Autism Intake Forms

Name of child

Date of Birth

Parent/Guardian

Address

Phone Email

Emergency Contact

Physician’s Name and Telephone

Special Needs Diagnosis

Physical Symptoms

What are some ways the child stims?

Self-Injuries?

History of Cardiac Conditions

History of Seizures

Injury of joints, spine, bones, etc.

Is the child in pain? Recent illness or surgeries?

History of respiratory problems, asthma, allergic reactions

Medications taken at this time and reasons

Extreme Sensitivities: smells, sounds, touch, etc.

Behavioral Patterns: (aggressive, self-stimulation, self – injury, fearful, oppositional, anxious, withdrawn, resistant to touch)

Behavior with other children

Behavior with adults

Able to follow instructions: (circle)

* Verbal
* Visual Cues
* Tapping or Gestures
* Demonstration
* Other\_\_\_\_\_\_\_\_

Able to replicate teacher’s movements or body positions independently or with assistance

Developmental Delays: motor, speech, cognitive, other\_\_\_\_\_\_\_\_\_\_\_

Areas of special interest

Describe any pre-existing conditions that contraindicate yoga practice or specific positions

PLEASE CONSULT YOUR PHYSICIAN BEFORE CHILDS PARTICPATION

To the best of my knowledge, my child is in good health and able to participate in yoga therapy: YES / NO

I GIVE THE YOGA THERAPIST PERMISSION TO TOUCH AND ADJUST MY CHILD IN POSTURE

SIGNATURE

PRINT NAME AND DATE