



## School Aged Intake Form

North Vancouver BC - 604-351-7842 - info@ablockabove.com

### Personal

Child's Full Name: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

Full Address: \_\_\_\_\_

Parent's Name #1: \_\_\_\_\_

Parent's Name #2: \_\_\_\_\_

Primary Telephone: \_\_\_\_\_

Primary E-mail: \_\_\_\_\_

Does child have siblings, if so ages of siblings: \_\_\_\_\_

Does child split their time between multiple homes, if so describe living arrangements or current custody details: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Primary Language spoken at home: \_\_\_\_\_

Other: \_\_\_\_\_

### Medical

Primary Diagnosis: \_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_

Age at Diagnosis: \_\_\_\_\_

Diagnosis Received by (professional's name and agency): \_\_\_\_\_

\_\_\_\_\_

Other Upcoming Assessments / Appointments: \_\_\_\_\_

Other (if your child is not currently diagnosed, please specify why you are seeking services):

\_\_\_\_\_  
\_\_\_\_\_



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### Medical Cont.

Confirmed Allergies: \_\_\_\_\_

Special Diet: \_\_\_\_\_

Food Intolerances: \_\_\_\_\_

Other Biological Interventions: \_\_\_\_\_

Current Medication / Supplements: \_\_\_\_\_

Other / Concurrent Medical Conditions: \_\_\_\_\_

### Learning History

Has your child received intervention prior to our services? \_\_\_\_\_

List other professionals your child has received treatment from:

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Location: \_\_\_\_\_

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Location: \_\_\_\_\_

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Location: \_\_\_\_\_

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Location: \_\_\_\_\_

What assessment(s) have been implemented?

\_\_\_\_\_  
\_\_\_\_\_

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### Documentation

Do you have documentation you can share with our team, please circle all that apply:

- Diagnostic Report
- Letter from Paediatrician
- Genetic Information
- Speech and Language Pathologist Assessments / Notes
- Occupational Therapist Assessments / Notes
- Social Worker Reports
- Behaviour Analyst Assessments / Plans / Progress Reports
- School Documentation such as: Individual Education Plan (IEP); Safety Plan
- Assessment Summaries such as: VB-MAPPS; ABLLS-R; AFFLS; TOPS-E; SLDT-3; other: \_\_\_\_\_
- Original Child Development /IDP Forms

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### Educational Background

A ) Name of School / Home School Currently Attending: \_\_\_\_\_

Describe any extra assistance child receives in the classroom: \_\_\_\_\_

\_\_\_\_\_

Behavioural challenges in classroom: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current behavioural plan in place to address challenges: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Social functioning with peers at school:

\_\_\_\_\_

\_\_\_\_\_

B) Name of school(s) attended in past:

\_\_\_\_\_

Reason for withdrawal: \_\_\_\_\_

\_\_\_\_\_

Reason for withdrawal: \_\_\_\_\_

C) Is your child on an Individual Education Plan (IEP) at school? Y / N

D) Does your child have another designation at school, please specify:

\_\_\_\_\_

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**History with Applied Behavior Analysis Intervention**

**Home Based Intervention Program**

Current Consultant(s): \_\_\_\_\_

Previous Consultant(s): \_\_\_\_\_

Dates services provided: \_\_\_\_\_

Type of home-based ABA program instruction: \_\_\_\_\_

Your / family member's experience with past treatment plan(s): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**School Based Intervention Program**

Current Consultant(s): \_\_\_\_\_

Previous Consultant(s): \_\_\_\_\_

Dates services provided: \_\_\_\_\_

Type of home-based ABA program instruction: \_\_\_\_\_

Your / family member's experience with past treatment plan(s): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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### General Information About Child

Your child's preferred leisure activities (what does he / she like to do in their down time?):

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Your child's current hobbies, interests or extra curricular activities (any favourite toys, tv shows / movies, characters, subject matter etc):

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Tell us what your child's strengths are:

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### Family Goals

Please indicate your family's biggest goals for your child:

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### Communication

How does your child communicate their needs with others:

*(does he / she use words, how many words per utterance / picture exchange system / augmentative communication device / gestures / approach person / reach or take items?)*

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Does your child imitate sounds, words or phrases he / she hears? (give examples)

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Is your child able to independently tell you about events in their day?

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Does your child ask WH questions (what / where / when / who / why)? Provide examples:

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### Following Functional Instructions and Imitation Skills

How does your child respond to verbal instructions (such as following 1 or 2 step commands such as “get your lunch bag and bring it to the kitchen” or models of what to say “ask me for help by saying I need help with this” or respond to “tell us who you played with at school today?”):

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How does your child respond to visual models of gross motor or fine motor responses (*such copying dance moves, tying their shoes, making marks with markers, using a pencil or pen, typing on a keyboard, closing zippers, opening and closing buttons, dressing, using brushes etc*):

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### Social Skills

Does your child have a group of friends or one close friend? Describe their friendship(s).

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Does your child maintain conversations with his / her peers? Do they stay on topic? Does your child initiate conversations?

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Has your child struggled with either being bullied, or becoming a bully, in the past?

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### Executive Functioning and Life Skills

Areas in which your child struggles can include:

- Getting ready in the morning
- Gathering needed items for an activity
- Getting out the door on time for activities
- Selecting outfits
- Making meals
- Self Grooming
- Toileting
- Dressing

### General Behaviour Challenges

Tell us about your child's biggest behavioural challenges:

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### Sleep

Describe your child's sleep routine:

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Does your child have significant sleep disturbances, please describe:

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### Eating

Does your child have significant eating issues?

\_\_\_\_\_ Y / N \_\_\_\_\_

Describe what your child will eat, and how:

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Describe what your child will not eat, and behaviours when introduced to new foods:

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### Toileting

Is your child toilet trained?

\_\_\_\_\_ Y / N \_\_\_\_\_

Does your child initiate toilet use or require reminders or being brought to the toilet?

\_\_\_\_\_ Y / N \_\_\_\_\_

**Please provide copies of any relevant supporting documents, such as the diagnostic report, specialist assessments or notes. Providing as much information as possible will assist our team with understanding your child's learning profile, and assist us with the initial intake meeting. We ensure complete confidentiality with the information you decide to share with our team for this intake process.**