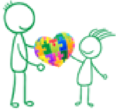


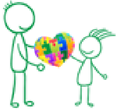
Intake Application

General Information	
Child's Name:	
Date of Birth:	**Phone Number:**
Address:	

Insurance Information
Primary Insurance Provider:
Name of Policy Holder:
Policy Number:
Secondary Insurance Provider:
Name of Policy Holder:
Policy Number:
Does your child have Medical Assistance? ☐ Yes ☐ No

Parent/Legal Guardian	
Parent/Legal Guardian Name:	
Home Phone:	**Cell Phone:**
Address:	
Occupation:	**Relation to the child:**
Marital Status:	
Parent/Legal Guardian Name:	
Home Phone:	**Cell Phone:**
Address:	
Occupation:	**Relation to the child:**
Marital Status:	

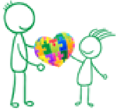
Race/Ethnicity/Religion/Language (this section is option)
Check all that apply: ☐ Asian ☐ Black-African American ☐White ☐ Other
_ ☐ American Indian or Native Alaskan ☐Pacific Islander or Native Hawaiian
Hispanic or Latino ☐ yes ☐ no
Primary Language:
Secondary Language:
Religious Affiliation:
Any Cultural or Religious Considerations:



Pregnancy/Delivery
Please provide any details about your child's pregnancy/delivery (any complications, birth weight, born full term or premature, any visit to the NICU)

Child's Developmental Milestones			
Please Include the age of each milestone met or leave blank if not met yet:			
Sat:	Rolled Over:	Crawled:	Stood:
Walked:	Toilet Trained:	Babbled:	First Word:
Combined Words:		Complete Sentences:	

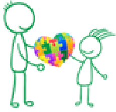
Communication
How does your child communicate their wants and needs, if verbally, how many terms do they use at once?
Does your child spontaneously label items?
Does your child answer questions?
Is your child able to engage in conversations?
Does your child follow one or two step instructions?
Does your child use a range of facial expressions to communicate their emotions?
Does your child seem to understand your non-verbal cues (facial expressions and gestures?
Social/Play Skills
Does your child show an interest in peers?
Does your child seek out peers?
What does your child do when peers try to engage with him/her?
Will your child play next to another child while engaging in different activities?
Will your child engage in sharing or turn taking?
What does your child do for fun?
Does your child bring your things they are proud of or try to get you to share in their enjoyment?
Does your child try to comfort others or notice the emotions of others?



Daily Living Skills (include specific ages your child began to display these skills when applicable)		
Eating table foods:	Using a fork:	Using a spoon:
Drinking from an open cup:	Toilet trained:	
Undressing:	Dressing:	Bathing self:
Sleep through the night:	Teeth brushing:	
List any sleeping concerns:		
List any feeding concerns:		

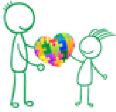
Restrictive/Repetitive Behaviors
Does your child struggle with changes in routine?
Does your child become fixated on objects/activities?
Does your child display ritualistic behaviors?
List any repetitive behaviors:
List what your child does when upset (e.g.: cry, whine, flop to the floor, scream, throw items, aggression towards self, aggression towards others) and what makes them upset:

Biggest Areas of Concern



Previous Assessments
Please list any previous assessments or evaluations (where completed, when, by whom, and diagnosis given):

Previous Treatment
List any current/previous ABA therapy treatment (provider, frequency, length of services, when discontinued):
List any current/previous Speech Therapy treatment (provider, frequency, length of services, when discontinued):
List any current/previous Occupational Therapy treatment (provider, frequency, length of services, when discontinued):
List any current/previous Physical Therapy treatment (provider, frequency, length of services, when discontinued):
List any current/previous school-based services (provider, frequency, length of services, when discontinued):



Medical Concerns
When was your child's last well check visit? Who is their primary care provider?
Does your child have a history of seizures?
Does your child have any medical diagnosis, if yes explain?
List any hospitalizations or surgeries:
List any medications:
List any known allergies:

Additional Providers/Support
Please list any additional service providers, any grants or waivers, or any social workers/case managers that are involved in your child's care (include name, contact information and level of involvement):

Additional Information
Please use this space to provide any additional information about your child:

Once this application has been completed, please either mail it to 4635 Nicols Rd, Suite 104, Eagan MN 55122 or email the completed application to pberland@mnbehavioral.com