
**Intake Form:**

**Personal Information:**

Name:_____ Date_____

Gender: F M Date of Birth:_____ Age:_____

Form completed by (if other than the client):_____

Address:_____ City:_____ State:_____ Zip:_____

Phone (home):_____ Cell:_____

Email:_____

Referred by:_____

Mother's name:_____ Father's name:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone (home):_____Work:_____ Cell:_____

Email:_____

Emergency Contact:_____

**Educational History:**

School/Placement:_____

**Medical History:**

Child on medication: Yes No

Type:_____ Reason_____

Dosage:_____ Doctor:_____

Allergies to medicine: Yes No

If Yes, please describe:_____

Food Allergies: Yes No

If Yes, please describe:_____

Family history of Spectrum Disorder (if any)_____

**Current Services:**

Type of Therapy:_____

Type of Provider:_____

Additional Services:_____

**Work Experience:**

Have you ever had a job/internship? Yes No

If Yes, where and how long?_____

Was the experience positive or negative?_____

**Please describe initial goals you would like to work on:**

_____

_____

_____

_____

**What are you hoping to accomplish from coaching?**

_____

_____

_____

_____