INTEGRATE
HEALTH SERVICES

ABA SERVICES INTAKE - UNDER 18

Date: _____How did you learn about our services?_____

Person completing Form: _____

What service are you interested in?

☐ Centre-based ABA ☐ Home-based ABA ☐ Afterschool ABA ☐ Parenting Training ☐ Behavioural Consultation

Is your child/youth and family registered with the Ontario Autism Program (OAP)? ☐ Yes ☐ No

If no, are you choosing to pay privately for services? ☐ Yes ☐ No

If yes, please specify:

☐ We have selected DFO ☐ We are currently on the waitlist for OAP services
☐ We are currently receiving OAP services but wish to change providers

OAP Family Service Worker Information (if registered with OAP):

Name: _____

Phone Number: _____

Email: _____

CLIENT INFORMATION:

Name: _____D.O.B _____ Age _____ Gender: ☐ M ☐ F ☐ Other

Address: _____ City: _____ Postal Code: _____

Health Card #: _____ Version Code: _____

Does your child have a diagnosis or exceptionality? (if yes, please identify)_____

Age of diagnosis: _____

PARENT/GUARDIAN INFORMATION:

Name: _____ Relationship to Child: _____

D.O.B: _____ (Age) _____ Gender: ☐ M ☐ F ☐ Other

Main Contact #: _____ Alternate: _____

Address: ☐ Same as above OR _____ City: _____ Postal Code:_____

Do you have a diagnosis or exceptionality?_____

Do you have a family history of mental or physical health concerns? _____

☐ Married ☐ Common-law ☐ Separated ☐ Divorced ☐ Widowed -Please indicate date: _____ or ☐ Single

Email * (We will use email for important correspondence):_____

***Please add me to your mail list so that I receive information about programs and services*: ☐ Yes ☐ No**

PARENT/GUARDIAN 2 INFORMATION:

Name: _____ Relationship to Child: _____

D.O.B: _____ (Age) _____ Gender: ☐ M ☐ F ☐ Other

Main Phone #: _____ Alternate: _____

Address: ☐ Same as above OR _____ City: _____ Postal Code:_____

Do you have a diagnosis or exceptionality?_____

Do you have a family history of mental health or physical concerns? _____

Marital Status:

☐ Married ☐ Common-law ☐ Separated ☐ Divorced ☐ Widowed -Please indicate date: _____ or ☐ Single

Email * (We will use email for important correspondence):_____

***Please add me to your mail list so that I receive information about programs and services*: ☐ Yes ☐ No**

CHILD CUSTODY: Joint ☐ Sole ☐ If sole, with whom? _____ *(If sole custody, we must receive court order)*

Is this child: Natural ☐ Adopted ☐ Foster ☐ ____ Date of placement/adoption:_____

EMERGENCY CONTACTS (other than parent):

Name: _____ Relationship to Child: _____

Main contact # ( ) _____ Alternate # ( ) _____

Name: _____ Relationship to Child: _____

Main contact # ( ) _____ Alternate # ( ) _____

Previous/current contact with Mental Health Professionals or Support Services:

Name of Agency	Professional Involved	Type of Support (medication, counselling, etc.).	Date and Duration of Treatment	Was it effective?

Are you currently on any wait lists for services?: _____

How familiar are you with what ABA services entail? ☐ Very familiar ☐ Somewhat familiar ☐ Not at all familiar

Family Contacts	Biological	Step/Half	Adoptive	Foster/Guardian
Parent/Guardian □ M □ F □ Other	Name (age)	Name (age)	Name (age)	Name (age)
	Phone	Phone	Phone	Phone
	Work/Occupation	Work/Occupation	Work/Occupation	Work/Occupation
Parent/Guardian □ M □ F □ Other	Name (age)	Name (age)	Name (age)	Name (age)
	Phone	Phone	Phone	Phone
	Work/Occupation	Work/Occupation	Work/Occupation	Work/Occupation
Sibling 1 □ M □ F □ Other	Name (age)	Name (age)	Name (age)	Name (age)
Sibling 2 □ M □ F □ Other	Name (age)	Name (age)	Name (age)	Name (age)
Sibling 3 □ M □ F □ Other	Name (age)	Name (age)	Name (age)	Name (age)
Sibling 4 □ M □ F □ Other	Name (age)	Name (age)	Name (age)	Name (age)
Sibling 5 □ M □ F □ Other	Name (age)	Name (age)	Name (age)	Name (age)
Sibling 6 □ M □ F □ Other	Name (age)	Name (age)	Name (age)	Name (age)

Who lives in the home (names, relationship and ages)?

