ABA Therapy Intake Packet

Intake packet and required documents must be filled out in entirety, and returned before initiation of ABA Services.

Last Name:	First Name:
Age: Gender: M or F	Date of Birth:
Social Security Number:	Home phone:
Address:	City:
State: Zip code:	Country:

Diagnosis Information

Primary Diagnosis:	Date of Diagnosis:
Other condition:	Date of Diagnosis:
Other condition:	Date of Diagnosis:

Mother or Legal Guardian Information

Full Name:	Relationship to Child:
Address: (if different from applicant)	Social Security Number: *Not needed
Email:	Phone:
City:	Occupation:
State:	Name of Employer:
Home Phone: (if different from applicant)	Business Phone:

Father or Legal Guardian Information

Full Name:	Relationship to Child:
Address: (if different from applicant)	Social Security Number: *Not needed
Email:	Phone:
City:	Occupation:
State:	Name of Employer:
Home Phone: (if different from applicant)	Business Phone:

Marital Status between Legal Guardians (circle one) ***married*** ***separated*** ***divorced***

Custody Details: _____

- *Please attach any relevant legal custody documents*

- **Alternate Emergency Contact (please supply at least two emergency contacts)**

Full Name: Relationship to child:	Phone Number(s):
Full Name: Relationship to child:	Phone Number(s):
Full Name: Relationship to child:	Phone Number(s):

Sibling Information:

Name:	Age:	Gender:
Name:	Age:	Gender:
Name:	Age:	Gender:

School Information (if school age)

Name of School:	Years attended:
Address:	Placement: Hour included in Regular Education Curriculum per day:
Phone:	IEP Case Coordinator:

What services is your child currently receiving both in-school and out of school?

Please enclose a copy of the child's most recent IEP or IFSP, and therapy goals from each area that is checked.

Service/Therapy	Location/Minutes per week	Outcome/Comments
❒Early Intervention Services Provider:	❒School ❒Out of School Minutes per week:	
❒Speech and/or Language Therapy Provider:	❒School ❒ Out of School Minutes per week:	
❒Occupational and/or Physical Therapy Provider:	❒School ❒ Out of School Minutes per week:	
❒Vision services Provider:	❒School ❒ Out of School Minutes per week:	
❒Hearing services Provider:	❒School ❒ Out of School Minutes per week:	
❒Other Provider:	❒School ❒ Out of School Minutes per week:	

Medical Information: Is your child currently taking any medication? ❒ Yes ❒ No

If yes; please list medication, administration times, dosage, and any side effects.

Medication	Administration Time(s)	Dosage/Side Effects

******Additional medications can be attached on a separate sheet of paper and stapled to this intake.*

History of Treatment (if applicable) ***Please list most recent services first.**

Provider Information:	Dates of service: _____ to: _____
Provider Agency:	
Provider Name:	
Provider Phone:	
Frequency of provider therapy/consultation:	

Methods of treatment by the provider. __ABA Lovaas-based __ABA Verbal Behavior-based __TEACCH	__Greenspan/Floortime __RDI __Other _____
Please describe services and program information.	

Provider Information:	Dates of service: _____ to: _____
Provider Agency:	
Provider Name:	
Provider Phone:	
Frequency of provider therapy/ consultation:	

Methods of treatment by the provider. __ABA Lovaas-based __ABA Verbal Behavior-based __TEACCH	__Greenspan/Floortime __RDI __Other _____
Please describe services and program information.	

Provider Information	Dates of service: _____ to:_____
Provider Agency:	
Provider Name:	
Provider Phone:	
Frequency of provider therapy/consultation:	

Methods of treatment by the provider. __ABA Lovaas-based __ABA Verbal Behavior-based __TEACCH	__Greenspan/Floortime __RDI __Other _____
Please describe services and program information.	

Are there any medical conditions that need to be considered when delivering ABA Therapy? ❒Yes ❒No If yes, please explain.
Has the child ever been admitted to a hospital/treatment center for psychiatric, behavioral, or crisis situations? ❒Yes ❒No If yes, please explain.
Please summarize the hospital/treatment facilities observation, treatment(s), and effectiveness of treatment(s).

Is your child toilet trained? Yes or No Comments:
Does your child have any dietary restrictions and/or allergies? Yes or No Comments:
Please describe your child's current sleep patterns.
Please describe your child's strengths:

What are your immediate goals for your child?
Please describe activities/things that are motivating and reinforcing to your child.
Please describe any aversions that your child currently has.

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What current communication skills does your child have? Ex., sign language, PECS, verbal
Please explain:

Does your child display any behavior issues that require attention? (i.e. head banging, hitting, self-harm, aggressive behaviors) Please describe:

The behavior(s) typically occur: ___at home ____at school __other (please describe)
(check all that apply)

The behavior(s) typically occur: ____daily ____weekly ____monthly ___rarely
(check all that apply)

The behaviors seem to be triggered by:

Please describe method and/or discipline typically used for the behavior(s) listed above:

Does your child have difficulty with transitions? Yes or No
Please describe:

Does your child have any repetitive interests or perseverative behaviors (intense preoccupations with certain objects, preference to do the same activity repeatedly)? Please describe:

What would you like us to know about your child?

What level of commitment are you willing to make at home to support your child in achieving these goals?

Insurance Information *Please attach a copy of the front and back of your insurance card.

Insurance Provider:	Subscribers Birthdate:

Office Use Only:

❒I allow NOAC to send emails and/or leave voicemails with specific personal information regarding assessment and ABA Treatment Planning to the below contact information.
Email(s) _____ Phone #_____

❒I do not allow NOAC to send emails and/or leave voicemails with specific personal information regarding assessment to and ABA Treatment Planning.

❒I have received and reviewed a copy of NOAC's Privacy Practices.

The undersigned hereby acknowledge that the information contained in this application is accurate in all respects.

Parent/Guardian (print name) _____ Date: _____

Signature of PARENT/GUARDIAN: _____

Please include all of the below required documents with your Intake Packet.
*All documents and required information is needed before the initiation of ABA Therapy.

- ❒ Copy of the front and back of your insurance card.
- ❒ Copy of Autism Diagnosis from an approved AAEC
- ❒ Authorization to Release/Receive Medical Information Form
- ❒ Consent for Assessment, Treatment, and Disclosure of Protected Health Information Form
- ❒ Home and/or Center-Based Signed Agreement
- ❒ Copy of most recent IEP/IFSP (for school-age children)
- ❒ Copy of most recent comprehensive evaluation (if applicable)
- ❒ Copy of your child's completed ABLLS-R or VB-MAPP profile (if applicable)