



CLIENT INFORMATION

Date _____

Last Name _____ First Name _____ Middle Initial _____

Age _____ Primary Diagnosis _____

Birthday (mm/dd/yyyy) _____ Sex _____

Address _____ City _____

State _____ ZIP Code _____ Country _____

Current Medication(s)	Dosage(s)
(1)	(1)
(2)	(2)
(3)	(3)

Biomedical Treatment(s): GFCF Diet HBOT Chelation Other _____

Disabilities: Visual Impairment Hearing Impairment Physical Disability None

Primary Care Physician _____ Phone _____

Other Treating Physician(s) _____

PARENT/CAREGIVER INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Relationship to Client _____ Phone _____

Address _____ City _____

State _____ ZIP Code _____ E-mail _____

SCHOOL INFORMATION

School _____ Grade: Pre-K K-5 6-8 H

Contact _____ Phone _____

Address _____ City _____

State _____ ZIP Code _____

OTHER TREATING PROFESSIONALS

Currently receiving services?	Type of Service	Contact Information
<input type="checkbox"/> Yes <input type="checkbox"/> No	Speech and Language	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Dietician	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Physical Therapy	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Occupational Therapy	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Professionals	

DAILY ROUTINE

In the schedule below, please record what typical activities make up the person's routine.

Time of Day	Typical Weekday Activities
6 a.m.	
7 a.m.	
8 a.m.	
9 a.m.	
10 a.m.	
11 a.m.	
noon	
1 p.m.	
2 p.m.	
3 p.m.	
4 p.m.	
5 p.m.	

Describe how the individual communicates with others:

Describe some of the things the individual does well:

Preferred activities/items

REASON FOR REFERRAL: PROBLEM BEHAVIOR

NOTE: IF MORE THAN ONE BEHAVIOR/CONCERN IS TO BE ADDRESSED, MAKE ADDITIONAL COPIES OF THIS PAGE BEFORE COMPLETING INSTRUCTIONS (For multiple concerns): Complete one page for each behavior/concern. Number the sheets sequentially with #1 being the most serious concern.

Describe the behavior concern. (Be as specific as possible):

About how often does it occur? (e.g., twice per week, 30 times an hour, etc.)

Provide some description of the severity. (e.g., the extent of injuries, property damage, etc.)

What events seem to increase the likelihood the behavior will soon occur?

What events seem to increase the likelihood the behavior will immediately occur?

What do others do when the behavior occurs?

Has anything about this behavior changed and if so, when and what?

If yes to the last question, were there any changes in the individual's living situation coinciding with the behavior change?

What is generally believed as the "cause" of this behavior for this person?