



Initial Intake for Giborim U



Date of Intake: \_\_\_\_\_ Completed By: \_\_\_\_\_

Interviewee: \_\_\_\_\_ Relationship to Participant: \_\_\_\_\_

Participant's Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

How Referred to Gib U? \_\_\_\_\_

Disability/Diagnosis/Eligibility: \_\_\_\_\_

Exceptionality. Circle all that apply:

- |                           |                                      |                  |                |
|---------------------------|--------------------------------------|------------------|----------------|
| Learning Disability (SLD) | Autism Spectrum Disorder(ASD)        | Fragile X        | Down syndrome  |
| Speech or Language        | Intellectual Disability (InD)        | Hearing Impaired | SMS            |
| Developmentally Delayed   | Emotional/Behavioral Disability(EBD) | ADD or ADHD      | Cerebral Palsy |
| Other _____               |                                      |                  |                |

Participant Resides With: \_\_\_\_\_

Parent 1: \_\_\_\_\_ Parent : \_\_\_\_\_ Other: \_\_\_\_\_

Cell: \_\_\_\_\_ Cell: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_ Email: \_\_\_\_\_

School/Adult Day Program Name/Employment Site:

\_\_\_\_\_

Number of days per week in school or adult program/job schedule: \_\_\_\_\_

Current Educational Setting (children): Public School: \_\_\_\_\_

Grade (if applicable) \_\_\_\_\_ 100% Gen Ed or \_\_\_\_\_% \_\_\_\_\_,  
\_\_\_\_\_ 100% Cluster or \_\_\_\_\_% \_\_\_\_\_, Private School, Center School \_\_\_\_\_

Number of Students in class: \_\_\_\_\_ Number of teacher/aides (ratio): \_\_\_\_\_

Any unique, specific or individual needs required in order to participate in the program?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Likes and dislikes? (class preferences)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Communication: \_\_\_ Non-Verbal \_\_\_ AT Device \_\_\_ Words \_\_\_ Phrases \_\_\_ Sentences

\_\_\_ Reads Printed Material \_\_\_ Writes Describe: \_\_\_\_\_  
\_\_\_\_\_

Mobility: \_\_\_\_\_ Does not need assistance \_\_\_\_\_ Needs Assistance: \_\_\_\_\_

Bathroom: \_\_\_ Independent: \_\_\_ Needs Assistance: Describe: \_\_\_\_\_  
\_\_\_\_\_

**Sensory Issues:** \_\_\_ Loud Noises \_\_\_ Large Groups \_\_\_ Dark lights \_\_\_ Clapping

Other: \_\_\_\_\_

**Transition Issues (Moving from one activity to another); if any** \_\_\_\_\_

\_\_\_\_\_

**Aggressive Type Behavior(s); if any:** \_\_\_\_\_

\_\_\_\_\_

**Behavior Management:**

What positive reinforcements work? (i.e. high fives, sticker, specific responses or food items)

\_\_\_\_\_

\_\_\_\_\_

What behavioral interventions do not work?

\_\_\_\_\_

\_\_\_\_\_

**Safety:** \_\_\_ Runner (Elopes) \_\_\_ Roamer (Walks away) \_\_\_ Eats non-edible items

**Health concerns:** \_\_\_\_\_ **Special Diet?** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Medication(s):** \_\_\_\_\_

**Swim:** \_\_\_ independent \_\_\_ learning \_\_\_ unable \_\_\_ fearful of water \_\_\_ ear plugs

**Additional Notes:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_