

CHILD MEDICAL HISTORY QUESTIONNAIRE

Client Name:	Age:
Form Completed by:	Relationship to Client:
Are you the legal guardian of the client and can you make medical decisions on their behalf? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Medical History

Does your child have allergies? <i>If yes, please describe:</i> _____ Are they life threatening?	__Yes	__No
Is your child currently being treated for any chronic health problems? <i>If yes, please describe:</i> _____	__Yes	__No
<i>Has your child...?</i>		
<ul style="list-style-type: none"> • Ever been hospitalized? (non-surgical) <i>If yes, please describe:</i> _____ 	__Yes	__No
<ul style="list-style-type: none"> • Ever had surgery? <i>If yes, please describe:</i> _____ 	__Yes	__No
<ul style="list-style-type: none"> • Ever required medical treatment at an Emergency Room/Hospital? <i>If yes, please describe:</i> _____ 	__Yes	__No
Does your child have any diet restrictions or special dietary needs? <i>If yes, please describe:</i> _____	__Yes	__No

Birth History

<i>Was your child...</i>		
<ul style="list-style-type: none"> • Born on time? 	__Yes	__No
<ul style="list-style-type: none"> • Born after their due date? 	__Yes	__No
<ul style="list-style-type: none"> • Born early (not premature)? 	__Yes	__No
<ul style="list-style-type: none"> • Born prematurely? 	__Yes	__No
<ul style="list-style-type: none"> • Born by cesarean section (C-Section)? 	__Yes	__No
Did you experience any pregnancy complications? <i>If yes, please describe:</i> _____	__Yes	__No

Did you experience any labor and/or delivery complications? <i>If yes, please describe:</i> _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did your child require time in the NICU after birth? <i>If yes, please describe:</i> _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did you or your child experience any other pregnancy or birth complications that we should be aware of? <i>If yes, please describe:</i> _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Health Review

<i>Does your child experience any of the following GENERAL symptoms?</i>		
• Nose/sinus problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Skin problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Throat problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Eye problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Head problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Ear problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Lungs/Breathing Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Gastrointestinal (GI) problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Nervous System/Neurological (brain) Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Heart problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Urinary tract problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Blood or metabolic problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<i>Does your child experience any of the following NOSE/SINUS symptoms?</i>		
• Itching/Sneezing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Drainage	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Change in sense of smell	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Congestion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Year-round symptoms	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Frequent sinus infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Nasal polyps	<input type="checkbox"/> Yes	<input type="checkbox"/> No

• Snoring	__Yes	__No
• Mouth breathing	__Yes	__No
Any other nose/sinus related symptoms we should know about? <i>If yes, please describe:</i> _____	__Yes	__No

<i>Does your child experience any of the following EAR symptoms?</i>		
• Itching	__Yes	__No
• Fullness/Popping	__Yes	__No
• Hearing problems	__Yes	__No
• Frequent ear infections	__Yes	__No
Has your child's hearing been tested before? <i>If yes, what were the results?</i> _____	__Yes	__No
Any other ear-related symptoms we should be aware of? <i>If yes, please describe:</i> _____	__Yes	__No

<i>Does your child experience any of the following THROAT symptoms?</i>		
• Itching	__Yes	__No
• Post-nasal drip	__Yes	__No
• Bad breath	__Yes	__No
• Soreness	__Yes	__No
• Throat clearing	__Yes	__No
• Tonsillitis/Strep throat/Throat infections	__Yes	__No
Any other throat-related symptoms we should be aware of? <i>If yes, please describe:</i> _____	__Yes	__No

<i>Does your child experience any of the following PULMONARY/RESPIRATORY symptoms?</i>		
• Frequent/chronic cough	__Yes	__No
• Shortness of breath	__Yes	__No
• Sputum (mucus) production	__Yes	__No
• Wheezing	__Yes	__No
• Chest tightness	__Yes	__No

• Bloody/blood streaked sputum (mucus)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Chronic bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any other lung/breathing related symptoms we should know about? <i>If yes, please describe:</i> _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<i>Does your child experience any of the following EYE symptoms?</i>		
• Itching/burning	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Frequent tearing/discharge	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Redness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Swelling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Eyelid irritation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Pain when exposed to bright light.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Farsightedness (difficulty seeing up close)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Myopia (difficulty seeing far distances)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any other eye-related symptoms we should be aware of? <i>If yes, please describe:</i> _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<i>Does your child experience any of the following SKIN symptoms?</i>		
• Rashes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Itching (skin)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Hives	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Swelling (skin)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Eczema	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any other skin-related symptoms we should be aware of? <i>If yes, please describe:</i> _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<i>Does your child experience any of the following GASTROINTESTINAL (GI) symptoms?</i>		
• Frequent nausea/vomiting	__Yes	__No
• Diarrhea	__Yes	__No
• Constipation	__Yes	__No
• Heartburn/acid reflux	__Yes	__No
• Abdominal pain	__Yes	__No
Any other gastrointestinal (GI) related symptoms we should know about? <i>If yes, please describe:</i> _____	__Yes	__No

