EAT SLEEP AND GROW INC.
occupational therapy services

SABRINA TANGUAY
SPEECH-LANGUAGE PATHOLOGY

Ideal Insight
psychological services

9901 – 97 Ave, Unit 203
Grande Prairie, AB, T8V 0N2
Tel : 780.402.1394
Fax : 587.316.5161
E : office@eatsleepandgrow.org

AUTISM ASSESSMENT INTAKE FORM

We ask that you complete this form and return it to our main office via email: office@eatsleepandgrow.org or by fax at 587.316.5161.

Today's Date:_____

Child Information			
Name *(First & Last)*		DOB	
Address		Age	
		Gender	
School Name		Grade	
Resides with		AB Health Care #	
Main language spoken in the home			
Diagnosis *(please list)*			
Medication *(please list)*			

Parent/Guardian Information					
Guardian 1			Relationship		
Email			Custody	Yes	No
Address if not residing with Child					
Please check if it's ok to leave a message			Yes	No	
Home Phone					
Cell Phone					
Work Phone					
Preferred method of communication	Home ph.	Cell ph.	Work ph.	Email	
Guardian 2			Relationship		
Email			Custody	Yes	No
Address if not residing with Child					
Please check if it's ok to leave a message			Yes	No	
Home Phone					
Cell Phone					
Work Phone					
Preferred method of communication	Home ph.	Cell ph.	Work ph.	Email	

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Please attach a copy of court order re: custody arrangement, if applicable.

Referred by:		
	Google	
	Media	
	Family Member *(please list)*	
	Friend *(please list)*	
	Other *(please explain)*	

Emergency Contact Information			
Name		Relationship	
Address			
Home Phone			
Cell Phone			
Work Phone			
Physician Contact Information			
Name			
Address			
Work Phone			

Roles/Relationship				
Family Member	Relationship	Age	Gender	Lives in Home

Medical History							
Please place a check mark by any current or past challenges							
Chicken Pox		Mumps		Pneumonia		Tonsillitis	
Bronchitis		Reflux		Allergies		Head Injury	
Ear Infections		Seizures		Measles		Asthma	
Cardiac Issues		Poor Sleep		Torticollis		Colic	

Trauma History		
Has your child ever been abused, a victim of a crime, or experienced a significant trauma?	Yes	No

Immunization/Illness		
Is your Child up to date with immunizations?	Yes	No

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Please place a check mark by any services your child has accessed						
Psychologist		SLP		PT		Dietician
Psychiatrist						
Surgeries		Age		Type		
Evaluation or Testing		Age		Type *(attach documents if possible)*		

In the First two Years	
Number of earaches in the first two years	
Number of other infections in the first two years	
Number of times you had antibiotics in the first two years	

Sleep / Rest				
Average Number of hours your child sleeps at night	>12	10-12	8-10	<8
What time does your child go to bed?	Week:		Weekend:	
Does your child have difficulty falling asleep?			Yes	No
Does the child tend to wake refreshed?			Yes	No
Does your child snore?			Yes	No
Does the child wake during the night?			Yes	No

Prenatal/Birth History							
Please place a check mark beside any complications experienced during pregnancy							
Diabetes		Measles		Toxemia		Strep	
Drug Use		Alcohol Use		Preeclampsia			
Please place a check mark beside any labour and delivery complications experienced							
C-Section		Vacuum		Forceps		Other	
Premature		Low Weight		IUGR		NICU Stay	

Pregnancy Duration: Please place a check mark following the week of gestation											
24	25	26	27	28	29	30	31	32	33	34	35
36	37	38	39	40 (full term)			41	42	43	44	

Easily Consoled during the first month	Yes	No
Antibiotics first month	Yes	No
Experienced no complications first month of life	Yes	No

Weight at Birth	lbs	oz	
Please describe labour			

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Developmental History							
Please note when each of the following occurred (months/years)							
Sat (no support)		Rolled Over		Crawled		Stood	
Walked		First Word		Spoke Clearly		Dressed Self	
Lost Eye Contact		Lost Language		Toilet Trained		Fed Self	

Hearing and Vision				
	Yes	No		
Has your child ever had a vision test			Results	
Does your child wear glasses			Near or Far	
Has your child ever had a hearing test			Results	
Does your child where a hearing aid			Left/Right/Both	

Behaviour and Social Skills					
Please indicate if any statements describe your child					
	Yes	No		Yes	No
Follow verbal directions			Takes turn with peers		
Initiates conversation			Displays aggression		
Makes eye contact			Prefers to play alone		
Has safety awareness			Has tantrums		
Impulsive/takes risks			Extremely sensitive		
Pays attention			Unable to self-calm		
Listens well			Does not like crowds		
Plays well with others			Does well with change		

Sensory Status		
Please indicate if any statements describe your child	Yes	No
Tolerates self-care activities (bathing, tooth brushing, hair brushing)		
Appears clumsy/awkward (trips, bumps into other people or objects, trouble coordinating body)		
Has fear of using playground equipment (swinging, feet leaving ground, heights or head being upside down)		
Is constantly moving/seeks certain types of movement		
Has difficulty keeping hands to themselves (touching others or touching material objects)		
Avoids messy play/doesn't like when hands get dirty		
Appears overly sensitive to certain textures, smells, noises		
Chews on non-edible objects/puts them in mouth		
Often invades others personal space		
Is unaware of being touched or bumped unless with extreme force and does not notice when face or hands are dirty		

