

**New Patient ABA Intake Form**

**This is the intake paper work for Empowering Choices Counseling & Consultation. We understand that this is a long packet and that some of our questions are in-depth, and we understand, we may, at times, ask for personal information, but it is intended to be an all-inclusive look at you as a person. Our intent is to collect as much information as we can about you, in order to provide the best counseling services we can for you. If there are questions that you do not feel comfortable answering or would rather talk with your counselor about, please mark “Will talk to my counselor about”. As there are several parts to this paperwork (some portions for adults, some for children, some for adolescents, and others for guardians/care providers/foster parents), you may find that you do not need to fill out everything. Several of the sections are marked, “Adults” “children” or “adolescents”. Please return the paper work to your counselor on your initial session.**

Client Name: Social Security No.

|  |  |  |
| --- | --- | --- |
| Today’s Date: |  | Date of Birth: |
| Age: | Gender: | Street Address: |
| City: | State: | Zip Code: |
| Phone(Home): |  | (Cell): |
| May we leave messages for you? | Home: Yes  No | On Cell: Yes  No |
| Preferred Contact E-Mail Address in relationship to client: |  |  |
| Emergency Contact Name: |  | Relationship: |
| Emergency Contact Phone Number: |  |  |
| How did you hear about us? |  |  |

May we contact mail correspondence at the above address? Yes  No

Initial here: Click or tap here to enter text.

May we contact you by E-mail? Yes  No  Initial here:

Initial here Click or tap here to enter text. if you authorize receiving information and correspondence via text message

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Person #2/Legal Guardian:

**Full Name:** Click or tap here to enter text.

**Address:** Click or tap here to enter text. City: Click or tap here to enter text. **Zip:** Click or tap here to enter text.

Ok, to mail correspondence to this address? Yes  No

Home Phone: Click or tap here to enter text. Ok, to Contact and leave message? Yes  No

Work Phone: Click or tap here to enter text. Ok, to Contact and leave message? Yes  No

Cell Phone: Click or tap here to enter text. Ok, to Contact and leave message? Yes  No

E-Mail: Click or tap here to enter text. Ok, to Contact and leave message? Yes  No

Age: Click or tap here to enter text.

Marital Status: Click or tap here to enter text. Occupation: Click or tap here to enter text.

Employer: Click or tap here to enter text.

Names/Ages of Children: Click or tap here to enter text.

Church Affiliation: Click or tap here to enter text.

Primary Physician: Click or tap here to enter text.

Previous Counselor(s): Click or tap here to enter text.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Type of Service** | **Indicial visit cost** | **Cost per session** | **Number of Sessions** | **Other services cost** |
| **COMMUNITY COUNSELING** |  |  |  |  |
| Mental Health Assessment | $300 for assessement |  |  |  |
| Individual therapy | $140.00 per hour/sliding scale | $100 per hour/or sliding scale |  |  |
| Family Therapy | $140 per hour/ sliding scale | $100 per hour/or sliding scale |  |  |
| Group Therapy |  | $50 per hour |  |  |
| Classes |  | $65 per series |  |  |
| Work shops |  | Varied |  |  |
| Seminars |  | Varied |  |  |
| Consultation | $100.00 per hour/sliding scale | $100 per hour/or sliding scale |  |  |
| NSF Check Fee –Returned Checks | $30.00 each |  |  |  |
| Phone calls |  |  |  | $25 per quarter hour |
| Letters/Reports  (Includes Pet Letters) |  |  |  | $50 per page |

The following statement expresses the current policies and procedures of this office. Please read it carefully and, if you have any questions, ask your counselor for additional information or clarification.

# **Your health record contains personal information about you and that information about you may identify you as it relates to your past, present, or future physical and/or mental health and/or condition and related health care services is commonly referred to as: Protected Health Information (PHI). This Notice of Privacy Practices describes how Empowering Choices counseling and Consultation (ECCC) may use and disclose your PHI in accordance with state and federal law which includes the Health Insurance Portability and Accountability Act (HIPAA) regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules. It also describes your rights regarding how you may gain access to and control your PHI.**

# **Our Obligations:**

# **ECCC is required by State and Federal law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. ECCC is required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practice will be effective for all PHI that we maintain at that time. ECCC will provide you with a copy of the revised Notice of Privacy by posting a copy on our website, sending a copy to you in the mail up request or providing one to you at your next appointment.**

**Uses and Disclosure. ECCC may use and disclose protected health information without your consent in the following ways:**

