

FACE AUTISM, INC.

5333 Rio Vista Street

Sarasota, Fl. 34232

Fax (941) 925-7270

Intake Form

(Please Print)

Child's Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code _____

County: _____ Parent/Guardian: _____

Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip Code _____

County: _____ E-mail: _____

Reason for concern: _____

Language/Communication

Does your child look at you with appropriate eye gaze? Yes No

Does your child respond to his name? Yes No

Does your child gesture to you? Yes No

Is your child vocal? Yes No

Age started babbling? _____

Use words? Yes No Use words to get needs met? Yes No

If your child is using words, is he/she using sentences? Yes No

If yes, please give exact examples of sentences he/she says

If your child **is** using words, is he/she using sentences? If yes, please give examples. _____

Sounds

How does your child respond to sounds in general? _____

Movement

What kind of movement and touch does your child like?

What kind does he/she dislike?

Play

Favorite thing/person/activity to play with?

Medical

Child's overall health? _____

Current Medications and reason for taking them? _____

Picky eater? Yes No Dietary Concerns: _____

Other Medical Concerns? _____

Educational Information

Is your child in a Special Educational Program (ESE)? Yes No

What program(s) is your child currently enrolled in? _____

Name of School: _____ County: Sarasota Manatee
Zip: _____

Age when first enrolled in preschool/school? _____

Total number of hours your child spends in the Special Education Program per week, if applicable _____

Therapies/Interventions – (Please complete the following chart)

Therapy/Intervention	Agency	Start Date	Frequency	Session Length

Goals you want to see for your child and you? _____

