

0-3 Intake/Evaluation Form
(with VABS embedded)

Child Name _____ Gender _____

Age/DOB _____ Ethnicity _____

Referral Source _____

Present during interview: (Circle all that apply) Mother _____

Father _____

Child _____

Other, specify _____

CHIEF CONCERNS (Brief statement in family's words as to the reason for this evaluation)

HISTORY OF PRESENTING PROBLEM / MAIN CONCERNS:

(Initial description of problem quality, severity, duration, timing, content, modifying factors, precipitating events, and associated signs/symptoms of problem/s.)

FAMILY DEMOGRAPHICS

Who lives in the home?

Have there been any major stressful events in your family in recent years?

PREGNANCY & DELIVERY

_____ Complications during pregnancy (specify, toxemia, measles, vomiting, swelling, stress, bleeding, BP, flu, anemia, accidents):

_____ Exposed to substances/alcohol/medications:

_____ Delivery complications:

_____ Special care after delivery? (e.g., NICU; incubator, jaundice - bilirubin, supplemental oxygen)

How long did your baby stay in the hospital after birth? _____

Apgar scores? DNR _____ Birthweight? DNR _____

MEDICAL HISTORY

_____ Major illnesses (specify): Has your child had any major illnesses, such as seizures?

_____ Surgeries

_____ Hospitalized

_____ Accidents/Injuries

_____ Head Injuries

_____ Frequent Ear Infections

_____ Chronic illness (Asthma, allergies, sickle cell, diabetes)

Has your child had a recent vision and hearing screen? Y / N

Wear glasses? Y / N Near-sighted / Far-sighted

Hearing or vision difficulties? Y / N

TOILETING

Is child toilet trained? Y / N When was your child fully toilet trained?

Day _____ Night _____

Current toileting issues and accidents: Y / N

Void in the toilet? Urinate? _____ Defecate? _____ Ask to use toilet? _____

SLEEP

_____ Sleep difficulties?
_____ Too much _____ Too little _____ Nightmares _____ Frequent waking
_____ Inability to sleep alone _____ Difficulties settling _____ Snoring _____ Grinds teeth
Hours per night? _____

EATING

_____ Appetite/Feeding/Weight Concerns?
Eat solid food? _____ Finger foods? _____ Use spoon/fork? _____ Spill? _____
Suck from straw? _____ Drink from cup? _____ Spill? _____
Chew with mouth closed? _____ Clean/wipe face during meals? _____
GI FUNCTIONING: constipation (current / past) diarrhea (current / past)

PERSONAL INDEPENDENCE

Take clothes off (what) _____ Put clothes on _____
Zippers? _____ Shoes on? _____ Wipe nose? _____
Help with bathing? _____
Careful around hot objects?
Help with simple chores (feed pet, p/u toys) _____ Clear tables? _____ Breakable?
Clean up play area at end of activity w/o prompts?
Understand function of telephone? _____ Talk to anyone on phone? _____
Turn on TV or radio w/o help? _____ Count 10 objects one by one? _____

MOTOR SKILLS: MILESTONES AND CURRENT

Sit Up: DK _____ First Steps: DK _____

_____ Can he/she ride a bike/tricycle (6 ft.?) _____ Walk and Run w/o difficulty

Stairs: Going up: alternate feet? Hold on to rail?

Going down: alternate feet? Hold on to rail?

Climb on adult size chair? _____ Climb on jungle gym/ladder on slide? _____

Roll ball? _____ Throw ball? _____ Specific direction? _____

Catch beach ball? _____ Kick ball? _____

Jump both feet off floor? _____ Hop on one foot? _____ forward? _____

Stack 4 blocks w/o fall? _____ Turn doorknobs? _____ Unwrap gum/candy? _____

Puzzle w/ two shapes? _____ Turn pages of boardbook? _____ magazine? _____

Use twisting hand-wrist open jar? _____ Hold crayon correctly? _____

Coloring? _____ Scissors? _____

COMMUNICATION: MILESTONES AND CURRENT

First Words: DK _____ Phrases (2-3 words) DK _____

Regression? _____

Understand meaning of: "no" yes"

Listens to a story for roughly _____ minutes

Point to body parts? Major / Minor

Level of instructions followed: If/Then? 1 step? 2 step?

Let you know when soiled? _____ How? _____

Say name or age? _____ Know any colors? _____ Any W questions? _____

ASSESSMENT HISTORY (Age, Agency, Dx/Results)

- 1) _____
- 2) _____
- 3) _____
- 4) _____

INTERVENTION HISTORY

____ Current/Previous psychiatric treatment: List names of current treaters/agencies:

____ Psychologist/Therapist _____

____ Assessments/Testing _____

____ Speech Therapy _____

____ OT/PT _____

____ ABA _____

____ School Based Services _____

____ Psychiatrist _____

____ Hospitalizations _____

____ Other _____

EDUCATIONAL HISTORY

Current school/daycare: _____ Special Services? Y / N

Current Services: _____

Behavioral Issues in Classroom? _____

Success/Competencies in Classroom? _____