**Child Abuse or Neglect**

**Judicial and Administrative Proceedings**

**Deceased Patients (with your prior signed consent)**

**Medical Emergencies**

**To those you give consent too. Such as: friends and family also involved in your treatment.**

**Law Enforcement (But only absolutely necessary information to the emergency)**

**Health Oversight Agencies**

**Public Health (preventing, treating, or controlling diseases)**

**Public Safety**

**Verbal Permission (once you have given it and to be followed by a signed release)**

**Other members of our clinic team for consultation**

# **Professional Ethics and Accountability.** Empowering Choices Counseling and Consultation is a community of clinicians with a mission to provide compassionate and competent counseling services to children, adolescents, individuals, couples, and families. We are a group of professionals, most of which are preliscensed professionals, who practice according to the state board Code of Ethics. We encourage you to ask any further questions concerning our academic preparation, counselor training, professional credentials, theoretical orientations, case consultation, clinical supervision, or continuing education.

**Treatment Risks and Alternatives.** Please be informed that there are risks involved in the counseling process. For example, some people experience an increase in stress, especially during the early stages of treatment. In some cases, a discussion of long-standing unresolved issues can seem to aggravate rather than alleviate a problem. These are natural occurrences of which you need to be aware. While we cannot guarantee the success of our outcomes, we nonetheless intend and attempt to provide you with the highest possible quality of care. If we determine we cannot provide treatment to meet your personal or particular needs, your counselor will inform you at the earliest opportunity and assist you in finding more appropriate services.

In addition to providing direct services, Empowering Choices Counseling and Consultation offers clinical training, experience, and supervision to post-graduate residents pursuing their professional credentials. Occasionally, these counselors will require recordings of their clinical work with clients to serve their educational needs. Accordingly, your counselor may ask your permission to record a session. Please allow your personal discretion to inform your consent. If you feel hesitant to give permission, speak with your counselor about your reluctance, or simply say “I would rather not.” Recordings are subject to our strict policy of confidentiality, are used exclusively to assist supervisors in helping counselors to develop their clinical skills, and are destroyed immediately following their use in supervision.

**Legal Issues and Proceedings.** Our mission includes helping children, adolescents, individuals, couples, and families resolve their psychological, spiritual and relationship conflicts through the counseling process; rather, than providing them advocacy, evaluation or testimony in the judicial system. Clients who consent to treatment with us agree not to involve our counselors in their legal proceedings. If you need a forensic assessment or a clinician who will testify in court, we will attempt to assist you in finding a provider who offers those services.

**Office Hours.** Office hours are by appointment only. Appointments are forty-five (50) minute sessions and begin promptly at the appointed time.

**Initial Sessions.** Your first appointment will be fifty (50) minute session with one of our counselors. The counselor will review the information you shared when you called for your appointment, listen to your concerns and assess your needs, answer any of your questions, and plan with you how to proceed. You may decide mutually to work together, be referred to another clinician at Empowering Choices Counseling and Consultation, or be referred to another person or agency in the community for appropriate assistance.

**Fees**. The standard fee for service at Empowering Choices Counseling and Consultation is $100.00 per session. If you need an adjusted fee based on your ability to pay, please ask your counselor for a copy of the Fee Adjustment Scale.

**Payment Policy.** Our policy is to receive payment in full at each session. Please make checks payable to “ECCC” (i.e., Empowering Choices Counseling and Consultation).

**Insurance.** Although our clinic does is not set up directly with insurance companies, a large number of insurance companies will work with what is referred to as: **Out of Network Providers** on several different levels. On our website, under “payments” we explain how to talk to your insurance company to see if they will allow us to bill them for our services. Some insurance plans do reimbursements. Please check with your insurance company prior to your appointment. We will be happy to do what we can in talking with your insurance company; however, you are responsible for keeping current with payments.

**Cancellation Policy.** Our policy is to charge your regular fee for all cancellations and missed sessions that are under 24 hours except in the case of occasional emergences.

**Telephone Calls.** See table at the beginning of this paperwork or on the website under “payments”**.**

**Emergency Procedures.** Empowering Choices Counseling and Consultation is not a crisis response facility. **In the event of an emergency—defined here as an imminent danger to yourself, others or both—please call 9-1-1 for immediate assistance.**

**Support Services.** All functions concerning billing and payment, insurance reimbursement, case documentation, and other support services are provided with the same concern for professionalism and quality. In order to protect your confidentiality, a written authorization will be required for the release of information. A service fee may be charged for duplication, summarization, and other document preparation. Many of our prices are listed on the table at the beginning of this paperwork or on our relationship under “payments”. Please direct any questions about any other services you do not see listed to your counselor. ECCC does not provide general case management, medication management, and or housing; however, our counselors do have access to other community resources and/or agencies which do provide those services.

