



**CHAMPION**  
Autism Therapy Center

3055 Old Hwy 8, Suite 190 Saint  
Anthony, MN 55418  
TEL: 612-345-7659  
FAX NUMBER: 612-605-6300

**All pages of the intake form MUST be completed and mailed, faxed, or e-mailed to our office for registration.**

Child's Name: \_\_\_\_\_  
First Last Middle Initial Nickname

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Male Female

Parents Names: (Mother) \_\_\_\_\_ (Father) \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

**Child's Health Insurance:** \_\_\_\_\_  
**Policy Number:** \_\_\_\_\_

Has your child had a CMDE Assessment or Diagnostic Assessment? Yes  No   
If yes, where was the assessment done? \_\_\_\_\_  
Has your child ever utilized ABA services?  Yes  No

**Preferred Language:** \_\_\_\_\_  
Do you need an interpreter?  Yes  No

Does your child have a Case Manager?  Yes  No If yes, name of case manager: \_\_\_\_\_  
Which agency/county? \_\_\_\_\_

Is/was your child attending school  Yes  No If yes, name of school: \_\_\_\_\_

Individual Education Plan (IEP)?  Yes  No Which school? \_\_\_\_\_

PCA Company: \_\_\_\_\_ Amount of Hours: \_\_\_\_\_



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**Autism & Other Conditions:**

- Autism
- Asperger's Syndrome
- Allergies to: \_\_\_\_\_
  - Reaction to allergies: \_\_\_\_\_
- Anaphylaxis
- Asthma
- Fragile X
- Attention Deficit Disorder
- Attention Deficit Hyperactivity Disorder
- Blind/Vision Impaired
  - Glasses\_\_Cane\_\_Arthritis\_\_
- Uses Sign Language
- Diabetes/Insulin dependent
- Developmental/Cognitive or Intellectual Disability
- Down Syndrome
- Epilepsy/Seizures, type and frequency: \_\_\_\_\_
- Pervasive Development Disorder
- Prader Will Syndrome
- Rhett Syndrome
- Traumatic Brain Injury
- Other: \_\_\_\_\_

**Eating:**

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Assistance Level:  Independent  Some Assistance  Total Assistance

Food Allergies:

Reaction:  Hives  Difficulty Breathing  Nausea  Anaphylaxis  Other

Special Diet:  None  Diabetic  Lactose Intolerant  Gluten Free  Pureed  Chopped

Difficulty with:  Swallowing  Chewing  Drinking Liquids

Are there any foods or drinks you prefer your child not to eat? \_\_\_\_\_



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**Safety and Behaviors:**

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Self-injurious Behavior  Verbal Aggression  Eloping/Bolting

Comments: \_\_\_\_\_  
\_\_\_\_\_

**Communication:**

**Communication:**

Able to communicate wants/needs verbally?  Yes  No

Uses communication device?  Yes  No If yes, please explain: \_\_\_\_\_

Understands/responds to questions:  Yes  No

Able to read?  Yes  No Able to write?  Yes  No

Can child communicate pain?  Yes  No

Further Instructions: \_\_\_\_\_  
\_\_\_\_\_