<i>Does your child experience any of the following HEAD/NEUROLOGICAL symptoms?</i>		
• Frequent headaches	__Yes	__No
• History of concussion, head trauma, or brain injury	__Yes	__No
• Weakness/clumsiness	__Yes	__No
• Tingling/burning	__Yes	__No
• Delayed development	__Yes	__No
• Numbness	__Yes	__No
Any other head-related or neurological symptoms we should be aware of? <i>If yes, please describe:</i> _____	__Yes	__No

<i>Does your child experience any of the following URINARY TRACT symptoms?</i>		
• History of frequent bladder or urinary tract infections	__Yes	__No
• Frequent urination	__Yes	__No
• Trouble starting urine	__Yes	__No
Any other urinary tract-related symptoms that we should be aware of? <i>If yes, please describe:</i> _____	__Yes	__No

Mental Health		
<i>Has your child ever been diagnosed with or struggle with symptoms of...</i>		
• Autism Spectrum Disorder (ASD)	__Yes	__No
• Attention Deficit/Hyperactivity disorder (AD/HD)	__Yes	__No
• Obsessive-Compulsive Disorder (OCD)	__Yes	__No
• Learning Disability	__Yes	__No
• Global Developmental Delay	__Yes	__No
• Intellectual Disability/Cognitive Impairment	__Yes	__No
• Anxiety	__Yes	__No
• Depression	__Yes	__No
• Bipolar Disorder	__Yes	__No
• Sleeping issues	__Yes	__No
• Feeding or eating issues	__Yes	__No
Any other mental health symptoms or diagnosed conditions that we should be aware of? <i>If yes, please describe:</i> _____	__Yes	__No

Medications and Immunizations		
<i>Does your child regularly take...</i>		
• Prescription medication? <i>If yes, which medication(s)? Include name(s) and dosage:</i> _____	__Yes	__No
• Over-the-counter medications? <i>If yes, which medication(s)? Include name(s) and dosage:</i> _____	__Yes	__No
• Vitamins/supplements? <i>If yes, please provide a list of vitamins/supplements, including name and dosage.</i> _____	__Yes	__No
Are your child's immunizations up to date? <i>If not, explain why:</i> _____	__Yes	__No

Family Medical History		
<i>Do any of the following conditions run in your child's family?</i>		
• Nose/Sinus problems	__Yes	__No
• Skin problems	__Yes	__No
• Throat problems	__Yes	__No
• Eye problems	__Yes	__No
• Head problems	__Yes	__No
• Ear problems	__Yes	__No
• Lungs/Breathing Problems	__Yes	__No
• Gastrointestinal (GI) problems	__Yes	__No
• Muscle/bone problems	__Yes	__No
• Nervous System/Neurological (Brain) problems	__Yes	__No
• Heart problems	__Yes	__No
• Urinary tract problems	__Yes	__No
• Blood or metabolic problems	__Yes	__No
Any other conditions we should know about? <i>If yes, please describe:</i> _____	__Yes	__No

Developmental Milestones		
<i>When did your child reach the following milestones?</i>		
• Independent walking	___ years ___ months	
• Speaking in single words	___ years ___ months	
• Speaking in sentences	___ years ___ months	
• Daytime toilet trained	___ years ___ months	
• Night toilet trained	___ years ___ months	
Has your child ever experienced language or developmental regression (lost skills)?	__Yes	__No

Family Needs		
<i>Does your family...</i>		
<ul style="list-style-type: none"> • Speak a language other than English at home? 	__Yes	__No
<ul style="list-style-type: none"> • Have any legal issues/situations that may impact treatment (e.g. divorce, custody, child protective services, etc)? <i>If yes, please describe:</i> _____	__Yes	__No
<ul style="list-style-type: none"> • Have any spiritual or religious needs that may affect treatment? <i>If yes, please describe:</i> _____	__Yes	__No
<ul style="list-style-type: none"> • Have any cultural needs that may affect treatment? <i>If yes, please describe:</i> _____	__Yes	__No