Do any siblings or cousins have a diagnosis or exceptionality? If yes, what age were they diagnosed.

If child lives in more than one home please provide details on living arrangements?

CHILD'S EDUCATION:

Name of School: _____ School Board: _____

☐ Special Education Class ☐ IEP (Individualized Education Plan) ☐ Resource Period
☐ Educational Assistance ☐ Tutoring ☐ Other

Please attach most recent copy of your child's IEP

CHILD'S DEVELOPMENTAL HISTORY:

Prenatal and Birth Events:
Pregnancy complications?(bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use etc.) _____

_____

Delivery Complications? _____

_____

Toilet Training:(Age Reached) Bowel Control: *Day*_____ *Night*_____ Bladder Control: *Day*_____ *Night* _____
Current Concerns/Goals: _____

Sexual Development/ Gender identity:_____
Current Concerns/Goals: _____

Motor Development: (Please describe any concerns or goals for your child's motor skill development)

_____

_____

Does your child favour a hand when writing, or a foot when playing sports (e.g., kicking)? _____

Language Development: (please describe any concerns or goals for your child's language development)

_____

_____

Social Development: (please describe any concerns or goals for your child's social development)

_____

_____

Current peer interactions: _____

_____

Special interests/hobbies: _____

_____

EATING BEHAVIOURS:

Eats healthy foods: ☐ Yes ☐ No Eats mostly junk food: ☐ Yes ☐ No
Over-eats: ☐ Yes ☐ No Does not eat enough: ☐ Yes ☐ No

Feeding: ☐ Orally fed ☐ G-tube fed ☐ Yes GJ-tube fed
Difficulty swallowing foods (i.e. may cough, gag, vomit during or between meals): ☐ Yes ☐ No
If yes please explain, _____
Gags when new foods are introduced: ☐ Yes ☐ No

Drinks liquid from: ☐ Sippy cup ☐ Bottle ☐ Regular Cup Has challenges drinking liquids: ☐ Yes ☐ No
Types of liquids consumed: _____

Exhibits inappropriate behaviours at mealtimes: ☐ Yes ☐ No
If yes, please explain: _____

Dietary Requirements (select all that apply)**:**

☐ Regular, diet as tolerated
☐ Lactose-Intolerant
☐ Vegetarian:
  ☐ Semi-Vegetarian (no beef or pork) ☐ Lacto-Ovo (no beef, pork, chicken, seafood, or fish)
  ☐ Vegan (no meats, eggs, or dairy) ☐ Other- Please specify: _____
☐ Gluten Free diet
☐ Picky Eater (please explain): _____
☐ Other food restrictions: _____

SLEEP BEHAVIOR:

Has a consistent bedtime routine ☐ Yes ☐ No Bedtime: _____ Wake-time: _____
Goes to bed and falls asleep with no delay: ☐ Yes ☐ No If yes, please explain: _____
Falls asleep without assistance: ☐ Yes ☐ No
Falls asleep with assistance of caregiver/parent: ☐ Yes ☐ No
Remains asleep throughout the night: ☐ Yes ☐ No
Wakes up several times: ☐ Yes ☐ No If yes, how many times?_____
Please describe how to get your child to fall back asleep:_____
Please describe what your child does if he/she wakes up in the middle of the night:
_____
Naps during the day ☐ Yes ☐ No Nap time: _____ Duration: _____

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PROBLEM BEHAVIOUR INFORMATION

Problem Behaviour (Describe what your child does/says)	**Frequency** (hourly, daily, weekly)	**Duration** (how long the behavior lasts)	**Severity** **Mild** – disruptive but little risk **Moderate** – somewhat significant damage. **Severe** – very significant threat to health or safety	**Describe how your child calms down**	**Is the calming technique effective both short and long term?**

Please describe the situations that these problem behaviours are most likely to occur: _____

_____

_____

Please describe the situations that the behaviours are least likely to occur: _____

_____

_____

Please list the techniques implemented in the past to decrease problem behavior occurrences: _____

_____

Please describe how your child requests for items: _____

_____

Please describe your child's ability to answer questions: _____

CHILD'S MOOD:

How would you describe your child's personality?_____

Does your child have any fears/phobias? ☐ Yes ☐ No If yes, please describe:_____

_____

How does your child express their feelings?:_____

CHILD'S HEALTH INFORMATION AND HISTORY:

Anaphylactic Allergies:

Does your child have any life threatening allergies? ☐ Yes ☐ No

If yes, please list the anaphylactic allergies: _____

Type of auto-injector: EpiPen: ☐ Junior ☐ Adult Allerject: ☐ Junior ☐ Adult

If your child has a life-threatening allergy you MUST complete the ANAPHYLAXIS EMERGENCY PLAN FORM AND ADMINISTRATION OF MEDICATION FORM.

All Other Allergies:

Does your child have any non life-threatening allergies? ☐ Yes ☐ No

If yes, please complete information below:

Allergy: Drugs/Food/Environment	**Reaction or Symptoms: Allergy or Side Effect**	**Recommended Response**

Do you administer medication for allergic reactions? ☐ Yes ☐ No

If yes, please complete the ADMINISTRATION OF MEDICATION FORM.

Health Conditions or Complications:

Does your child have any current health complications or conditions?

If yes, please explain:

_____

_____

Other Health Issues (check all that apply):

☐ Asthma	☐ Arthritis	☐ Bowel Issues	☐ Bleeding Disorder
☐ Concussion: Date: _____	☐ Diabetes	☐ Chronic Ear Infections	☐ Ear Tubes
☐ Chronic Nose Bleeds	☐ Frequent Colds	☐ Heart Condition	☐ Headaches
☐ Hearing Difficulties	☐ Hearing Aids	☐ High Blood Pressure	☐ Seizures
☐ Sight/Vision Difficulties	☐ Sinus Trouble	☐ Skin Conditions/Rashes	☐ Toothaches
☐ Other: _____	☐ Other: _____	☐ Other: _____	☐ Other: _____

MEDICATIONS – CURRENT

Name of Medication	Dosage	# Times /day	Other Directions:

PAST MEDICAL HISTORY:

1. MAJOR ILLNESSES No ☐ Yes ☐

Year	Illness	Treatment	Result

2. SURGERY No ☐ Yes ☐

Year	Type of Surgery	Reason for Surgery	Result

3. HOSPITALIZATIONS No ☐ Yes ☐

Year	Illness	Treatment	Result

4. INJURIES/ACCIDENTS No ☐ Yes ☐

Year	Injury

5. PHYSICAL/SEXUAL ABUSE No ☐ Yes ☐

Year	Relevant Information

IMPORTANT INFORMATION:

Please describe your child's strengths and interests (extracurricular activities, hobbies, things they enjoy):

What are your goals for your child/What are you hoping to achieve?

Please describe any stressors/ triggers and when your child is experiencing difficulties:

Please describe your child's most prefer items/activities

Please describe your child's least preferred items/activities

Is there anything else you would like us to know?

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Please check any areas of concern that apply and provide details

☐ Delays in fine motor skills (printing, gripping items, using scissors) _____

_____

☐ Daily living/ self-care skills (dressing, toileting, hygiene, eating) _____

_____

☐ Sensory processing challenges (overly/under sensitive) _____

_____

☐ Gross motor skills (hand eye coordination, balance) _____

_____

☐ Anxiety, depression or mental health challenges _____

_____

☐ School performance (attention, organization, remaining seated, academic difficulties) _____

_____

☐ Social skills (maintaining relationships, social boundaries, initiating conversation) _____

_____

☐ Communication (language delays, currently using communication tools) _____

_____

☐ Family/sibling relationships _____

☐ Regulation of emotions/irregular mood_____

☐ Developmental/Learning delays _____

_____

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INFORMED CONSENT

Thank you for your interest in Integrate Health Services. Please be aware that all client information will be stored as confidential clinic records. Where assessment services are provided, information shared will become part of a consult letter, which will be forwarded to the client and/or parent(s)/guardian(s) and referring physician. Any additional information shared outside the clinic would require the written permission of the client or parent(s)/guardian(s) (when the client is under the age of 16 or unable to provide consent).

CONFIDENTIALITY:

There are by law, certain circumstances in which confidentiality cannot be maintained.
These situations would include: (1) suspected child abuse or neglect (2) circumstances where the client has become a danger to themselves or others, (3) when information has been subpoenaed by the court. Should you have any questions about the limits of confidentiality, please contact an Integrate Health Services team member.

PARENTAL CONSENT:

All children under 16 years of age require parental/guardian consent to access services at Integrate Health Services. Clients over the age of 16 (who are believed to be capable of understanding the details of informed consent) are able to sign their own consent for services.

APPOINTMENTS:

Please ensure you arrive on time for your scheduled appointment, as we are unable to extend your session time. No show appointments will be subject to a half-session charge.