**Consent to Treatment.** I have read the above information about which I have had the opportunity to ask questions. I understand the limits of confidentiality and the risks associated with counseling. If there are children involved in counseling, I hereby consent to their treatment and affirm I am the legal guardian with the authority to consent to their treatment. I agree to the payment and billing policies outlined above and accept full responsibility for any and all fees charged for counseling sessions, cancellations, or missed appointments. I consent to participate in counseling and understand that I may decline services at any time. I am aware that my counselor may consult periodically on client issues with other clinicians at Empowering Choices Counseling and Consultation, with clinical supervisors, or both. My signature below indicates that I have read, understand, and agree to accept the policies outlined on both sides of this document, and have received a copy of these policies for further reference.

I agree to pay the standard fee of $100. **OR**  I need an adjusted fee based on my ability to pay.

I have received a copy of Empowering Choices Counseling & Consultation for Protecting Client Privacy (HIPAA).

|  |  |  |  |
| --- | --- | --- | --- |
| Client Signature: |  | Date: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Client Signature: |  | Date: |  |

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**Empowering Choices Counseling & Consultation Authorization for Insurance Billing**

Counselor: Click or tap here to enter text.Client: Click or tap here to enter text.

Please check with your insurance company (there are tips on our web site) prior to receiving services to answer the following questions:

Deductible Amount: Click or tap here to enter text.

How much of your deductible have you met for the current year? Click or tap here to enter text.

Co-Pay Amount: Click or tap here to enter text.

Does your insurance require pre-authorization?: Click or tap here to enter text.

Anniversary date of Coverage: Click or tap here to enter text.

Copy of insurance card has been provided: Click or tap here to enter text.

**(Fill out the following ONLY if copy of card was NOT provided)**

**Primary Insurance**:Click or tap here to enter text. ID#:Click or tap here to enter text.

Group#:Click or tap here to enter text.

Subscriber (Name on policy): Click or tap here to enter text. DOB:

Employer Click or tap here to enter text.

**Secondary Insurance:** Click or tap here to enter text. ID#: Click or tap here to enter text.

Group#: Click or tap here to enter text.

Subscriber (Name on policy): Click or tap here to enter text. DOB: Click or tap here to enter text.

Employer: Click or tap here to enter text.

I authorize that the above information is accurate and true to the best of my knowledge. I authorize my insurance company to pay Empowering Choices Counseling & Consultation directly for services rendered according to my mental health coverage. I authorize Empowering Choices Counseling & Consultation to provide all information my insurance company(ies) request(s) concerning my treatment. I understand that I am responsible for pre-authorization or doctor’s referral if required. I understand that I am financially responsible for services performed whether or not paid by insurance. I understand that any money received in excess of my charges will be refunded when my bill is paid in full. I understand I am responsible for full payment for any missed sessions, or sessions canceled without 24 hour notice.

Signature of client or responsible party: Click or tap here to enter text.

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Section II

Personal, Family, and Relationship Information

|  |
| --- |
| Does either parent’s job require him/her to be away from home long hours or extended periods? Click or tap here to enter text. |

Are parents:  married  divorced  separated? If divorced, what is the custody arrangement of children? Click or tap here to enter text.

If divorced, how long have the biological parents been divorced? Click or tap here to enter text.

Please list the name(s) of the stepparents: Click or tap here to enter text.

Is there a birth parent living outside the home:  MOTHER  FATHER

Name: Click or tap here to enter text. Where do they live?Click or tap here to enter text.

If birth parent(s) do not live in the child’s home, how much contact does the child have with the parent not having custody, with stepsiblings, etc.?

Click or tap here to enter text.

SIBLINGS

|  |  |
| --- | --- |
| Name: Click or tap here to enter text. Age: Click or tap here to enter text. | DOB: Click or tap here to enter text. Grade: Click or tap here to enter text. |
| Name: Click or tap here to enter text. Age: Click or tap here to enter text. | DOB: Click or tap here to enter text. Grade: Click or tap here to enter text. |
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| Name: Click or tap here to enter text. Age: Click or tap here to enter text. | DOB: Click or tap here to enter text. Grade: Click or tap here to enter text. |

Please indicate any special needs or concerns regarding the other children living in your home:

Click or tap here to enter text.

Please indicate any concerns you have regarding the child for whom you are seeking services and these siblings’ relationship(s):

Click or tap here to enter text.

