
   Years of attendance: _____ Grade Levels: _____

   B. School Name: _____ School District: _____
   Years of attendance: _____ Grade Levels: _____

   C. School Name: _____ School District: _____
   Years of attendance: _____ Grade Levels: _____

3. Is the client receiving or has the client received special services or accommodations at school? ☐ No ☐ Yes

   If yes, please explain what type: (e.g. IEP, IFSP, 504 Plan) _____
   _____
   _____

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Client's Interests

Please indicate anything that the clinicians should know when working with him/her.

1. Preferences (favorite activities, food, interests/topics, sensory):

_____
_____
_____
_____
_____

2. Dislikes (aversions):

_____
_____
_____
_____
_____

3. Other:

_____
_____
_____
_____
_____

Concerns

1. Reason for seeking ABA Services [Please explain]:

_____
_____
_____
_____
_____
_____

2. Developmental Concerns [Please indicate by marking the box and explaining each domain]

☐Cognitive/Learning

☐Motor

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☐Behavior

☐Language

☐Social

☐Peer Interaction

☐Play/Leisure

☐Self-Help (Dressing/Toileting/Feeding/Etc.)

☐Dietary/ Allergies

☐Other

☐Academics (Reading/Writing/Math)

☐Executive Functioning (Organization/Flexibility/Attention)

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Description of Services

Applied Behavior Analysis (ABA) Intervention Services: Behavior and Education Consultants (BECs) provide evidence-based treatment using Applied Behavior Analysis (ABA) strategies to teach new skills, develop meaningful learning tasks, address challenging behavior, and support individuals with autism in a variety of settings.

1. Please mark the type of service you are interested in hearing more about. Please indicate the intensity/duration you are looking for each service of interest.
   - € Short Term Consultation: Can include parent or school consultations focused on a specific skill or behavior.
     Number of hours per week: _____ (please provide a range)
   - € Parent Coaching: Consultants coach parents who want to implement ABA-based techniques in the home.
     Long or Short Term (Please circle one)
   - € Client-Focused Skills Coaching: Consultants work directly with the client to build specific skills.
     Long or Short Term (Please circle one)
     Number of hours per week: _____ (please provide a range)
   - € Intensive In-Home ABA Program: The BEC team works with families to develop, implement, and refine an in-home, intensive, comprehensive ABA-based programs individualized for each child.
     Long or Short Term (Please circle one)
     Number of hours per week: _____ (please provide a range)

Hours of Availability

Please mark the times you and the client **ARE** available for services.

	Monday	Tuesday	Wednesday	Thursday	Friday
8:00 am					
9:00 am					
10:00 am					
11:00 am					
12:00 pm					
1:00 pm					
2:00 pm					
3:00 pm					
4:00 pm					
5:00 pm					
6:00 pm					

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Additional Comments

_____
_____
_____
_____
_____
_____
_____

Evaluations/Assessment Reports

Please attach a copy of your child's reports

- ☐ Diagnostic Evaluation Report
- ☐ IEP/IFSP/504 Plan
- ☐ Functional Behavior Assessment (FBA) /Behavior Intervention Plan (BIP)
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____