Behavioral Focus, LLC
Phone: 325-530-4089
Fax: 866-373-8243

Behavioral Focus, LLC
749 Gateway, STE F-702
Abilene, Texas 79602

Clinical Interview Form

Client Name: _____ **Client Birthdate:** _____

General Contact Information

Email Address:			
Preferred method of Contact & Information	***Phone Call***	***Text***	***Email***
Best times to contact			

Home Information

People Living in the Home			
Name	***Relationship to client***	***Age***	***Approved Pick-up Person***
Languages Spoken in the home			

***If divorced, a copy of the custody agreement indicating which parents have the right and responsibility for dependent's healthcare may be needed before the assessment or treatment is started.**

Evaluation History

Please list any doctors or professionals who have evaluated or diagnosed the client*		
Professional or Educational?	***Date of Evaluation***	***Diagnosis***

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***Please provide a copy of any reports that are available and that may be useful in developing a comprehensive treatment plan**

Family Psychological History

Relationship	*Diagnosis*	*Age at Diagnosis*

Developmental History

Please indicate your child's approximate age for each milestone. If you are having trouble remembering the approximate age just indicate "normal", "late, or early", or put a '?'. Leave the box blank if your child has not yet reached the milestone.

Rolled over		Sat Up		Stood	
Crawled		Walked		Hops on 1 foot	
Pointing		Dresses Self		Toilet trained (day)	
Toilet trained (night)		Drinks out of a sippy cup		Drinks out of a regular cup	
Uses utensils to eat		Requests Items Using 1 word		Requests Items Using more than 1 word	

Medical History

Primary Care Physician	
Phone Number	
Address	

Please list current &/or previous medical diagnoses:

Doctor	*Diagnosis*	*Date*

Medications: Please list any current or previously prescribed medications, the prescribing doctor, what the medication has been prescribed to treat, and the length of time that your child has taken the medication.

Medication	*Doctor*	*Reason*	*Currently or previously taking?*	*Length of time taken*

Trauma History

Our relationships and experiences—even those in childhood—may affect our health and well-being. Please tell us whether your child has had any adverse experiences, such as abuse, neglect, domestic violence, death or incarceration of a family member, medical trauma, or other experiences you would consider significant, as they may be affecting their health today or may affect their health in the future. This information will help us better understand how to work together to support your child's health and well-being.

Significant Event	*Approximate Date*

Allergies

Does your child have any allergies?	
***If answered YES....**	
Please list allergies:	
Allergy Medicine Currently Taken (Dosage and Time of Day Taken)	
Are the allergies life threatening?	

***If YES, please describe:**	
Is there an action plan in case of emergency?	
*If YES, please attach or describe the action plan, along with emergency contact information.	

Education Information

School Name:		***District:***	
Grade:		***Class Type/Placement:***	
Homeroom teacher(s):			
Does your child have a current IEP?		***Does your child have a current: Behavior Intervention Plan?***	

***If IEP and BIP are present, please have school fax it to us at: 866-373-8243 or bring with you to the testing appointment.**

Additional School Services

Service	***Minutes per week***	***Service Goals***
Occupational Therapy		

Speech Therapy		
Physical Therapy		
Counseling		
Other:		

Private Therapies

Current & Past Therapies				
Therapy Type	***Provider***	***Hours/week***	***Months/Years with provider***	***Comments***

Communication

How does your child communicate?	
Does your child have any assistive technology?	
Other:	

Preferences

How does your child typically express what they want?	
What are things that your child likes to do?	
What are some items that your child really enjoys?	
What does your child like to watch on TV or look at?	
Does your child enjoy listening to music or any other types of sounds?	
What are your child's favorite toys?	
What are your child's favorite foods?	
Who does your child's enjoy playing with most?	
Does your child enjoy playing or being outdoors?	

Feeding

How long does it normally take your child to finish a meal?	
How many meals does your child typically eat per day?	
What times does your child generally eat?	
What type of setting (i.e., sitting down at the table; pacing around the house – grazing; sitting in front of TV while eating) does your child eat in?	
What variety of foods from each food group does your child eat?	

Sleep Habits

What is your child sleep pattern?	
Does your child have trouble falling asleep?	

Does your child have trouble staying asleep?	
Does your child wake up early?	

Community Participation

How well does your child do in these environments?	
Grocery store	
Restaurants	
Religious services	
Parks	
Indoor recreational activities/events	
Outdoor recreational activities/events	

Doctor's office	
Dentist's office	

Challenging Behaviors

What does your child do or not do that concerns you the most?	
What do these behaviors look like?	
How intense are these behaviors? On a scale of 1 to 5, with 1 meaning "my child may fuss, or I know they are upset" to 5 meaning "my child's behavior is aggressive or violent enough to hurt someone or to harm themselves."	
How often do these behaviors occur?	

Are there triggers that you have pinpointed that seem to occur before these behaviors happen?	
Are there particular times of the day that these behaviors are more likely to occur?	
Are there particular times of the day when the behavior(s) does not occur?	

What environments is the behavior(s) likely to occur in?	
What environments do you never see these behavior(s) in?	
Does the behavior, or behaviors seem to occur when a routine or preferred activity is interrupted?	
What has been tried in the past to reduce these behavior(s)?	

Strength-Based Skills

What is your child's greatest strengths?	
What additional skills would you like for your child to acquire?	

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