WAIVER:

My child's photograph/visual likeness may be displayed at Integrate Health Services office (for the purposes of client awards/recognition). ***I give consent*** ☐ ***I do not give consent*** ☐

INTEGRATE HEALTH SERVICES TEAM APPROACH- CIRCLE OF CARE:

Integrate Health Services is a multi-disciplinary team working in partnership with The Kids Clinic. We are comprised of various health professionals and in circumstances where it is believed to be in the best interest of the client, please be aware that personal health information may be shared among healthcare providers at Integrate Health Services and Kids Clinic. Information shared will be determined on a case-by-case basis dependant upon the needs of the individual client(s). *When you access Speech Therapy or Occupational Therapy Services, please be aware that the information you provide to Integrate Health Services is shared with our partners, Speech Therapy Centres of Canada and Ashley Rego Occupational Therapy Services. By signing this form, you are consenting to all services provided through Integrate Health Services, including those affiliated with Speech Therapy Centres of Canada and Ashley Rego Occupational Therapy Services and understand that the same limits of confidentiality apply.

CONFIDENTIALITY WITH CHILDREN:

In order for children and adolescents to feel safe and be able to identify and discuss concerns, they must feel a sense of privacy and some control over the information they share. At Integrate Health Services, it is our responsibility to honour and respect the child or adolescent's confidentiality- this is crucial to developing trust and achieving positive outcomes. We understand that parent(s)/guardian(s) want to be updated regarding the assessment/counselling process and be made aware of any information that would assist them in better supporting their child/adolescent. We will always seek permission from the child / adolescent to share relevant themes or details where it is determined to be in their best interest to do so.

If other family members may participate in counselling sessions, please list them below:

	Name	Relationship	Date of Birth
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Integrate Health Services provides the following support programs and services:

- *Psychological Assessments*
- *Counselling Services*
- *Art Therapy*
- *Behavioural Therapy- Applied Behaviour Analysis (Comprehensive and Focused ABA)*
- *Behaviour Consultation*
- *Child/Youth/Adolescent Group Programs*
- *Parent Support and Skills Training*
- *Education Services*
- *Speech and Language Therapy (through our partnership with speech therapy centres of Canada)*
- *Occupational Therapy Services (through our partnership with Ashley Rego Occupational Therapy Services)*

CLIENT CONSENT:

I, _____ have reviewed the above information and fully understand the details of informed consent. An Integrate Health Services team member has answered any questions I had. At this time, I make an informed choice (for myself or child) to access services at Integrate Health Services. ***Please Note**: Children enrolling in a group program must have the ability to manage in a 3:1 or 4:1 ratio (dependant upon program). If you have concerns about suitability or would like to discuss options for additional support, please contact us.

_____	_____	_____
Client Name	Signature (if over 16)	Date

If the client is under 16 years, parent/guardian consent is required (***BOTH parents in the case of a joint custody***)

_____	_____	_____
Parent / Guardian Name	Signature	Date
_____	_____	_____
Parent / Guardian Name	Signature	Date
_____	_____	_____
Witness Name	Witness Signature	Date

***To be completed for client under the age of 16 prior to accessing services if parents are separated or divorced**

PARENTAL CONSENT (Custody Agreement)

Thank you for accessing services at Kids Clinic/Integrate Health Services. Please be aware that all children under the age of 16 require parental/guardian consent to access services. **In situations in which parents/guardians are separated or divorced and there is joint custody (even if the child lives only with one parent), both parents must provide signed consent before a child can access services.**

In Circumstances of Sole Custody:

I, (*parent/guardian name*)_____ being the sole custodial parent of

child's name _____, D.O.B.: _____

hereby consent to assessment or support services for this child, at Kids Clinic/Integrate Health Services.

Is there a current court order regarding custody/access for this child ☐ Yes ☐ No (this must be provided to clinic)
Does the agreement allow non-custodial parent access to information? ☐ Yes ☐ No
This custodial arrangement is: ☐ Permanent disposition ☐ Interim disposition until (date)_____

In Circumstances of Joint Custody:

I, _____ and _____
parent/guardian name *parent/guardian name*

being joint custodial parents/guardians of (*child's name)* _____,

D.O.B.: _____ hereby consent to assessment support services for this child, at Kids Clinic/Integrate Health Services.

It is my/our understanding that accessing services are intended to support my/our child's overall well-being. The purpose of accessing these services is to benefit the child involved and not to collect or gather information for court purposes. *It is parent's responsibility to advise the clinic of any changes to child custody, access to information, etc. and to provide the supporting documentation.

_____	_____	_____
Parent/Guardian Name	Signature	Date
_____	_____	_____
Parent/Guardian Name	Signature	Date
_____	_____	_____
Parent/Guardian Name	Witness Signature	Date