Others: List any other people who currently live in your home?

Name Age Relationship to Child Years Living in Home

1. From To

Name Age Relationship to Child Years Living in Home

1. From To

Name Age Relationship to Child Years Living in Home

1. From To

Name Age Relationship to Child Years Living in Home

1. From To

Name Age Relationship to Child Years Living in Home

1. From To

Are there any other people who have a significant role on how this child is raised?

Click or tap here to enter text.

FAMILY PSYCHOLOGICAL HISTORY:

Is there a history in your immediate or in the mother’s or father’s extended family, of the following, and if so who?

**Yes NO Who**

Autism Spectrum Disorder Click or tap here to enter text.

Learning Problem/Disabilities Click or tap here to enter text.

ADHD - ADD - Attention Problems Click or tap here to enter text.

Depression OR Bipolar Disorder Click or tap here to enter text.

Behavior Problems in School Click or tap here to enter text.

Anxiety Disorders (OCD, Phobias, etc.) Click or tap here to enter text.

Mental Retardation Click or tap here to enter text.

Psychosis/Schizophrenia Click or tap here to enter text.

Substance Abuse/Dependence Click or tap here to enter text.

Other Mental Health Concerns Click or tap here to enter text.

MEDICAL INFORMATION

PREGNANCY, DELIVERY AND FIRST YEAR:

|  |  |
| --- | --- |
| Were there any complications with your pregnancy or delivery? If so, please explain. | Click or tap here to enter text. |
| Did your child experience any illnesses during his or her first year? If so, please list the illnesses and how each was treated. | Click or tap here to enter text. |

PSYCHOLOCICAL HISTORY:

Has the individual had a psychological evaluation? Yes  No

If yes, please list the following information on the previous evaluation(s).

Who When Copy Available

1. Click or tap here to enter text.Click or tap here to enter text. Y  N
2. Click or tap here to enter text.Click or tap here to enter text. Y  N
3. Click or tap here to enter text.Click or tap here to enter text. Y  N
4. Click or tap here to enter text.Click or tap here to enter text. Y  N
5. Click or tap here to enter text.Click or tap here to enter text. Y  N
6. Click or tap here to enter text.Click or tap here to enter text. Y  N

If yes, what were their general findings, recommendations and treatment?

Click or tap here to enter text.

Please provide us with any other information from the other providers that you feel would be helpful to us in understanding your child: Click or tap here to enter text.

DEVELOPMENTAL HISTORY:

1. Please indicate the age at which your child did the following:

Rolled Over consistently Click or tap here to enter text.

Sat up unsupported Click or tap here to enter text.

Stood Click or tap here to enter text.

Crawled Click or tap here to enter text.

Walked Unassisted Click or tap here to enter text.

Said 1st Word Intelligible to strangers Click or tap here to enter text.

Said two-three word phrases Click or tap here to enter text.

Used Sentences regularly Click or tap here to enter text.

Toilet trained during the day Click or tap here to enter text.

Dry through the night (6+ months) Click or tap here to enter text.

Dressed Self Click or tap here to enter text.

2. Please indicate if your child is experiencing any of the following:

Problems with eating Click or tap here to enter text.

Isolated socially from peers Click or tap here to enter text.

Problems making friends Click or tap here to enter text.

Problems keeping friends Click or tap here to enter text.

Problems getting to sleep Click or tap here to enter text.

Problems controlling temper Click or tap here to enter text.

Problems sleeping through the night Click or tap here to enter text.

Trouble waking up Click or tap here to enter text.

Fatigue/tiredness during the day Click or tap here to enter text.

Nightmares Click or tap here to enter text.

Bed wetting Click or tap here to enter text.

Soiling Click or tap here to enter text.

Problems with authority Click or tap here to enter text.

Anxiety Click or tap here to enter text.

Unmotivated Click or tap here to enter text.

Stress from conflict between parents Click or tap here to enter text.

Legal situation (anyone in the family) Click or tap here to enter text.

History of abuse Click or tap here to enter text.

Alcohol/drug use/abuse Click or tap here to enter text.

School concentration difficulties Click or tap here to enter text.

Grades dropping or consistently low Click or tap here to enter text.

Sadness or Depression Click or tap here to enter text.

1. List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other special conditions your child has had.

Click or tap here to enter text.

1. Child’s current height:Click or tap here to enter text. Ft. Click or tap here to enter text.Inches Weight: Click or tap here to enter text.Lbs.

