Oliver Behavioral Consultants

OBC INTAKE

Patient Name: DOB:

Parent/Guardian:

Provider Completing Form:

Reason for seeking services

Goals for evaluation and treatment

Describe Strengths

Describe challenges (communication, play, social)

Family History

Parents: ☐ Married ☐ Divorced ☐ Separated

Child custody:

Death in family:

Household members:

Name	Age/DOB	Gender	Relationship	Reside in Home

Family members receiving services (e.g., behavior therapy, psychiatric): ______________
____
____

Pregnancy / Delivery

Were you under a doctor's care? ☐ Y ☐ N
What types of medication(s) were used during pregnancy? _____
Did the mother of the child drink alcohol during pregnancy? ☐ Y ☐ N
Did the mother or others in the house smoke during pregnancy ☐ Y ☐ N
Was this child born in a hospital? ☐ Y ☐ N
Duration of pregnancy (weeks) _____
Duration in labor (hours) _____
Delivery method _____
Apgar score (if available) _____
What was the child's birth weight? _____
How long was the child in the hospital? _____

Complications during pregnancy

☐	Abnormal weight gain	☐	Excessive vomiting	☐	Hospitalization from injury
☐	Anemia	☐	Flu/COVID	☐	Toxemia
☐	Difficulty in conception	☐	High blood pressure	☐	Vaginal bleeding
☐	Emotional problems	☐	High blood sugar	☐	X-rays, MRIs, Scans

Complications during birth

☐	Breathing problems	☐	Incubator	☐	Pre-term labor
☐	Breech	☐	Induced labor	☐	Seizure
☐	C-section Emerg or Planned	☐	Jaundice	☐	Vacuum used
☐	Forceps	☐	Oxygen		

Was the baby breastfed? ☐ Y ☐ N
When did the child begin using formula? _____
When did the child begin eating solid foods? _____

Medical / Dental history

Last physical exam or visit to the physician _____
Last dental exam _____
Describe your child's health as an infant _____
_____
Describe your child's health now _____
Did your child pass a vision test? ☐ Y ☐ N
Did your child pass a hearing test? ☐ Y ☐ N
Did your child have surgery? ☐ Y ☐ N

How is your child's sleep? _____

How is your child's appetite? _____

Any problems with bowel and/or bladder control? ☐ Y ☐ N

Check all that apply

☐	Anemia	☐	Fever over 104	☐	Meningitis	☐	Scarlet fever
☐	Ear infections	☐	Mumps	☐	Head injury	☐	Sustained fever
☐	Coma diphtheria	☐	Loss of consciousness	☐	Measles	☐	Allergies/reactions
☐	Encephalitis	☐	Pressure equalizing	☐	Rheumatic fever	☐	Pneumonia
☐	Whooping cough	☐	Broken bones	☐	Chicken pox	☐	Asthma
☐	Lead or other poison	☐	Severe cuts / bruises	☐	Seizures	☐	Headaches
☐	Migraines	☐	Stomach aches	☐	Diarrhea	☐	Nausea
☐	Vomiting	☐	Rashes	☐	Surgeries	☐	Other

Is your child being treated for any medical condition (including feeding)? ☐ Y ☐ N

Are there special protocols necessary for care? ☐ Y ☐ N

What are the signs or symptoms? _____

What may typically occur? _____

When it occurs, what specific actions must be taken? _____

_____

Current Medications

Name of medication	Dosage and frequency	Prescribed for	Prescribing physician	Date of last visit

Past Medications

Name of medication	Medication began	Medication ended	Reason for prescribing	Reason for ending

Has your child ever been prescribed:

Ritalin, Concerta, Adderall, Strattera ☐ Y ☐ N

Anticonvulsants ☐ Y ☐ N

Antidepressants ☐ Y ☐ N

Antianxiety ☐ Y ☐ N
Antipsychotics ☐ Y ☐ N

Treatment history

Has your child ever received:		Response to treatment:	Reason for discontinuing:
☐	Developmental intervention		
☐	Physical therapy		
☐	Speech therapy		
☐	Occupational therapy		
☐	Behavior therapy / ABA		
☐	Play therapy		
☐	Mental health therapy		

Self-Help Skills

	Activities of Daily Living	Assistance level
☐	Finger eating	
☐	Eating with utensils	
☐	Dressing of upper body	
☐	Dressing of lower body	
☐	Brushing teeth	
☐	Brushing hair	
☐	Toileting self (clothes and cleaning)	
☐	Shower/bath	
☐	Bedtime routines	