School History		
<i>Does your child</i>		
<ul style="list-style-type: none"> • Attend school? 	__Yes	__No
<ul style="list-style-type: none"> • Have an Individualized Education Plan (IEP)? 	__Yes	__No

Parent/Guardian Questionnaire
To be filled out on behalf of minor/legal ward client

Child's Name: _____

Questionnaire Completed by: _____

Instructions:

*Please provide the following information as part of your child's ABA Skills Assessment. **Please answer each question to the best of your ability.** If you encounter any questions that are unclear or require assistance, please mark an X in the margin next to that question. Your clinician will review your responses with you during the ABA Skills Assessment and may ask follow-up questions to gain a better understanding of your child and family's needs.*

Family Information:

Parent/Guardian Name:	
Relationship to Child:	<input type="checkbox"/> Biological <input type="checkbox"/> Foster <input type="checkbox"/> Adoptive <input type="checkbox"/> Step <input type="checkbox"/> Caregiver <input type="checkbox"/> Other: _____
Home Phone:	
Cell Phone:	
Work Phone:	
Email:	
Parent/Guardian Name:	
Relationship to Child	<input type="checkbox"/> Biological <input type="checkbox"/> Foster <input type="checkbox"/> Adoptive <input type="checkbox"/> Step <input type="checkbox"/> Caregiver <input type="checkbox"/> Other: _____
Home Phone:	
Cell Phone:	
Work Phone:	
Email:	

Are your child's parents divorced, separated, or not married? YES NO

If yes:*

- Who is legally responsible for making medical decisions for your child? Joint Sole
 - If sole custody, please specify which parent:
- Are both parents in agreement about ABA services being sought through Apex Therapy Services?

YES NO

 - If no, please explain:

- Please describe your child’s current living arrangement, including visitation schedule (if applicable)

*** Please provide a copy of any formal custody arrangements or related legal documentation to your first appointment**

Does your child have any siblings? ___ YES ___ NO *If yes, please provide information below:*

Name of Sibling	Date of Birth	Age	Gender	Relationship to Child
				__ Biological __ Foster __ Adoptive __ Half __ Step __ Other: _____
				__ Biological __ Foster __ Adoptive __ Half __ Step __ Other: _____
				__ Biological __ Foster __ Adoptive __ Half __ Step __ Other: _____
				__ Biological __ Foster __ Adoptive __ Half __ Step __ Other: _____
				__ Biological __ Foster __ Adoptive __ Half __ Step __ Other: _____
				__ Biological __ Foster __ Adoptive __ Half __ Step __ Other: _____

Does anyone else live in your home? ___ YES ___ NO *If yes, please provide information below:*

Name of Individual	Age	Gender	Relationship to Child

Which language is primarily spoken within your home? ___ English ___ Other (specify): _____

Approximately what percent of the time is your child exposed to non-English languages? _____ %

Do you require or would like to request an interpreter? ___ YES ___ NO

Please describe any cultural and/or spiritual practices, rituals, traditions, or beliefs that you feel are important for us to understand before working with your family.

Are there any legal issues in your family that may impact your child's treatment? ___ YES ___ NO

If yes, please describe:*

** Please provide a copy of any relevant legal documents with you to your first appointment.*

Emergency Contact Information:

Name	
Relationship to Child	
Home Phone	
Cell Phone	
Work Phone	
Email Address	

Name	
Relationship to Child	
Home Phone	
Cell Phone	
Work Phone	
Email Address	

Hours of Availability

*Please mark the times your child is available for **1:1 ABA therapy**:*

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
8:00 AM							
8:30 AM							
9:00 AM							
9:30 AM							
10:00 AM							
10:30 AM							
11:00 AM							
11:30 AM							
12:00 PM							
12:30 PM							
1:00 PM							
1:30 PM							
2:00 PM							
2:30 PM							
3:00 PM							
3:30 PM							
4:00 PM							
4:30 PM							
5:00 PM							
5:30 PM							
6:00 PM							
6:30 PM							
7:00 PM							
7:30 PM							

Please mark the times your family is available for **Family/Caregiver meetings:**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
8:00 AM							
8:30 AM							
9:00 AM							
9:30 AM							
10:00 AM							
10:30 AM							
11:00 AM							
11:30 AM							
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5:00 PM							
5:30 PM							
6:00 PM							
6:30 PM							
7:00 PM							
7:30 PM							

Previous Evaluations/Assessments:

