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Child's name_______________________________ Your name____________________ Date______________

A: Beginning Information

1. Tell me about the abilities and achievements that make you most proud of your child:

2. Tell me about the actions and problems that make you most fearful for your child's future:

3. Please tell about other immediate family members – the persons s/he interacts with on a regular basis:

4. Are there other individuals in your household not listed above?

5. Describe any other people, not mentioned above, who have significant contact with your child:

6. Please describe a typical weekday for your child: What does s/he do? Who does s/he interact with? What is the quality of those interactions?

7. Please share a bit about your philosophy, principles and beliefs about parenting.

8. Tell me about any special factors, such as family culture, languages, parenting and custodial arrangements, which would be helpful for me to know about:

9. What do you think is your greatest strength as a parent (each parent)?

10. What do you think is your greatest limitation as a parent (each parent)?

11. Tell me about how you as parents cope with stress and take care of yourselves: Time spent away from your children, things you do for your own enjoyment or self-care, what you do for fun or stress release. Who provides respite for you? How often do you get a "vacation" from parenting?

12. Tell me about the experience of pursuing a diagnosis for your child. What led you to suspect a neurodevelopmental disorder? What diagnoses were assigned to your child? What was that experience like for you?

13. Please share what life has been like for both you and your child since receiving the diagnosis. How has your life changed? How has your child's life changed? What kinds of treatments and programs have you tried (both traditional and non-traditional)? What changes have you noted in your child for better or worse?

14. Each parent: please describe the periods of time you spend with your child that provide you with the most satisfaction as a parent:

15. Please share about the periods of time that are the most difficult for you as a parent:

16. Which medical or other professionals have been most helpful to you in regard to understanding and caring for your child? In what ways have these individuals helped you?

17. What experiences have been the most helpful to you as a parent?

18. If your child attends or has attended school, please describe school history and current status. What are some of your child's strengths and areas of challenge in regard to school?

19. Please tell me about any major crises, stressors, and traumas experienced by immediate family members during the child's lifetime:

20. Chief complaint and goals: What is your main reason for seeking these services at this time? What outcome are you hoping for as a result of your visits (please list at least two)?

B. Current and Past Treatment Providers

Please list all treatment providers:	Dates	Active Patient? Yes/No
Pediatrician		☐ ☐
Neurologist		☐ ☐
Other MD/Specialist		☐ ☐
Naturopath		☐ ☐
Occupational/Physical Therapist		☐ ☐
Speech & Language Pathologist		☐ ☐
Psychiatrist (MD)		☐ ☐
Counselor / Psychologist		☐ ☐
Social Skills		☐ ☐
Home-based intervention/ABA (Applied Beh. Analysis)		☐ ☐

Other treatment providers

/Specialty		☐ ☐
/Specialty		☐ ☐
/Specialty		☐ ☐

Most recent diagnosis: By whom? When?

Other:

Other

C. Current and Past Treatment Information

Intervention Type:	Duration/Frequency:	Describe program goals/outcome:
Behavioral/ABA		
Biomedical		
Classroom interventions/ Modifications		
Diets		
OT/PT		
Speech		
Other		
Other		
Medication Name, dose and prescriber/Purpose		
Medication Name, dose and prescriber/Purpose		
Medication (Attach sheet if needed)		

School and district your child attends Grade
Are you satisfied with how your child is served? Yes☐ No☐ Not Sure☐
Is this an area you would like to discuss? Yes☐ No☐ Not Sure☐
Does your child qualify for special services? Yes☐ No☐ Not Sure ☐
If yes, please describe the services your child receives:

D. Child and Family History

Medical History: Please check all that apply to your child

Hospitalization	no	yes:__________
Surgery	no	yes:__________
Major medical condition	no	yes:__________
Allergy	no	yes:__________
Seizure history	no	yes:__________
Infectious disease	no	yes:__________
Sleep problems	no	yes:__________
Feeding problems	no	yes:__________
Delays in development	no	yes:__________
Tobacco use	no	yes:__________
Substance use	no	yes:__________
Other	no	yes:__________

Mental Health History: does your child have a history of any of the following?

