Integrated Autism Consulting Intake Form

LAST NAME:	FIRST NAME:
DATE OF BIRTH: ______/_______/______ (dd/mm/yyyy)	AGE:
ADDRESS: CITY:	PROVINCE: POSTAL CODE:
PHONE #:	CELL/OTHER #:
E-MAIL:	
GENDER: ☐ MALE ☐ FEMALE ☐ NON-BINARY	FIRST LANGUAGE: OTHER:
EMERGENCY CONTACT(S): NAME: ______________________________________ NAME: ______________________________________	EMERGENCY PHONE(S): ( ) ____ - _____________ ( ) ____ - ______________
CURRENT RESIDENDENTIAL SITUATION: ☐ Family Home ☐ Own Residence ☐ Group Home ☐ Other – specify:	

1. PRIMARY DIAGNOSIS AND OTHER AREAS OF NEED:

____
____
____

2. MEDICATION (Please circle one) **YES/NO** STABILIZED? (Please circle one) **YES/NO**

Please Specify:

____

____

____

3. OTHER SIGNIFICANT MEDICAL CONCERNS (i.e. Diabetes, Blood pressure, Allergies, etc.)

Please circle one: **YES / NO / UNKNOWN** If you circled YES, describe:

____

____

____

4. HISTORY OF BEHAVIOURAL ISSUES [verbal/physical aggression, threats/bullying, inappropriate sexualized behaviour, violence towards self or others?]

(Please circle one): **YES / NO** If you circled YES, describe:

____

____

____

5. LEVEL OF COGNITIVE FUNCTIONING? **Average / High**

____

____

____

6. INVOLVEMENT IN CONFLICT WITH THE LAW/CRIMINAL JUSTICE SYSTEM?

(Please circle one): **YES / NO** If you circled YES, indicate involvement and date(s):

____

____

____

7. OTHER INFORMATION WE SHOULD KNOW

____

____

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All information on this form is confidential.

Contact:
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