Has your child ever been assessed/evaluated by an Occupational Therapist, Speech and Language Therapist, Psychiatrist, Psychologist, Special Educator, or other professional? ___ YES ___ NO

If yes, please provide the following information:*

Name	
Type of Specialist	
Date of Evaluation	
Reason for Evaluation/Services	
Evaluation Results	

Name	
Type of Specialist	
Date of Evaluation	
Reason for Evaluation/Services	
Evaluation Results	

Name	
Type of Specialist	
Date of Evaluation	
Reason for Evaluation/Services	
Evaluation Results	

**Please provide a copy of any previous evaluations/assessments with you to your first appointment.*

Treatment History

Has your child previously received ABA therapy? YES NO

If yes:

Name of Agency/Center			
Dates Attended	From _____ until _____		
Average Number of Hours Per Week			
ABA Therapy Location (mark all that apply)	<input type="checkbox"/> Home-based <input type="checkbox"/> Clinic-based <input type="checkbox"/> Community-based		
If you recall, what were names of the BCBA(s)/ABA Supervisor(s) who oversaw your child's treatment?			
Did your child's BCBA/ABA supervisor offer parent/family training?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
If yes – how often did you meet 1:1 with your child's ABA supervisor?	_____ times per month		
Overall, how satisfied were you with your child's treatment?	Very satisfied	Satisfied	Neither satisfied nor dissatisfied
	Dissatisfied	Very dissatisfied	
Any other information that you would like us to know?			

Name of Agency/Center			
Dates Attended	From _____ until _____		
Average Number of Hours Per Week			
ABA Therapy Location (mark all that apply)	<input type="checkbox"/> Home-based <input type="checkbox"/> Clinic-based <input type="checkbox"/> Community-based		
Did your child's BCBA/ABA supervisor offer parent/family training?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
If yes – how often did you meet 1:1 with your child's ABA supervisor?	_____ times per month		
Overall, how satisfied were you with your child's treatment?	Very satisfied	Satisfied	Neither satisfied nor dissatisfied
	Dissatisfied	Very dissatisfied	
Any other information that you would like us to know?			

**Please provide any information you have regarding your child's prior ABA program(s) with you to your first appointment*

Does your child currently receive any other therapies (outside of school)? YES NO

If yes, which therapies?

- Speech Therapy
 Occupational Therapy
 Physical Therapy
 Psychotherapy
 Other (list): _____

Educational History:

Does your child currently enrolled in school or attend Early-On services?* YES NO

** Mark YES if your child attends school but is currently on break (e.g., winter, spring, or summer recess).*

If yes, please provide information below:

School Name	
School Address	
School Contact Information	Phone: Email:
Teacher's Name:	
Grade	
Type of Classroom:	
Therapies/Supports Provided at School	<input type="checkbox"/> Speech Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Social Work <input type="checkbox"/> Resource Room <input type="checkbox"/> Other: _____

Does your child currently have an Individualized Education Plan (IEP) or 504 Plan*?

YES NO

**If yes, please bring a copy of your child's current IEP or 504 Plan with you to your first appointment.*

What kind of programs, playgroups and schools has your child attended in the past?

School/Program Name	Type of Program	Dates Attended	Therapies/Supports Provided
		From _____ to _____	

Developmental Milestones and History:

Please fill out the following table regarding your child's development.

Developmental Milestone	Has Milestone been Met?	Approximate Age when First Occurred
Independent walking	__ YES __ NO	__ years __ months
Speaking in single words	__ YES __ NO	__ years __ months
Speaking in 2 word phrases	__ YES __ NO	__ years __ months
Speaking in 3 word sentences	__ YES __ NO	__ years __ months
Daytime Toilet Trained – Urine	__ YES __ NO	__ years __ months
Daytime Toilet Trained – Bowel	__ YES __ NO	__ years __ months
Nighttime Toilet Trained – Urine	__ YES __ NO	__ years __ months
Nighttime Toilet Trained – Bowel	__ YES __ NO	__ years __ months

At what age were you first concerned about your child's development or behavior?

__ years __ months

What did you notice?

Do you recall ever noticing your child may have lost language skills during the first years of life or a time where your child stopped speaking for some months after learning to talk? __ YES __ NO

If yes:

- **How old were they when they first began to lose language skills? __ years __ months**
- **How much language did they have before they began to lose it?**

- **Has your child regained the language that they previously lost? __ YES __ NO**
 - **If yes, at what age did your child's language begin to return? __ years __ months**

Did your child ever lose any other skills that they previously had? __ YES __ NO

If yes:

- **What skill(s) did they lose?**

- **Has your child regained the skill(s) that they previously lost? __ YES __ NO**
 - **If yes, at what age did the skill(s) begin to return? __ years __ months**

Current Strengths and Areas of Need:

Please indicate anything that your child's ABA team should know about when working with him/her/them.

