SUMMIT AGENCY
Your Journey to Independence

Family Information:

Client's Name: _____ Client's Nickname: _____

Today's Date: _____ Date of Birth: _____

Current Age: _____ Client's Gender: _____

Address:

_____

_____

Primary Parent/ Guardian's Full Name: _____

Home Telephone #: _____ Cell Phone #: _____

Work Phone #: _____ e-mail Address: _____

Second Parent/ Guardian's Full Name: _____

Home Telephone #: _____ Cell Phone #: _____

Work Phone #: _____ e-mail Address: _____

Please List all Siblings:

1. Name: Age: Gender:
2. Name: Age: Gender:
3. Name: Age: Gender:
4. Name: Age: Gender:

Family Religious Preference: _____

Primary Language: _____

Secondary Language(s): _____

Emergency Contact:

1. Name: Telephone: Relationship to Family:

2. Name: Telephone: Relationship to Family:

Referral Information:

Referral Source Name: _____

Referral Source Phone Number: _____

Insurance Information:

If applicable, please include the following information regarding your insurance:

Name of Insurance Company: _____
Insurance Card Number: _____

Developmental History:

List any childhood illnesses of the client (Please include the age of illness' onset, the illness & the treatment prescribed):

_____
_____
_____
_____
_____
_____

Describe the client's sleep habits:

_____
_____
_____
_____
_____
_____

Describe the client's eating habits:

_____
_____
_____
_____
_____
_____

Is the client on any dietary restrictions? If so, please explain:

_____
_____
_____
_____
_____
_____

Medical History:

Diagnoses (including dates of diagnosis and diagnosing physician):

_____
_____
_____
_____

Hospitalizations/ Operations/ Other Medical Conditions:

_____
_____
_____
_____

Please inform us of any complications during pregnancy or birth:

_____
_____
_____
_____

Does the client, or has the client ever had an infectious disease? If so, please list/ explain

_____
_____
_____
_____

Medication (List all medicine including dosage, time, etc.):

_____
_____
_____
_____
_____
_____

What allergies does the client have (if any):

_____
_____
_____
_____

Does the client require an epi-pen? Please circle: **YES** **NO**
If yes, can they implement it themselves or need assistance? _____

Does the client have seizures? Please circle: **YES** **NO**
If yes, please indicate the type, frequency & average duration:

_____

_____

Does the client have Diastat? Please circle**:** **YES** **NO**
Any other Seizure Medication? _____
If no, have they had seizures in the past? _____

Please list all medical/developmental disorders or conditions that run in your family:

_____

_____

_____

_____

Does the client currently have a Primary Care Physician (PCP)? Please circle: **YES** **NO**
If yes, please list their information below:
Name: _____ Title: _____
Telephone #:_____ Address:_____

Please list the names & addresses of medical professionals and/or service providers involved with your child:

Name: _____ Title/Type of Service: _____
Telephone #:_____ Address: _____

Dates of Treatment: _____ Client response to treatment:

_____

_____

Name: _____ Title/Type of Service: _____
Telephone #:_____ Address: _____

Dates of Treatment: _____ Client response to treatment:

_____

_____

Name: _____ Title/Type of Service: _____
Telephone #:_____ Address: _____

Dates of Treatment: _____ Client response to treatment:

_____

Name: _____ Title/Type of Service: _____
Telephone #:_____ Address: _____

Dates of Treatment: _____ Client response to treatment:

Name: _____ Title/Type of Service: _____
Telephone #:_____ Address: _____

Dates of Treatment: _____ Client response to treatment:

General Behavior:

How would you briefly describe the behaviors of the client?

What are your major concerns with the client?

Social Behavior:

Please briefly describe the client's social engagement with:

Peers:_____

Family:_____

Adults:_____

General Language:

What is the client's primary mode of communication (Gestural, verbal, augmentative)?

Do you have any concerns with the client's mode of communication? If so, please explain:

Educational Background:

Does the client attend school? Please circle: **YES** **NO**

What is the name of the school?

_____

_____

_____

What type of program(s) does the client attend (If any)?

_____

_____

How long has the client been attending school? _____

Does the client have an aide/ shadow while attending school? Please circle **YES** **NO**

If yes, is the aide/ shadow with the client full or part time? _____

Is there a current IEP? Please circle: **YES*** **NO**

**If yes, please provide a recent copy*

Which areas are you satisfied with the school program?:_____

_____

_____

_____

_____

_____

_____

_____

_____

Overview/ Other Information

What is the reason you are seeking services? _____

_____

_____

_____

_____

_____

_____

Is there any other additional information you would like us to know about the client or family involved?

_____

_____

_____

_____

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Your Journey to Independence

Please indicate time blocks when your child is available for services

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
6:00 am - 8:00 am							
9:00 am – 12:00 pm							
12:00 pm – 3:00 pm							
3:00 pm – 6:00 pm							
6:00 pm – 8:00 pm							

Intake completed by: _____

Date of Intake completion: _____

Date intake was received (Staff Only): _____

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