1. With which hand does the child write? Click or tap here to enter text.

1. Does the individual have any vision problems? Click or tap here to enter text.

Please list date of last vision test and who performed (pediatrician, optometrist & school)

Click or tap here to enter text.

1. Does the child have any hearing problems?: Click or tap here to enter text.

Please list date of last hearing test and who performed (pediatrician, audiologist & school)

Click or tap here to enter text.

1. Name of child’s primary physician(s): Click or tap here to enter text.

Practice Name: Click or tap here to enter text.

Address:

Click or tap here to enter text.

Phone Number:Click or tap here to enter text. Fax Number: Click or tap here to enter text.

Please list any additional Physicians and/or specialists who you believe would be helpful for us to have additional records from: Click or tap here to enter text.

EDUCATIONAL HISTORY:

1. List in chronological order all schools your child has attended:

Name System Year(s) Grade Special Ed?

• Click or tap here to enter text.

• Click or tap here to enter text.

• Click or tap here to enter text.

• Click or tap here to enter text.

• Click or tap here to enter text.

1. Name(s) of current teacher(s): Click or tap here to enter text.

1. Does your child’s teacher have concerns about him/her (list):

Click or tap here to enter text.

1. What is your child’s favorite subject/class?

Click or tap here to enter text.

1. What is your child’s least preferred subject/class?: Click or tap here to enter text.

1. Has your child ever repeated a grade? Y/N If yes, what grade(s)? Click or tap here to enter text.

1. If your child has been in Special Education, did they have a:

504 Plan  I.E.P.

Psychological Evaluation  Speech Evaluation

Behavior Intervention Plan  Occupational Therapy Evaluation

Physical Therapy Evaluation Adaptive Technology Evaluation Other(s):

Click or tap here to enter text.

1. If your child has been in Special Education, how were they served?

Consultation  Resource Classroom

Collaborative Education  Team Taught Classes

Pull-Out  Self-Contained Classroom

Special Program Psychoeducational Center

1. Child’s extracurricular activities, including sports, clubs, hobbies, lessons, etc.:

Football  Karate  Dance (type) Click or tap here to enter text.

Baseball  Piano  Music (type) Click or tap here to enter text.

Cheerleading  Scouts  Gymnastics (type) Click or tap here to enter text.

Basketball  Soccer  other(s): Click or tap here to enter text.

1. List any special abilities, skills and strengths your child has:

Click or tap here to enter text.

DISCIPLINE INFORMATION:

Below is a wide range of discipline strategies that are frequently used. Please rate how likely you are to use each of the strategies listed:

Intervention Very Unlikely Sometimes Very Likely Effectiveness

Let situation go 1  2 3 Click or tap here to enter text.

Take away a privilege 1  2 3 Click or tap here to enter text.

Assign additional chore 1  2 3 Click or tap here to enter text.

Take away object/toy 1  2 3 Click or tap here to enter text.

Send to room 1  2 3 Click or tap here to enter text.

Physical punishment 1  2 3 Click or tap here to enter text.

Reason with child 1  2 3 Click or tap here to enter text.

Ground child 1  2 3 Click or tap here to enter text.

Yell at child 1  2 3 Click or tap here to enter text.

Send to time out 1  2 3 Click or tap here to enter text.

List anything else you may do:

Click or tap here to enter text. 1  2 3 Click or tap here to enter text.

Click or tap here to enter text. 1  2 3 Click or tap here to enter text.

Click or tap here to enter text. 1  2 3 Click or tap here to enter text.

Go back and rate the THREE MOST effective strategies. That is, place a 1 by the most effective, a 2 by the next most effective, and a 3 by the third most effective. Please circle the LEAST effective. Please rate what percentage of discipline is handled by each of the following:

Father: Click or tap here to enter text.% Mother:Click or tap here to enter text.%

Other:Click or tap here to enter text. % (Please specify):Click or tap here to enter text.

Comments: Click or tap here to enter text.

GENERAL INFORMATION:

Please list the five things you would like for your child to do more of and less of in order of priority to you. For example, instead of saying, “I want my child to be more responsible,” translate that into actual behaviors such as do household chores, care for brothers and sisters, etc.

Like Child to do More Often Like Child to do Less Often

1. Click or tap here to enter text. Click or tap here to enter text.
2. Click or tap here to enter text. Click or tap here to enter text.
3. Click or tap here to enter text. Click or tap here to enter text.
4. Click or tap here to enter text. Click or tap here to enter text.
5. Click or tap here to enter text. Click or tap here to enter text.

