

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 [] TRANSGENDERED	FIRST LANGUAGE: _____ OTHER: _____
EMERGENCY CONTACT(S): NAME: _____ NAME: _____	EMERGENCY PHONE(S): () ____ - _____ () ____ - _____
CURRENT RESIDENTENTIAL SITUATION: [] Family Home [] Own Residence [] Group Home [] Other - specify: _____	

1. PRIMARY DIAGNOSIS AND OTHER AREAS OF NEED:

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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**
date(s):

If you circled YES, indicate involvement and

All information on this form is confidential.

Contact:

Patricia O'Connor

Director, Integrated Autism Consulting

www.integratedautismconsulting.com

Email: patricia@integratedautismconsulting.com

