HEATHER BATALDEN, MA

NEW CLIENT 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 Heather?			
Insurance company:			

Primary Diagnosis:	**Date of Diagnosis:**
Secondary Diagnosis:	**Date of Diagnosis:**
Secondary Diagnosis:	**Date of Diagnosis:**
Other condition:	**Date of Diagnosis:**
Date of last assessment?	**Who evaluated your child?**

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:**

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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 or medical issue(s)? Yes No	
Primary Physician:	**Phone Number**
Please list Specialists or other Physicians treating your child:	
Special diets/supplements/naturalistic treatments:	

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

History of Treatment	
Provider/Name Agency:	
Frequency of provider/agency consultation:	
Methods of treatment by the provider. ABA Lovaas-based ABA Verbal Behavior-based TEACCH RDI SLP OT	Greenspan/Floortime Other Other
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Methods of treatment by the provider. ABA Lovaas-based ABA Verbal Behavior-based TEACCH RDI SLP OT	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 feel free to attach additional pages as needed:

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 currently 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 utilized to address presenting behaviors or concerns:

PLEASE LIST THE TOP THREE BEHAVIORS OR CONCERNS YOU WOULD LIKE TO ADDRESS: (START WITH THE MOST CONCERNING)

Behavior/Issue (Describe what the behavior/issue looks like)	**Frequency** (Approx-imate 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 oc-cur?** (Home, school, etc.)
1.				
2.				
3.				

Once treatment is complete what would life look like to you?

What current communication and computer skills does your child have? Ex., sign language, PECS, verbal, is your child familiar with Zoom? Can your child engage in Telehelath sessions or online learning without ongoing support? Please explain:

If you are seeking school readiness skills or social and emotional learning skills and/or play support, please describe your child's current social skill level and environments where a clinician could "push in" to support if in-person services are warranted.

Please include a history of any social skills groups and/or curriculums that your child has participated in, as well as your opinion on effectiveness of said program.

What are your child's strengths, interests or quirks that make him/her special? What motivates your child? Are there things that your child strongly dislikes, perseverates on?

Additional notes: