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## INTAKE APPLICATION

Date of Application: \_\_\_\_\_

Student's Name: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ Current Age: \_\_\_\_\_ Male / Female (please circle)

Address: \_\_\_\_\_  
City, Province Postal Code

Citizen of Canada? Yes No If no, Landed Immigrant? Yes No

Parent 1/Legal Guardian: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

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

Parent 2/Legal Guardian: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

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

Sibling Name: \_\_\_\_\_ Age/Relationship \_\_\_\_\_

Sibling Name: \_\_\_\_\_ Age/Relationship \_\_\_\_\_

### Medical Information

Primary Diagnosis: \_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_



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Age at Diagnosis: \_\_\_\_\_ Diagnosed by: \_\_\_\_\_

Current Medication: \_\_\_\_\_

Please note that PALS will develop a protocol for administering medications on a case by case basis.

Past Medication: \_\_\_\_\_

Allergies, include life threatening allergies or medical conditions:

Special Diet: \_\_\_\_\_

Seizures/Convulsions? yes  no

Treatment: \_\_\_\_\_

Recurring Health Ailments: \_\_\_\_\_

List of Physical Sensitivities/Disabilities: \_\_\_\_\_

History of Childhood Diseases/Operations: \_\_\_\_\_

Other Biological Interventions: \_\_\_\_\_

Has an ABLLS (The Assessment of Basic Language and Learning Skills) been completed and if so, when? \_\_\_\_\_



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**Description of current intervention programs:**

*In home program:*

Type of programming and Dates: \_\_\_\_\_

Past Consultant(s): \_\_\_\_\_

Current Consultant: \_\_\_\_\_

*School:*

Dates Attended: \_\_\_\_\_ School: \_\_\_\_\_

Grade/Level: \_\_\_\_\_

Dates Attended: \_\_\_\_\_ School: \_\_\_\_\_

Grade/Level: \_\_\_\_\_

How much assistance in the classroom? \_\_\_\_\_

Describe any problem behaviours within a teaching setting and any plan for addressing them:

**Therapies**

Occupational Therapy: yes  no  Hours per week: \_\_\_\_\_

Goals: \_\_\_\_\_

Who provides service? \_\_\_\_\_

Physical Therapy: yes  no  Hours per week: \_\_\_\_\_

Goals: \_\_\_\_\_



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Who provides service? \_\_\_\_\_

Speech and Language Therapy: yes  no  Hours per week: \_\_\_\_\_

Goals: \_\_\_\_\_

Who provides service? \_\_\_\_\_

**Other therapies**

Describe: \_\_\_\_\_

Number of hours in school per week: \_\_\_\_\_

Number of hours at home with therapist per week: \_\_\_\_\_

**General Information about your child:**

What current communication skills does your child have? (*For example, vocalizations, words, sign language, PECS, etc.*)

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

Does your child initiate play with other peers? yes  no

If yes, describe how (stands close to the peer, looks at the peer, vocal request, etc...)

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

Does your child comply with your requests to do what you ask? yes  no

If yes, describe how:

\_\_\_\_\_

How long will your child sit at a table and participate in an activity with an adult?

\_\_\_\_\_

Does your child respond appropriately when you tell him/her no? yes  no

If no, describe your child's behaviour when you say "no":

\_\_\_\_\_



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Can you take away reinforcers (preferred items) at home or in public places without behavioural problems? yes  no

If no, describe your child's behaviours when you take something away:

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Does your child have any behaviour issues (such as self-injurious, aggressive towards others, self-stimulatory, etc.) yes  no

If yes, describe what they are:

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List types of toys, social games, etc... that are motivating to your child:

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List types of activities, etc... that your child dislikes:

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### ***Toileting***

Is your child toilet trained? yes  no

Can your child go to the toilet independently? yes  no

If not, describe assistance required in toileting:

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### ***Eating Issues***

Does your child have significant eating issues? yes  no

If yes, describe the issues:

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**Sleep Issues**

Does your child have significant sleep issues? yes  no

If yes, describe the issues:

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**Primary Goals**

List your three major goals for your child over the next year:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

What commitment level are you willing to make at home in order for your child to achieve such goals?

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List your long term goals for your child (For example: classroom integration, community integration, number of years at PALS, etc.):

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**Other**

As a member of a non-profit school, what talents, interests, resources or professional training can you share in order to enhance PALS?

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*Once we receive this intake application, your child will be added to the PALS waitlist. If we have an opening, we will evaluate all children on the waitlist to choose the one who would best fit that specific grouping with the opening. If your child is selected, you will be contacted and your child will be scheduled to visit PALS and assessed by our Board Certified Behaviour Analyst.*



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*Please note: In order for your child's experience at PALS to be successful, we ask each family to attend team meetings and parent workshops so that effective follow through may occur in the home environment. The child who will benefit the most from enrollment at PALS is the child whose parents/legal guardians are supportive of the ABA methodology.*

*We also require that parents/legal guardians volunteer on the Parent Committee in order to keep our costs as low as possible.*

*Thank you for your interest in PALS.*

*The undersigned hereby acknowledges that the information contained in this application is complete and accurate to the best of their knowledge, and that the terms of this application has been read and understood.*

**Parent /Legal Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_  
*Signature*