Preferences/Interests:

Favorite Activities:
Favorite Foods/Drinks:
Favorite Interests/Topics:
Favorite Toys:
Any other favorites:

Dislikes/Aversions:

--

What types of foods does your child generally eat?

--

What types of foods does your child avoid?

--

Any other important information:

--

What are your child's top five (5) strengths?

1)
2)
3)
4)
5)

What are the top five (5) activities you like to do with your child?

“Activities” can include any time spent with your child - not just formal/structured time.

1)
2)
3)
4)
5)

How does your child communicate with you? (select all that apply)

<i>Vocalizations/Spoken Language</i>			
<input type="checkbox"/> Single words	<input type="checkbox"/> Phrase speech	<input type="checkbox"/> Sentences	<input type="checkbox"/> Non-word sounds/noises

<i>Sign Language</i>		
<input type="checkbox"/> Single words	<input type="checkbox"/> Phrase speech	<input type="checkbox"/> Sentences

<i>Alternative and Augmentative Communication (AAC) Device</i>		
<input type="checkbox"/> Picture Board/Core Board	<input type="checkbox"/> PECS book/Picture Exchange	<input type="checkbox"/> Electronic AAC device
<input type="checkbox"/> Other: _____		

<i>Non-Verbal Behavior</i>			
<input type="checkbox"/> Points to desired items	<input type="checkbox"/> Nodding/Shaking head	<input type="checkbox"/> Gestures	<input type="checkbox"/> Facial Expressions/Body Language
<input type="checkbox"/> Uses someone’s hand/arm as a tool (e.g. Places hand on refrigerator door to request food/drink, Places hand on doorknob to request to go outside)			
<input type="checkbox"/> Other: _____			

How does your child communicate with others? (select all that apply)

<i>Vocalizations/Spoken Language</i>			
<input type="checkbox"/> Single words	<input type="checkbox"/> Phrase speech	<input type="checkbox"/> Sentences	<input type="checkbox"/> Non-word sounds/noises

<i>Sign Language</i>		
<input type="checkbox"/> Single words	<input type="checkbox"/> Phrase speech	<input type="checkbox"/> Sentences

<i>Alternative and Augmentative Communication (AAC) Device</i>		
<input type="checkbox"/> Picture Board/Core Board	<input type="checkbox"/> PECS book/Picture Exchange	<input type="checkbox"/> Electronic AAC device
<input type="checkbox"/> Other: _____		

Non-Verbal Behavior

Points to desired items Nodding/Shaking head Gestures Facial Expressions/Body Language

Uses someone's hand/arm as a tool (e.g. Places hand on refrigerator door to request food/drink, Places hand on doorknob to request to go outside)

Other: _____

Please describe/explain your primary reason for seeking ABA services for your child.

Do you have any concerns regarding your child's:

Cognitive Functioning/Learning <input type="checkbox"/> YES <input type="checkbox"/> NO	<i>If yes, describe/explain:</i>
Motor Skills <input type="checkbox"/> YES <input type="checkbox"/> NO	<i>If yes, describe/explain</i>
Behavior <input type="checkbox"/> YES <input type="checkbox"/> NO	<i>If yes, describe/explain</i>
Language/Communication <input type="checkbox"/> YES <input type="checkbox"/> NO	<i>If yes, describe/explain</i>
Social Skills <input type="checkbox"/> YES <input type="checkbox"/> NO	<i>If yes, describe/explain</i>
Peer Interactions <input type="checkbox"/> YES <input type="checkbox"/> NO	<i>If yes, describe/explain</i>
Play and Leisure Skills <input type="checkbox"/> YES <input type="checkbox"/> NO	<i>If yes, describe/explain</i>
Self-Help Skills/Activities of Daily Living (dressing, toileting, feeding, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO	<i>If yes, describe/explain</i>

Please list the top five (5) areas or goals you would like your child to work on in ABA therapy over the next six (6) months of treatment:

1)
2)
3)
4)
5)

Client Home Safety Checklist

Animals/Pets		
Does your family have any pets?	__ Yes	__ No
<i>If yes:</i>		
• Do any of the pets live indoors?	__ Yes	__ No
• Do any of the pets live outdoors (do not come into the house)?	__ Yes	__ No
• Do any of your pets have a history of jumping or biting?	__ Yes	__ No
Is anyone in your family allergic to animals? (dander, saliva, fur, etc.)	__ Yes	__ No