Developmental history

Skill	Age	Skill	Age
Turn		Sit unsupported	
Crawl		Stand alone	
Walk alone		Walk up stairs	
Walk down stairs		Show interest in sounds	
Understands words		Speak first words	
Toilet training day		Toilet training night	

Has child experienced any of the following:

☐	Colic	☐	Learning to skip	☐	Separating from parents	☐	Underweight
☐	Follows instructions	☐	Learning to ride a bike	☐	Sleeping	☐	Walking
☐	Learning to catch	☐	Learning to throw	☐	Temper tantrums		

☐	Learning to kick	☐	Overweight	☐	Unclear speech		

Communication history

☐	Points	☐	AAC or "talker"
☐	Babbles with vowels	☐	Uses two-word phrases (e.g., "more water")
☐	Babbles with consonants	☐	Uses three-word phrases (e.g., " I want water")
☐	Leads you to what he/she wants	☐	Uses complete sentences

Social / Play history

How does your child play with peers? _____

_____

How does your child play with siblings? _____

_____

Can your child take turns? ☐ Y ☐ N

Can your child share toys? ☐ Y ☐ N

Is your child a leader or a follower? ☐ LEADER ☐ FOLLOWER

What is your child's favorite activity or interests? _____

_____

Does your child participate in extracurricular activities?

Check all that apply

☐	Problem relating to peers the same age	☐	Have difficulty making friends
☐	Often fights with playmates	☐	Prefers to play alone
☐	Prefers playing with younger children	☐	Recent decline in activities of interest

School history

Did or does your child attend preschool? ☐ Y ☐ N

Did or does your child attend kindergarten? ☐ Y ☐ N

Current or highest level of education completed? _____

Name and address of current school: _____

_____

Has your child ever received specialized supports at school (e.g, IEP, 504 plan) ☐ Y ☐ N

*obtain copy of these documents

What accommodations or modifications to instruction have been used? _____

_____

Where these accommodations successful? ☐ Y ☐ N

Describe if your child ever had a difficult time with school _____

_____

Has your child ever been suspended, held back, or expulsion? ☐ Y ☐ N

Tolerance problems for routines

- ☐ Haircuts
- ☐ Nails trimmed
- ☐ Doctor visits
- ☐ Dentist visits
- ☐ Sleeping through the night
- ☐ Sleeping in own bed
- ☐ Nightlight, sound machine, stuffed animal
- ☐ Picky eater
- ☐ Over eats
- ☐ Order of food items on plate
- ☐ Sits for duration of meal

Behaviors of concern

☐	Has short attention span/easily distracted	☐	Requires lots of parental attention
☐	Has fears	☐	Seems impulsive/acts without thinking
☐	Has trouble calming down	☐	Seems overly energetic in play
☐	Hides feelings	☐	Uncomfortable meeting new people
☐	Easily overstimulated in play, crowds, noise	☐	Seems unhappy most of the time
☐	Lacks self-control	☐	Withholds affection
☐	Excessive fidgeting/difficulty staying in seat	☐	Difficulty playing quietly
☐	Blurts out answers to questions/interrupts	☐	Difficulty waiting turn
☐	Often loses things	☐	Difficulty transitioning between activities
☐	Talks excessively	☐	Shifts activities without finishing them
☐	Unrealistic and persistent worry	☐	Sudden decrease or increase in appetite
☐	Excessive need for reassurance	☐	Frequent physical complaints
☐	Difficulty separating from family	☐	Unrealistic concern about performance
☐	Does things to deliberately annoy others	☐	Refuses to go to school
☐	Easily annoyed by others	☐	Often argues with adults or caregivers
☐	Often steals	☐	Often spiteful and vindictive
☐	Often lies	☐	Often swears and uses obscene languagr
☐	Cruel to animals and pets	☐	Runs away from home
☐	Initiates physical fights	☐	Deliberately sets fire
☐	Often loses temper	☐	Often angry and resentful
☐	Blames others for own mistakes	☐	Engages in risky/dangerous behaviors
☐	Depressed mood	☐	Substance abuse
☐	Thoughts of death, suicide, self-injury	☐	Diminished interest or pleasure in activities
☐	Too much or too little sleep	☐	Physical agitation or “jumpy”
☐	Reduced energy or fatigue	☐	Decreased ability to concentrate
☐	Feelings of hopelessness	☐	Obsessive / ruminating thoughts
☐	Feelings of worthlessness or guilt	☐	Compulsive rituals (e.g., checking, washing)
☐	Motor or vocal tics, pressured speech	☐	Stereotyped mannerisms

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