MEDICATIONS:

|  |  |  |
| --- | --- | --- |
| Please list any medications that your child is currently taking: | | |
| Medication Name | Dosage | Length of Time Taken |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Please list any supplements, vitamins, etc. that your child is currently taking: | | |
| Medication Name | Dosage | Length of Time Taken |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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PYSCHOLOGICAL/MEDICAL TESTING:

|  |  |  |
| --- | --- | --- |
| Please list any psychological/medical testing that your child has completed: | | : |
| Test Name | Month/Year | Results |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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CURRENT MEDICAL COND

ITIONS

Pleas

e list any medical

diagnosis:

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

Cerebral Palsy  Autism/PDD  ADHD  Aspersers

Hyperactivity  ADD  Physical/Speech Delay

Vision/Hearing  ODD (Noncompliance)  Other:

Please list any current

allergies that your child

may have:

Please list any special

nutritional needs:

Are im

immunizations up to

date? Attach a copy of the

child

’

s immunization

records:

CURRENT TREATING PHYSICIANS

|  |  |
| --- | --- |
| Doctor’s Name: Click or tap here to enter text. | Doctor’s Name: Click or tap here to enter text. |
| Specialty: Click or tap here to enter text. | Specialty: Click or tap here to enter text. |
| Address: Click or tap here to enter text. | Address: Click or tap here to enter text. |
| Phone Number: Click or tap here to enter text. | Phone Number: Click or tap here to enter text. |

Patient Information

Please state your child’s behaviors of concern:

Click or tap here to enter text.

Please state the expectation/goals that you have for child while engaging in a behavioral program:

Click or tap here to enter text.

Please list any other information that may be helpful while assessing and/or conducting therapy with your child:

Click or tap here to enter text.

Please describe the problems your child is now having and what type of services you are seeking from us to address these problems. Please use back of this sheet for addition space.

Click or tap here to enter text.

SKILLS ASSESSMENT LANGUAGE:

|  |  |  |
| --- | --- | --- |
| Does your child: |  | Comments |
| Match objects or pictures? | yes  no | Click or tap here to enter text. |
| Imitate actions of others? | yes  no | Click or tap here to enter text. |
| Follow directions without visual cues? | yes  no | Click or tap here to enter text. |
| Indicate his/her needs or wants? | yes  no | Check one:  words  pictures  gestures |

|  |  |  |
| --- | --- | --- |
| Imitate sounds or words when modeled? | yes  no | Click or tap here to enter text. |
| Use words to ask for things? | yes  no | Click or tap here to enter text. |
| Label items he or she sees or hears? | yes  no | Click or tap here to enter text. |
| Answer questions? | yes  no | Click or tap here to enter text. |
| Speak in sentences? (if no, skip remaining questions) | yes  no | If yes, average length? 3 5 8+ words  Click or tap here to enter text. |
| Participate in conversations? | yes  no | Click or tap here to enter text. |
| What are your principal concerns regarding your child’s language? |  | Click or tap here to enter text. |

PLAY SKILLS

|  |  |  |
| --- | --- | --- |
| Does your child: |  | Comments |
| Look at books? | yes  no | Click or tap here to enter text. |
| Play with cause/effect toys (i.e.: Jack in the Box)? | yes  no | Click or tap here to enter text. |
| Complete task completion toys (i.e.: puzzles, beads)? | yes  no | Click or tap here to enter text. |
| Play with toys by using them like real items (i.e. uses a play spoon to pretend to eat)? | yes  no | Click or tap here to enter text. |
| Play simple games like ring around the rosy? | yes  no | Click or tap here to enter text. |
| Construct items using blocks, legos, or other items? | yes  no | Click or tap here to enter text. |
| Play games with rules (i.e.; memory)? | yes  no | Click or tap here to enter text. |
| Engage in dress up or role play (i.e.; pretending to be a barber?) | yes  no | Click or tap here to enter text. |
| Play appropriately on his or her own for up to 5 minutes? | yes  no | Click or tap here to enter text. |
| What are your principal concerns regarding your child’s play skills? |  | Click or tap here to enter text. |

SOCIAL SKILLS

|  |  |  |
| --- | --- | --- |
| Does your child: |  | Comments |
| Respond to his or her name by looking at you? | yes  no | Click or tap here to enter text. |
| Make eye contact when speaking to you? | yes  no | Click or tap here to enter text. |
| Greet you when you arrive home? | yes  no | Click or tap here to enter text. |
| Respond to others emotions? | yes  no | Click or tap here to enter text. |
| Attempt to involve you in something that he/she is doing to share interest (not b/c he or she needs your help)? | yes  no | Click or tap here to enter text. |
| Observe other children playing? | yes  no | Click or tap here to enter text. |
| Join in with other children when they are playing? | yes  no | Click or tap here to enter text. |
| Take turns in games? | yes  no | Click or tap here to enter text. |
| Verbally interact with peers? | yes  no | Click or tap here to enter text. |
| What are your principal concerns regarding your child’s social skills? |  | Click or tap here to enter text. |

