Behavior By Design, LLC

Intake Questionnaire

Date Completed: _____
Completed By: _____

Demographic Information

Client Name: _____ DOB: _____
Parent/Guardian Name(s): _____
Primary Address: _____ Phone: _____
_____

Does the client reside with both parents? □ Yes □ No
If no, please explain: _____
_____

Who else resides in your home?

Name	Age	Relationship to Client

Are there any current custody or legal issues of concern? □ Yes □ No
If yes, please explain: _____
_____

Are there any cultural or religious practices that may impact treatment? □ Yes □ No
If yes, please explain: _____
_____

Referral Source

Name of Referral Source: _____
Address of Referral Source: _____
_____

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Chief Complaint(s)

Please list the behavior(s) of concern for which you are seeking treatment: _____
_____
_____
_____
At what age did these behaviors first appear? _____
What would you hope to accomplish with these services? _____
_____
_____
_____
Risk of Danger to Others

Please check all that apply:

□ Does not appear dangerous to others □ Threatens others □ Assaultive to others
□ Homicidal Ideation □ Homicidal Threats □ Homicidal Attempts

Risk of Danger to Self

Please check all that apply:

□ Does not appear dangerous to self □ Self injurious [explain: _____]
□ Suicidal ideation [□ current □ recent □ past] □ Suicidal attempts [□ recent □ past]

Educational Placement

Home School District: _____ Current Grade: _____
School Currently Attending: _____
Type of Placement: □ Regular Ed □ Learning Support □ Autism Support □ Emotional Support
Is there a 504 or IEP in place? □ Yes □ No
Are there any current concerns regarding your educational placement? □ Yes □ No

If yes, please explain: _____
_____
_____

Are there any current concerns with communication: □ Yes □ No

If yes, please explain: _____
_____

Current means of communication: _____

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Treatment History

Current Diagnosis (Axis 1): _____
Diagnosed By: _____ Date Diagnosed: _____
What behavioral health services/interventions have you tried in the past?

Provider	Service Provided	Date Started	Date Ended

What behavioral health services/interventions are you currently involved in?

Provider	Name of Clinician	Service Provided	Date Started

Medical History

Primary Care Physician: _____
Address: _____ Phone: _____
_____
Do you have any food and/or drug allergies? □ Yes □ No
If yes, please list (including allergic reaction):_____
_____

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Are there any past or current medical conditions that may impact treatment? □ Yes □ No

If yes, please list: _____

_____

Have you ever had any major surgeries/procedures/testing completed? □ Yes □ No

If yes, please list (including results): _____

_____

Are you currently receiving any medical interventions? □ Yes □ No

Provider	Name of Clinician	Service Provided	Date Started

Are you currently taking any prescription medication? □ Yes □ No

Medication	Dosage	Date Started	Prescribed By

Have you ever been abused (physically, verbally, emotionally, or sexually)? □ Yes □ No

If yes, please explain: _____

_____

Has the abuse been reported? □ Yes □ No

If yes, please explain who the report was made to: _____

_____

Do you currently use or abuse any substances (drugs, alcohol, and/or nicotine)? □ Yes □ No

If yes, please explain: _____

_____

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Family History

Please provide the following information regarding immediate and extended family members:

Concern	Affected Family Member(s)
Autism/Pervasive Developmental Disorder	
Intellectual Disability	
Learning Disability	
Attention/Hyperactivity	
Depression	
Anxiety	
Other Mental Illness	
Language/Communication Delays	
Trauma/Abuse	

Please list any relevant family medical history (including affected family members): _____

_____

_____

_____

Is there any other information you wish to share with us? _____

_____

_____

_____

_____

_____

_____

Thank you for taking the time to complete this form in its entirety. If you have questions regarding the information included in this form, please call the Behavior By Design office at (717) 885-5906.

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