Anxiety	no	yes:__________
Depression	no	yes:__________
Trauma	no	yes:__________
Bullied	no	yes:__________
Aggression	no	yes:__________
Video gaming problem or addiction	no	yes:__________
Unusual thoughts	no	yes:__________
Self-harm behaviors	no	yes:__________
Suicidal ideation or behavior	no	yes:__________
Homocidal ideation or behavior	no	yes:__________
Inpatient mental health treatment	no	yes:__________
Outpatient mental health treatment	no	yes:__________
Domestic violence in the home	no	yes:__________
Trauma	no	yes:__________
Sexualized behavior	no	yes:__________
Other	no	yes:__________

State law requires us to ask the following, per
WAC 388-877-0640 (4)(a-c); WAC 388-877-0610 (2)(f-k)

Please check all that apply to your child and/or family members living in your home:

	Child		Family Member	
Court ordered treatment	no	yes	no	yes
Under supervision by Department of Corrections	no	yes	no	yes
Threat to self or others	no	yes	no	yes
Gambling problem or addiction	no	yes		
Advanced mental health directive	no	yes		
Advanced medical directive	no	yes		

E. Foundations Questionnaire

Please indicate whether your child demonstrates the ability to do the following. Some items may not appear relevant to your child.	Yes	Not yet	Sometimes/ Emerging
Uses words to communicate needs	☐	☐	☐
Uses non verbal communication to express needs (eye gaze, gestures, sounds, facial expression)	☐	☐	☐
Feels a special bond with primary caregiver(s); clearly treats them differently from other adults	☐	☐	☐
Separates from caregiver willingly when expected to	☐	☐	☐
Initiates interactions with caregiver or others for enjoyment	☐	☐	☐
Remembers and requests to repeat pleasurable shared experiences	☐	☐	☐
Recognizes the need for soothing self when distressed	☐	☐	☐
Requests soothing from others when distressed	☐	☐	☐
Observes and imitates simple two-step actions	☐	☐	☐
Transitions from one activity to another without “melting down”	☐	☐	☐
Shows interest in or curiosity about people	☐	☐	☐
Manages toileting needs independently	☐	☐	☐
Tolerates bright lights (e.g., indoor fluorescent)	☐	☐	☐
Tolerates loud noises	☐	☐	☐
Tolerates busy settings (e.g., shopping, playground) for up to 15 minutes	☐	☐	☐
Recognizes physical discomfort, such as headache, stomach ache	☐	☐	☐
Communicates with caregiver about physical discomfort	☐	☐	☐
Engages in pretend play	☐	☐	☐
Plays with a peer independently (with supervision as appropriate)	☐	☐	☐
Maintains attention to a non-preferred task for at least 3 minutes	☐	☐	☐
Uses coping strategies to manage intense emotions (e.g., seeks help)	☐	☐	☐
Shows concern for others	☐	☐	☐
Recognizes when communication breakdowns occur	☐	☐	☐
Makes attempts to repair communication breakdowns	☐	☐	☐
Shows wariness and fear about taking actions that may cause harm to self	☐	☐	☐
Participates in back-and-forth turn-taking interactions for up to 30 seconds	☐	☐	☐
Tolerates mild discomfort for up to 3 minutes (e.g., waiting in line)	☐	☐	☐
Refrains from taking actions that may cause harm to others	☐	☐	☐
Orients to caregiver’s face when uncertain	☐	☐	☐
Understands caregiver’s basic non verbal cues (e.g., approval/disapproval)	☐	☐	☐
Observes others to learn how to do new things and use objects	☐	☐	☐

Stop Here
Please bring your completed form to your first appointment.

Form completed by____ Date___________