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Immediate or Extended Family History					
Is there any known history in the immediate or extended family?					
	Yes	No		Yes	No
Autism/ PDD			ADHD		
Learning disabilities			Speech and Language Delays		
Hearing Loss			Stuttering		
Depression			Anxiety		
Other mood disorder/mental illness			Addiction		

Nutrition History									
Type of Formula				Soy		Cow's Milk		Low Allergy	
Has your child ever had a nutrition consultation							Yes	No	
Have you made any changes in your child's diet because of health problems							Yes	No	
Height	ft	in	Current weight						
Does your child follow a special diet or nutrition program							Yes	No	
Check all that apply									
	Dairy Free		Diabetic		Feingold			Gluten Restricted	
	Gluten/Casein Free		Ketogenic		Low Oxalate			Specific Carbohydrate	
	Vegan		Vegetarian		Weight Management			Wheat Free	
	Yeast Free		Food Allergy (list)						
How many meals does your child eat out per week				0-1		1-3		3-5	>5
Check all the factors that apply to your child's current lifestyle and eating habits									
	Fast Eater				Most family meals together				
	Erratic Eating Pattern				Use food as a bribe or reward				
	Eat too much				Erratic meal times				
	Dislike healthy food				Most meals eaten at table				
	Time constraints				High juice intake				
	Eat more than 50% of meals away from home				Low fruit/vegetable intake				
	Poor snack choices				High sugar/sweet intake				
	Sensory issues with food				Gestational				
	Picky Eater				High blood pressure				
	Limited variety of foods (>5 per day)				High Blood				
	Prefers cold food				Have chemical exposure				
	Every meal is a struggle								
Does your child avoid any particular foods							Yes	No	
If yes, types and reason									

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If your child could only eat a few foods daily, what would they be?

Are there any strategies currently in place at school to assist your child? (e.g., computer use, sitting at the front of the class, additional time to complete work, educational assistant, ect.)
Please list any additional concerns:

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Billing and Consent

	AGREE
Cancellation Fees – It is the client's responsibility to ensure services are covered by their benefit plan. Cancellation or rescheduling of appointments must be done at least 48 hours prior to your appointment time. Should you fail to show up for your scheduled appointment there will be a $100.00 no show charge applied to your credit card. A $50 booking fee is required to secure your assessment appointment. This fee will be credited towards your final invoice.	
Credit Card Information will be obtained at the time of the booking. Final payment can be made with Cash, Certified Cheque, E-transfer or Visa (please note all Visa payments will include a convenience fee to offset charges of 3%)	

Consent for Photos/Videos

As therapy professionals, we find videos are very helpful in documenting a child's progress and to use for teaching purposes. I may share a photo or video with other families, or on social media to demonstrate a therapeutic strategy. As the guardian of the child, you have full right to consent or not consent to the use of this information. Please check off the applicable 'Agree' boxes below to indicate your preference for use of this information. (a check mark in an area will equal your initialed agreement that you are giving permission).	AGREE
I consent _ to my child being photographed or videographed for internal clinic use only. A copy will be kept on my child's file and will not be shared with anyone other than his/her therapy team	
I consent _ to my child's photo or video being used on social media to demonstrate a therapeutic strategy. I understand the photo/video will be approved by me prior to posting. My child's name will not be published	
I consent _ to my child's photo or video being used to teach other families in private sessions (i.e. no publication) My child's name will not be used	
I consent _ to my child's photo or video being used in educational presentations (e.g. PowerPoint presentations) to demonstrate a therapeutic strategy	
I DO NOT consent _ to any photo or video's being taken of my child	

I (parent/legal guardians name)	
Give permission for the child (child's name)	
To receive services from Eat Sleep and Grow Inc., Ideal Insight Psychological Services and Sabrina Tanguay Speech Language Pathology, the procedures, expected outcomes and consequences of assessment, intervention or of refusing intervention have been explained to me. I understand the information obtained during the assessment/consultation/s is confidential and will not be released without my informed written consent.	

Parents Signature	Date
Parents Signature	Date

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Release Of Information Form

A listed parent or legal guardian must complete and sign this form.

Today's Date _____
Child's Name _____
Child's Birthdate _____

	I authorize the release of Information to Eat Sleep and Grow Inc. (Melissa Renfree), Ideal Insight Psychological Services (Kalli Charbonneau) & Sabrina Tanguay, Speech & Language Pathologist, from
	I authorize the release of information from Eat Sleep and Grow Inc. (Melissa Renfree), Ideal Insight Psychological Services (Kalli Charbonneau) & Sabrina Tanguay, Speech & Language Pathologist to:
Please list individually all sources where you authorize the release of information from or to:	

Name/Clinic	Fax		Email	Contact Name
	Phone			
Name/Clinic	Fax		Email	Contact Name
	Phone			
Name/Clinic	Fax		Email	Contact Name
	Phone			
Name/Clinic	Fax		Email	Contact Name
	Phone			
Name/Clinic	Fax		Email	Contact Name
	Phone			
Name/Clinic	Fax		Email	Contact Name
	Phone			

I acknowledge by my signature that I understand that although I am not required to release my information, I am giving my consent to do so. Additionally, I understand that I may revoke this authorization in writing at any time, except for that information that has already been released with consent and prior to my revocation.

Print Name	
Relationship to Child	
Signature	