Designated Therapy Area		
Do you have an area within the home designated for ABA therapy?	__ Yes	__ No
<i>If yes:</i>		
• Will the designated ABA therapy area be occupied or shared by other family members while therapy is in session?	__ Yes	__ No
• Is the path to the designated ABA therapy location free of clutter or potential hazards?	__ Yes	__ No
• Is there a walkout exit (door leading to outside)?	__ Yes	__ No
Do you have a bathroom that your ABA team can use during therapy?	__ Yes	__ No
Is your home smoke-free?	__ Yes	__ No
Does your home have air conditioning?	__ Yes	__ No
Are you able to keep the indoor/room temperature of your home between 65 and 80 F during ABA sessions?	__ Yes	__ No
Are there areas of the home that are "off-limits" for ABA therapy? <i>If yes, please indicate:</i>	__ Yes	__ No
Are there any indoor areas of the home that may be potentially dangerous (hole in wall/floor, broken staircase, home construction in progress, etc.)? <i>If yes, please indicate:</i>	__ Yes	__ No
Are there any other indoor safety concerns we should be aware of? <i>If yes, describe:</i>	__ Yes	__ No

Parking and Outdoor Security		
Do you have parking readily available for your ABA team?	__Yes	__No
<i>If yes:</i>		
• Can your ABA team park in the driveway?	__Yes	__No
• Is street parking readily available?	__Yes	__No
○ <i>If yes:</i> Is there an alternative place to park when street parking is unavailable (garbage day, snow emergencies, etc.)?	__Yes	__No
Does your home have a parking lot?	__Yes	__No
• <i>If yes:</i> Does the parking lot have reserved space or a specified area for guests?	__Yes	__No
Is your home (driveway and sidewalk) and street adequately cleared of snow and ice during winter months?	__Yes	__No
Does your neighborhood have adequate outdoor lighting when arriving and leaving session?	__Yes	__No
Does your home have access to a backyard, courtyard, park, or similar outdoor area?	__Yes	__No
• <i>If yes:</i> Will this outdoor area be available for use during ABA therapy?	__Yes	__No
Does your home have access to a large body of water (pool, hot tub, lake, pond, river, etc.)?	__Yes	__No
• <i>If yes:</i> Is there a fence and/or gate surrounding the large body of water to restrict access and maintain safety?	__Yes	__No
Are there outdoor areas near the house that could be potentially dangerous (hole in the ground, outdoor construction, barbed wire fence, etc.)?	__Yes	__No
<i>If yes, describe:</i>		
Are there any other outdoor safety concerns we should be aware of?	__Yes	__No
<i>If yes, describe:</i>		

Safety and Emergency Preparedness		
Are there firearms and/or guns in the home? • <i>If yes:</i> Are these items stored in a gun safe or locked up?	__ Yes __ Yes	__ No __ No
<i>Does your house have...</i>		
• Working smoke detectors? ○ <i>If yes:</i> Is there at least one working smoke detector on each level of your home?	__ Yes __ Yes	__ No __ No
• Working carbon monoxide detectors? ○ <i>If yes:</i> Is there at least one working carbon monoxide detector on each level of your home?	__ Yes __ Yes	__ No __ No
• A working fire extinguisher? ○ <i>If yes:</i> Where is it located?	__ Yes	__ No
Does your family have a designated outdoor gathering place in the event of a fire, natural gas leak, chemical exposure, or similar event? <i>If yes, describe:</i>	__ Yes	__ No

Resources and Materials		
<i>Do you have...</i>		
• A table and chairs available for use during therapy?	__ Yes	__ No
• An area within the home to securely store ABA materials?	__ Yes	__ No
• Highly preferred toys, snacks, and/or other "favorite" items that can be offered during ABA therapy?	__ Yes	__ No
• Wi-Fi/Internet that can be used by your ABA team during therapy?	__ Yes	__ No

Family Needs and Preferences		
Would you like your ABA team to remove their shoes when indoors?	__ Yes	__ No
Are there any allergies or chronic medical conditions in the household that we should be aware of? <i>If yes, describe:</i>	__ Yes	__ No
Are there any specific foods that the ABA team should not bring into the home? <i>If yes, describe:</i>	__ Yes	__ No
Are there any other family needs or preferences we should know about? <i>If yes, describe:</i>	__ Yes	__ No