Pryor & Associates Counseling
and Diagnostic Center

Intellectual-Developmental Disabilities (IDD) Intake Form

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IDD COUNSELING INTAKE FORM (DEVELOPMENTAL DISABILITIES)

DEMOGRAPHIC INFORMATION

Date of Intake: ____/____/____

Name: _____

Last First Middle

DOB: ____/____/____ Age: _____ Sex: _____ Male _____ Female

Ethnicity: _____

Address:_____

_____

_____

County of Residence: _____ Phone: (_____) _____-_____

Primary Language: _____

Legal Guardianship: _____

REFERRAL INFORMATION

The individual has a diagnosis of:

_____ Intellectual Disability
_____ Autism
_____ PDD (Pervasive Developmental Disorder)
_____ Other: _____
_____ Other: _____

Birthplace (City): _____ Social Security #: _____-_____-_____

Benefits:

____ SSI
____ Medicaid #: _____
____ SSD
____ Medicare #: _____
____ Other: _____

Estimated age when the disability was identified: _____

What is believed to be the cause of the disability?

_____ Genetic _____ Illness _____ Birth Trauma _____ Accident _____ Unknown
_____ Other: _____

_____ Minor w/ Conservator
_____ Minor
_____ Adult w/ Guardian
_____ Other: _____
_____ Adult, No Guardian

Is there a family history of intellectual disability or mental illness? _____ Yes _____ No
If yes, explain: _____
_____
_____
_____

At what age did the individual walk? _____ Speak? _____ Complete toilet training? _____

What are the desired outcomes/supports for the individual?

_____
_____
_____
_____

Who referred you to our services? _____
Phone: (_____) _____-_____

FAMILY INFORMATION

Mother's Name:_____

Address: _____

Phone: (_____) _____-_____

Primary Caretaker (If different from parents)

Name: _____ Relationship: _____

Address:_____
_____

Phone: (_____) _____-_____

Father's Name: _____

Address: _____
_____

Phone: (_____) _____-_____

Emergency Contact (If different from parents)

Name: _____ Relationship: _____

Address:_____
_____

Phone: (_____) _____-_____

Total number in the household: _____
Who is serving as the informant? _____

EDUCATIONAL HISTORY

The individual is receiving or has received services through:

_____ Early Childhood Intervention (ECI)
_____ Preschool Program for Children with Disabilities (PPCD)
_____ Special Education Self-Contained Classroom
_____ Special Education Resource Program
_____ Other: Life Skills Program
_____ Day Habilitation Program
_____ _____

Has the individual finished school? _____ Yes _____ No

If yes, what was the age of the individual when he or she finished school? _____

If no, what school is the individual currently attending? _____
_____

MEDICAL INFORMATION

Medical/Health Problems:

_____
_____
_____
_____
_____

Physician's Name: _____

Address: _____
_____

Physician's Name: _____

Address: _____
_____

Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____

Date of last physical exam: ____/____/____

Date of last dental exam: ____/____/____

Date of last immunization: ____/____/____

Is the individual taking any prescribed medications? _____ Yes _____ No

Medications

Medication Name	Dosage	Frequency	Reason	Date Prescribed

Does the individual have any chronic illnesses or medical conditions? _____ Yes _____ No
If yes, explain: _____

_____

_____

Has the individual had surgery previously? _____ Yes _____ No
If yes, explain: _____

_____

_____

Does the individual have seizures currently? _____ Yes _____ No
If yes, explain: _____

_____

_____

Has the individual had seizures in the past? _____ Yes _____ No
If yes, explain: _____
_____
_____

Does the individual have any allergies (e.g., food, medications, and airborne allergies)?
_____ Yes _____ No
If yes, explain: _____
_____
_____

Is the individual currently ambulatory (i.e., able to walk)? _____ Yes _____ Yes, with assistance

_____ No BEHAVIOR PROBLEMS

Check all that apply

_____ Self-injurious
_____ Tantrums
_____ Hitting (self or others)
_____Biting (self or others)
_____ Ritualistic
_____ Jeopardizes personal safety
_____ Self-stimulatory
_____ Run-away
_____ Set Fires
_____ Depressive
_____ Suicidal
_____ Promiscuity
_____ Use of illegal drugs
_____ Excessive alcohol use
_____ Stealing
_____ Property destruction
_____ Doesn't relate well to peers
_____ Doesn't follow rules

Explain any items checked: _____
_____
_____
_____

Has the individual been arrested? _____ Yes _____ No
If yes, explain: _____
_____
_____
_____

Is the individual on probation now? _____ Yes _____ No
If yes, who is the Probation Officer? _____

Phone: (_____) _____-_____

PSYCHIATRIC HISTORY

_____ Inpatient _____ Outpatient _____ Currently in Therapy _____ None/Unknown

Diagnosis Facility/Counselor
_____
_____
_____
_____
_____

Does the individual have any sleep difficulties?

_____ Wakes frequently
_____ Cries in sleep
_____ Wakes unusually early
_____ Other: _____

COMMUNICATION (Check all that apply)

Expressive
_____ Uses complete sentences
_____ Speaks in phrases only
_____ Speaks in single words only
_____ Uses gestures and sounds
_____ Uses sign language
_____ No expressive communication
_____ Uses augmentative communication device
_____ Other: _____

Receptive

_____ Understands conversations
_____ Responds to simple commands
_____ Responds to name
_____ No responses

Articulation

_____ Good _____ Fair _____ Poor

VISION PROBLEMS

_____ No problems noted
_____ Near-sighted
_____ Far-sighted
_____ Astigmatism
_____ Glaucoma
_____ Cataracts
_____ Wears glasses
_____ Should wear glasses but doesn't
_____ Blind
_____ Other: _____

HEARING PROBLEMS

_____ No problems noted
_____ Deaf
_____ Hard-of-hearing
_____ Hearing aid
_____ Should wear hearing aid but doesn't
_____ Other: _____

Adaptive equipment not previously noted:

_____

PREVIOUS SERVICES (e.g., Supported Employment, Residential Services, Waiver Programs, and other MHMR Agencies)

Name: _____

Address: _____

Begin Date: ____/____/____

End Date: ____/____/____

Name: _____

Address: _____

Begin Date: ____/____/____

End Date: ____/____/____

Name: _____

Address: _____

Begin Date: ____/____/____

End Date: ____/____/____

INDIVIDUAL PROFILE

Strengths: _____
_____
_____
_____
_____
_____
_____

Likes: _____

Personal goals:

Needs:

Dislikes:

Describe a typical day:

Morning Afternoon Evening

Signature of Informant **Date**

Signature of Individual Seeking Services **Date**

Signature of Intake Worker **Date**