SELF HELP SKILLS

|  |  |  |
| --- | --- | --- |
| Does your child: |  | Comments |
| Sleep through the night? | yes  no | Click or tap here to enter text. |
| Sleep in his/her own bed without supervision? | yes  no | Click or tap here to enter text. |
| Drink from a cup? | yes  no | Click or tap here to enter text. |
| Eat a variety of foods (i.e. fruits, veggies, meats, grains)? | yes  no | Click or tap here to enter text. |
| Use a spoon and a fork to feed himself or herself? | yes  no | Click or tap here to enter text. |
| Remove pull-down garments independently? | yes  no | Click or tap here to enter text. |
| Remove socks and shoes independently? | yes  no | Click or tap here to enter text. |
| Remove shirts independently? | yes  no | Click or tap here to enter text. |
| Put on pull-up garments independently? | yes  no | Click or tap here to enter text. |
| Put on socks and shoes Independently? | yes  no | Click or tap here to enter text. |
| Put on shirts Independently? | yes  no | Click or tap here to enter text. |
| Use the toilet independently? | yes  no | Click or tap here to enter text. |
| What are your principal concerns regarding your child’s self-help skills? | Click or tap here to enter text. | Click or tap here to enter text. |

FINE MOTOR

|  |  |  |
| --- | --- | --- |
| Does your child….. |  | Comments |
| Unwrap presents? | yes  no |  |
| Pour water or sand from one object to another? | yes  no |  |
| Turn doorknobs to open doors? | yes  no |  |
| Use one hand consistently? | yes  no |  |
| Use a crayon with hand NOT fisted? | yes  no |  |
| Copy lines and simple shapes? | yes  no |  |
| Write his or her own name? | yes  no |  |
| Use scissors? | yes  no |  |
| What are your principal concerns regarding your child’s fine motor skills? |  | Click or tap here to enter text. |

GROSS MOTOR

|  |  |  |
| --- | --- | --- |
| Does your child: |  | Comments |
| Walk up and down stairs with alternating feet? | yes  no |  |
| Walk around or step over items that are on the floor? | yes  no |  |
| Jump off the ground with both feet? | yes  no |  |
| Kick a playground ball to you? | yes  no |  |
| Throw a playground ball to you? | yes  no |  |
| Catch a ball when thrown? | yes  no |  |
| Show interest in sports? | yes  no |  |
| What are your principal concerns regarding your child’s gross motor skills? |  | Click or tap here to enter text. |

ACADEMIC SKILLS

|  |  |  |
| --- | --- | --- |
| Does your child: |  | Comments |
| Identify shapes, colors, numbers and letters? | yes  no |  |
| Identify locations, occupations, and functions of objects (i.e.; the refrigerator keeps things cold) | yes  no |  |
| Use pronouns, plurals and prepositions appropriately? | yes  no |  |
| Identify cause/effect relationships? | yes  no |  |
| What are your principal concerns regarding your child’s academic skills? |  | Click or tap here to enter text. |

CHALLENGING BEHAVIORS

*Please list any challenging behaviors that your child may exhibit and complete the table accordingly.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Types of Behavior | Please describe the behavior. | What typically happens immediately before, or triggers the behavior? | How many times per day or week does this behavior  occur? If the behavior lasts for more than 10 seconds, list the average duration of the behavior as well. | What typically happens after the behavior, or, what do you do when this behavior occurs? |
| Tantrums | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Failing to Follow  Instructions | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Aggression | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Running  Away/Eloping | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Self Injurious  Behaviors | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Eating Inedible  Objects (Pica) | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Other: | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

SELF STIMULITORY BEHAVIORS

*Please list any self stimulatory/repetitive behaviors that your child may exhibit and complete the table accordingly.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Types of Behavior | Please describe the behavior. | What typically happens immediately before, or triggers the behavior? | How many times per day or week does this behavior occur? If the behavior lasts for more than 10 seconds, list the average duration of the behavior as well. | What typically happens after the behavior, or, what do you do when this behavior occurs? |
| Vocal (repeating vocalizations, words or phrases) | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Preoccupations  with items, topics, etc. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Repetitive motor mannerisms (hand flapping, spinning items, lining up objects, etc.) | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Routine behaviors  (insisting on the same cup, same route in the car) | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

WHAT ARE THINGS THE PERSON LIKES AND ARE REINFORCING FOR HIM OR HER?

