



Camper Intake



Child's Name: _____ Age: _____

Parent's Name: _____

Child Live With: _____

Diagnosis: _____

Describe your child's program at school in terms of priority goals and focus of education.

1. _____
2. _____
3. _____

Comments

Does your child have a personal assistant at school? Y / N _____

Does your child swim independently? Y / N _____

Social Communication

Avoids eye contact Y / N _____

Enjoys social interaction with others Y / N _____

Initiates with others Y / N _____

Participates in group activities Y / N _____

Participates in turn taking Y / N _____

Respond to name Y / N _____

Responds to "No" Y / N _____

Follows simple directions Y / N _____

Responds to verbal prompt Y / N _____

Requires a physical prompt to follow directions Y / N _____

Uses: Gestures, Sign Language, Picture exchange system (PECS), augmentative device.

List words or phrases used: _____

Sensory**Comments**

Aversive to:	Touch	Y / N _____
	Loud Noises	Y / N _____
	Rough Housing	Y / N _____
	Enclosed Spaces	Y / N _____
	Bright Lights	Y / N _____
	Obsession with object/toy/person	Y / N _____
	Mouths or smells objects	Y / N _____
	Has routines for eating, transitions	Y / N _____
	Prefers routine schedule	Y / N _____
	Becomes upset if routine not followed	Y / N _____

Physical Movement

	Walks without assistance	Y / N _____
	Walks with hand held	Y / N _____
	Walks with equipment (walker, etc)	Y / N _____
	Uses a wheelchair	Y / N _____
	Has significant weakness or in coordination	Y / N _____
	Falls frequently	Y / N _____
	Gets on/off of the floor independently	Y / N _____
	Is independent on the playground	Y / N _____

Self Care

<i>Toileting:</i>	Independent	Y / N _____
	Indicates need	Y / N _____
	Requires verbal cue/prompt	Y / N _____
		Comments
	Requires physical assistance	Y / N _____
	Washes hands by self	Y / N _____

Clothing Management: Puts shoes on & off Y / N _____
 Dresses self, no assistance Y / N _____
 Requires verbal prompt Y / N _____
 Requires assistance Y / N _____

Eating: Feeds self with utensils Y / N _____
 Drinks from an open cup Y / N _____
 Uses specific/adaptive utensils Y / N _____
 Opens containers by self Y / N _____
 Needs assistance with set-up Y / N _____
 Participates in food prep Y / N _____

Behavior

Impulsive Y / N _____

Frustration tolerance is high Y / N _____

Frustration tolerance is low Y / N _____

Stimulus for tantrums: Loud noises Y / N _____

Demands placed on child Y / N _____

High level environmental stimulation Y / N _____

Fear Y / N _____

Change in routine Y / N _____

Aversion behavior: Self-abusive (slapping, biting, etc) Y / N _____

Aggressive to others Y / N _____

Grabs/pinches/bites (others/self) Y / N _____

Runs away from group Y / N _____

Easily distracted Y / N _____

Comments

Poor safety awareness for self Y / N _____

Reinforces: Food Y / N _____

Verbal Praise	Y / N _____
Physical affection	Y / N _____
Toy	Y / N _____
Music	Y / N _____

Expresses Anger by:

Grunting	Y / N _____
Grimacing	Y / N _____
Kicking	Y / N _____
Pinch/Bite/Hit	Y / N _____

Please list strategies that calm your child:

What behavioral strategies have you found to be effective?

Any other information that you think might be helpful in working with your child?
