WHEELS OF WELLNESS INTAKE FORM
PLEASE COMPLETE EACH CELL WITH AS MUCH INFORMATION AS POSSIBLE

Child Information	**Today's Date:**
Last Name:	**Age: yrs months**
First Name:	**Date of Birth:**
Home phone:	
Address:	
City:	
State: Zip code: County: Country:	
How were you referred to WHEELS OF WELLNESS	

Primary Diagnosis:	**Date of Diagnosis:**
Secondary Diagnosis:	**Date of Diagnosis:**
Other condition:	**Date of Diagnosis:**

Legal Guardian Information	
Full Name:	**Relationship to Child:**
Address: (if different from applicant)	
City:	
State:	
Home Phone: (if different from applicant)	
Cell Phone:	**E-mail:**

Legal Guardian Information	
Full Name:	**Relationship to Child:**
Address: (if different from applicant)	
City:	

State:	
Home Phone: (if different from applicant)	
Cell Phone:	**E-mail:**

Applicant's Siblings:		
Name:	**Age:**	**Gender:**
Name:	**Age:**	**Gender:**
Name:	**Age:**	**Gender:**
Name:	**Age:**	**Gender:**

Present School/Placement:	**Teacher's Name:**
Name of School:	**Years attended:**
Address:	**Placement:**
Phone:	**IEP/504 Plan**

Medical Information	
Is your child on medication to treat behavioral issue(s)? Yes No	
Primary Physician:	**Phone Number**
Please list Specialists or other Physicians treating child:	
Special Diets:	

Are there any medical conditions that need to be considered when delivering treatment?	Yes No If yes, please explain.

History of Treatment	
❒ **Behavior Provider (Most Recent)**	Dates of service: to
Provider/Name Agency:	
Frequency of provider/agency consultation:	

Methods of treatment by the provider. ABA Lovaas-based ABA Verbal Behavior-based TEACCH RDI	Greenspan/Floortime Other Other

Please describe services by the provider as well as results of these therapies in regard to success in achieving goals.

History of Treatment	
❒ **Other Provider(s) utilized to address problem**	Dates of service: to
Provider Name/Agency:	
Frequency of Therapy:	

Please describe services by the provider as well as results in regard to success in achieving goals.

Supportive Services

What other services is your child <u>currently</u> receiving both in-school and out of school? Please enclose a copy of any document that can assist Wheels of Wellness with better understanding your child. (IEP, IFSP, Behavior Support Plan, Psychological Assessment, evaluation, etc.)

Service/Therapy	Location	Minutes/Week
Early Intervention Services	School Home	
Speech and/or language therapy	School Home	
Occupational Therapy	School Home	
Physical Therapy	School Home	
Other	School Home	
Other	School Home	
Other	School Home	

Please describe any techniques, strategies or interventions you have tried to stop problematic behaviors or increase appropriate behavior.

PLEASE LIST THE TOP THREE BEHAVIOR OF CONCERN
(START WITH THE MOST CONCERNING)

Behavior (Describe what behavior looks like)	**Frequency** (Approximate number of times the behavior occurs daily)	**Duration** (How long does each episode of the behavior last from start to finish)	**How long has this behavior been happening?** Days, weeks, months, year	**Location Where does this behavior occur?** (Home, school, etc.)
1.				
2.				
3.				

What is your main goal for Services?

What current communication skills does your child have? Ex., sign language, PECS, verbal, please explain:

If you are seeking consultation for social/play support please describe your child's current social skill level and environments where a clinician could have access to your child's peers. Please include a history of any social skill groups and/or curriculums that your child has participated in.

What are your child's strengths, interests or quirks that make him/her special?

Please share any additional information that may be important or considered when working in your home with your family including cultural or religious considerations, other persons living or working in your home, pets, etc.