1. Food Items: Click or tap here to enter text.
2. Toys and Objects: Click or tap here to enter text.

1. Activities at Home: Click or tap here to enter text.

Activities / outings in the community: Click or tap here to enter text.

Other: Click or tap here to enter text.

TREATMENT HISTORY

*Please list any treatments that your child has received in the past and complete the table accordingly.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Type of  Treatment | Service Provider or  Clinician And Contact  Information | How many hours per week was this treatment provided? | Dates of Treatment | Did you feel that this treatment was beneficial?  Please explain. |
| Special  Education  Classroom | Click or tap here to enter text. | Click or tap here to enter text. | Start Date:    End Date: | Click or tap here to enter text. |
| Speech Therapy | Click or tap here to enter text. | Click or tap here to enter text. | Start Date:    End Date: | Click or tap here to enter text. |
| Occupational Therapy | Click or tap here to enter text. | Click or tap here to enter text. | Start Date:    End Date: | Click or tap here to enter text. |
| Physical Therapy | Click or tap here to enter text. | Click or tap here to enter text. | Start Date:    End Date: | Click or tap here to enter text. |
| Other ABA Program | Click or tap here to enter text. | Click or tap here to enter text. | Start Date:    End Date: | Click or tap here to enter text. |
| Other: | Click or tap here to enter text. | Click or tap here to enter text. | Start Date:    End Date: | Click or tap here to enter text. |
| Other: | Click or tap here to enter text. | Click or tap here to enter text. | Start Date:    End Date: | Click or tap here to enter text. |
| Other: | Click or tap here to enter text. | Click or tap here to enter text. | Start Date:    End Date: | Click or tap here to enter text. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Other: | Click or tap here to enter text. | Click or tap here to enter text. | Start Date:    End Date: | Click or tap here to enter text. |
| Other: | Click or tap here to enter text. | Click or tap here to enter text. | Start Date:    End Date: | Click or tap here to enter text. |
| Other: | Click or tap here to enter text. | Click or tap here to enter text. | Start Date:    End Date: | Click or tap here to enter text. |
| Other: | Click or tap here to enter text. | Click or tap here to enter text. | Start Date:    End Date: | Click or tap here to enter text. |

CURRENT TREATMENT AND SCHEDULE

*Please list any treatments that your child is currently receiving and complete the table accordingly.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Type of  Treatment | Service Provider or  Clinician  And Contact Information | How many hours per week is this treatment provided? | Start Date of Treatment | Do you feel that this treatment is beneficial?  Please explain. |
| Regular  Education  Classroom | Click or tap here to enter text. | Click or tap here to enter text. | Start Date: | Click or tap here to enter text. |
| Special Education Placement | Click or tap here to enter text. | Click or tap here to enter text. | Start Date: | Click or tap here to enter text. |
| Speech Therapy | Click or tap here to enter text. | Click or tap here to enter text. | Start Date: | Click or tap here to enter text. |
| Occupational  Therapy | Click or tap here to enter text. | Click or tap here to enter text. | Start Date: | Click or tap here to enter text. |
| Physical Therapy | Click or tap here to enter text. | Click or tap here to enter text. | Start Date: | Click or tap here to enter text. |
| Other ABA Program | Click or tap here to enter text. | Click or tap here to enter text. | Start Date: | Click or tap here to enter text. |
| Other: | Click or tap here to enter text. | Click or tap here to enter text. | Start Date: | Click or tap here to enter text. |
| Other: | Click or tap here to enter text. | Click or tap here to enter text. | Start Date: | Click or tap here to enter text. |

*Please complete the schedule to indicate your child’s availability.*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

Please provide copies of the following documentation as applicable:

Immunization Record

IEP

504 Plan

Psychological Evaluation (School/Private)

Speech Therapy Progress Notes and Recommendations (School/Private)

Occupational Therapy Progress Notes and Recommendations (School/Private)

Physical Therapy Progress Notes and Recommendations (School/Private)

Adaptive Technology Evaluation

ISP – Babies Can’t Wait, NOW Waiver and COMP Waiver

Previous ABA Assessments and Behavior Plans

EFMP Enrollment (Military)

ECHO Application (Military)

Custody Agreement/Guardianship

Insurance Card

Driver’s License

Military ID