ABA Expressions

New Client Intake Packet

Child's Name: _____Date of Birth: ____ /____ /_____ Current Age:_____

Person Completing Form_____ Relation to child_____

Home Address:_____ Date completing_____

Parent information

Guardian's Name: _____ Relationship: _____

Physical Address: _____
Street Address City/Town State/Zip

Home Phone: (____)_____ Cell Phone: (____)_____ Work Phone: (____)_____

Email: _____

Parent/Guardian #2 Name: _____ Phone: (___)_____

Physical Address: _____
Street Address City/Town State/Zip

Emergency Contacts

Contact Name #1: _____ Phone: (____)_____

Contact Name #2: _____ Phone: (____)_____

Insurance Information

Insurance Provider: _____ Member ID: _____

Subscriber Name: _____ Subscriber ID: _____

Employer: _____ Group #: _____

Insurance Phone Number: _____

Please include a copy of the front and back of your insurance card

Family Information:

Siblings:

Name	Age	Relationship	Lives in home y/n	School Attends	Grade

Other people who are currently involved with the child at home

Name	Age	Relationship	Lives in home y/n

Cultural/Spiritual:

Are there any cultural or spiritual considerations that could impact therapy that you would like to note:

Current Legal Notes (ex. Divorce, custody etc.):

Medical Information

Does your child have any existing medical condition in which he or she is being treated for by a physician? _____

Seizure Disorder: □ Yes □ No If yes, please expand: _____

Current Diagnosis	Diagnosis Dr	Date of Diagnosis

Physician's Name	Specialty	Phone/Fax
	Primary Care	

Please list medications or circle none

Medications	Dosage	Date started	Date ended

Has your child had a hearing test_____ Vision_____

Allergies (including foods):_____

Special Diet(s): _____

Are there any medical concerns (such as medications, physical needs, communicable diseases), which may have an impact on services provided?

Family Medical Considerations:

Behavioral Health History

Has your child ever received behavioral services or therapeutic interventions in the past? yes/no

Please explain why those services are being discontinued or if you intend to maintain them?:

Additional pertinent information regarding behavioral health history:

Evaluation	Type	Date Completed	Copy Available?

List below therapies that are being provided outside of the school setting

Service	Where	How often
ABA		
Occupational Therapy		
Speech Therapy		
Physical Therapy		

Social Skills group		
Counseling		

School Information:

School Name: _____ District: _____ Grade:____

What is your child's favorite subject/class?

What is your child's least favorite subject/class?

Has your child ever repeated a grade? _____ If yes, which?_____

If your child receives special education services, please check all that apply and how much time they are receiving:

Special Educational Services			
	504 Plan		Psychological
	I.E.P.		Speech
	Behavior Intervention Plan		Occupational Therapy
	Physical Therapy		Adaptive Technology

Where does your child receive services

Special Ed. Location			
	Consultation		Resource Classroom
	Self contained Classroom		Pull out
	Special Program		In classroom

Child Profile

How does your child communicate? Are they verbal/non-verbal?

Child prefers to be (*circle one*): Alone / With Others

Please fill out to your best ability the following questions.

Category:	Likes:	Dislikes:
Food/Drink		
Toys		
Apps		
TV/Movies		
Songs		
Books		
Motor activities		
Other		

Developmental Progression

When did you first become concerned with your child's development?

Was there a regression or loss of skills? Explain

What are your child's strengths?

Explain any areas of concern within the following categories:

Feeding:

Toileting:

Dressing:

Grooming:

Describe any relevant information pertaining to interfering behaviors of concern (what does the behavior look like and how often does it occur and when):

Self-stimulatory behaviors:
How often:
What precedes and follows the behavior:

Aggression:
How often:
What precedes and follows the behavior:

Tantrums:
How often:
What precedes and follows the behavior:

Self-Injurious:
How often:
What precedes and follows the behavior:

Others:
How often:
What precedes and follows the behavior:

Basic Daily Schedule:

Please fill in any important scheduling information in the provided grid (ex. school schedule, related services, naps, etc.):

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Any other information that you feel is important for us to know:

Patient Rights & Responsibilities

Patients have the right to:

1. Refuse consent or withdraw from treatments without penalty. Client or parent/guardian agrees to procedures without coercion or duress.
2. Have procedures explained and all questions answered to their satisfaction prior to implementation, which should include risks/benefits.
3. Communicate feedback, including complaints, to the Director of ABA Expressions
4. These can be emailed, mailed or hand delivered but should be in written form. Written complaints will be reviewed and responded to within five (5) business days.
5. Not be discriminated against in the delivery of health care services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information or source of payment.
6. Accurately and easily understand information regarding treatment procedures or treatment programs. If you don't understand something about the healthcare being provided, help should be given so that you can make informed decisions.
7. Know your treatment options available and take part in decisions about the care provided.
8. Talk privately to healthcare providers, and to have healthcare information protected. You also have the right to read and copy your own medical records.
9. Expect to treat ABA Expressions employees and other patients and families with respect.
10. Expect to be invited, but not expected, to participate in treatment session and programs when needed.

I understand and agree to comply with all standards set by ABA Expressions.

I certify, by my signature below, that I am agreeing to comply with the listed patient rights and responsibilities listed above.

Signature:_____ **Date**:___/___/_____

I understand the guidelines outlined above as they pertain to my child. My signature below also confirms that all information above is accurate and truthful to my knowledge.

Parent Signature: _____ **Date:** ___ / ___ / _____

ABA Expressions

General Consent for Care and Treatment Consent

TO THE CLIENT: You have the right, as a client, to be informed about your condition and the recommended treatment to be used so that you may make the decision whether or not to undergo any suggested treatment after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or assessment for any identified area(s) of need.

This consent provides us with your permission to perform reasonable and necessary assessment, testing, and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a treatment recommendation; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your BCBA about the purpose, potential risks, and benefits of any treatment. If you have any concerns regarding any assessment or treatment recommend by your BCBA, we encourage you to ask questions.

I voluntarily request a BCBA, to perform reasonable and necessary assessments and treatment for the condition, which has brought me to seek care at this practice. I understand that if additional testing, invasive

or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Name of Client: _____

Client's Signature: Date:

_____ _____

Name of Witness and Title: _____

Signature of Witness: Date:

_____ _____