General Intake Form

Please include the following applicable documents

	Intake form
	Copy of most recent IEP/IFSP
	Most recent comprehensive evaluation
	Educational evaluation report
	Medical diagnostic report
	Copy of most recent speech/occupational therapy evaluations and goals
	Copy of medical insurance card (front and back)

***The undersigned hereby acknowledges that the information contained in this application is accurate, to the best of his/her knowledge.**

Parent/Guardian (Print name) _____

Parent/Guardian (Signature) _____

Date of completion _____

210 Bellefonte Ave
Wilmington, DE 19809
Phone: (302) 762-2636
Fax: (302) 762-2608
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www.brandwyinecenterforautism.com

Child's name	
Child's date of birth	
Child's diagnosis	

Medical information

Date of diagnosis	
Diagnosing doctor	Name: Practice: NPI #:
Allergies	
Dietary restrictions	

Is your child currently taking any medications? Yes No
If you answered "yes", please list medication(s), dosage, administration times, and purpose below.

Name of medication	Dosage	Administration times	Purpose

Supportive services: What other service(s) is your child currently receiving, both in school and out of school? Please enclose a copy of the child's most recent IFSP or IEP and therapy goals from each area that is checked.

Service/Therapy	Location	Minutes per week
Early intervention services		
Speech and/or language services		
Occupational therapy		
Physical therapy		

Vision services		
Hearing services		
Counseling		
Academic tutoring		

What are your immediate goals for your child?

What would you like us to know about your child?

What current communication skills does your child have (e.g. sign language, PECS, vocal)? Please be specific.

What, if any, behavior issues does your child have (e.g. self-injurious, aggression, etc.) Please be specific.

Are you willing to implement programs at home?

History of treatment

Behavior consultations	Start date: End date:
Provider agency	
Provider phone	
Frequency of treatment by provider	

Please describe the services of the provider. Include program information.

Present school/placement

Name of school	
Street address	
City	
State	
Zip code	
Phone	
Years attend	
Placement	

Has your child ever been admitted into a hospital/treatment center for psychiatric, behavior, or crisis situations? If yes, please explain.

Parent information

Mother's name	
Address	
Name of employer	
Occupation	
Home phone	
Cell phone	
Email address	

Father's name	
Address	
Name of employer	
Occupation	
Home phone	
Cell phone	
Email address	

Emergency contact information

Full name	
Relationship to child	
Address	
Name of employer	
Occupation	
Home phone	
Cell phone	
Email address	

Scheduling information
Current school schedule:

Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

Desired BCA therapy schedule

Monday	
Tuesday	

Wednesday	
Thursday	
Friday	
Saturday	
Sunday	