INTAKE APPLICATION

Personal Information:

Today's Date:_____

Child's Name:_____ DOB:_____ Age: _____

Address:_____

(street) (city,state) (zip code)

Mother's Name:_____ Cell #:_____

Employer: _____ Typical Work Hours: _____

Father's Name:_____ Cell/Work#:_____

Employer: _____ Typical Work Hours: _____

Who should be the first point of contact? ____ Mother ____ Father ____ Other:_____

Mother's Father's

Home Phone#:_____ Email:_____E-mail:_____

Parents living together: Y / N If no, who does the child live with:_____

Legal guardian: _____ Other regular babysitters:_____

Other people living in the house (e.g Siblings? Relatives? Roommates? Etc.):_____

_____

How did you find out about ABC Group:_____

Name of doctor that recommended ABA: _____Hospital: _____

Languages spoken in the home other than English: _____

Religious/ethnic/other cultural backgrounds that may impact child's service delivery: _____

Insurance Information:

If you are planning to use insurance, please bring ALL insurance cards (for primary and secondary plans if applicable) to be copied, front and back.

Name of Insurance Company: _____

Name of Policyholder: _____

Member ID: _____ DOB: _____Group ID: _____

Military:

Branch Served: _____ Enrolled in Exceptional Family Member Program (EFMP)? Yes / No

Highest Rank: _____ Registered for Extended Health Care Option (ECHO)? Yes / No

How long are you stationed in Hawaii? _____ PCS Date:_____

Is either parent anticipating or currently deployed? Yes / No if yes, when:_____

Medical Information: **Please attach a copy of each diagnostic report.**

Primary Diagnosis:_____ Age at Diagnosis:_____

Diagnosing Dr.:_____ Hospital: _____ State:_____

Other Diagnoses:_____ Age at Diagnosis:_____

Diagnosing Dr.:_____ Hospital: _____ State:_____

Other Diagnoses:_____ Age at Diagnosis:_____

Diagnosing Dr.:_____ Hospital: _____ State:_____

History of Seizures? Y/ N Any other health problems?_____

Current Mediation(s) (include over the counter medications given regularly- i.e. Miralax, melatonin, benedryl)

Medication Name	Dosage/Day or "as needed"	Date Began	Reason for Medication

Is there medication or supplements that may need to be administered at ABC Group? Y / N

Past mediations that were given daily:

Medication Name	Dosage/Day	Dates Given	Reason for Medication

Allergies (please indicate severity): _____

Any other medical treatments for autism being provided? _____

Diet Information:

Have you ever consulted with a nutritionist? Y / N Are there significant eating/feeding/food issues: Y / N

If yes, please describe:_____

What are the typical things your child eats? _____

What food do you have to hide from your child? _____

What do you wish your child would eat that they won't? _____

Is your child on a special diet? Y / N If yes, what is it? _____

Can your child have special treats at birthday celebrations? Y / N

Toileting Information:

Does your child use the toilet without accidents? Y / N Does they have accidents during the night? Y / N

Do they ask to use the toilet (vs. you just taking them)? Always / Sometimes / Never

Circle the activities that you help your child with: Pulling up /down clothes/ Wiping/ Flushing/ Washing Hands

What words are used to refer to toileting (potty, shi-shi, bathroom, etc)? _____

Has toilet training been attempted unsuccessfully in the past? Y / N Is toilet training a current goal? Y / N

Please add comments regarding toilet training if your child is not FULLY potty trained (i.e. bowel movements):

_____

Sleep Information:

Does your child sleep through the night: Y/ N When do they go to bed and wake up? _____

Does your child take naps during the day: Y/N If yes, when and for how long:_____

School Information: (If homeschooled, please just fill out school hours)

School Name:_____ Grade: _____ Teacher:_____

Does your child have an IEP: Y / N 504 Plan: Y / N **If yes to either, please attach**.

What are their school hours? _____

Classroom setting (not including recess, lunch, assemblies):

___ Inclusion (100% of the day): with general education students for the entire day

___ Fully Self Contained (FSC)- only children with special needs in the classroom

___ Other:_____

Does your child have a 1:1 aide in the classroom? Y / N Is there a BCBA supervising? Y / N

Does your school allow ABA Therapists in the classroom Y /N Have you observed your child at school Y /N

Are they assigned homework? Y / N If yes, how long does it take to complete by themselves? _____

Have there been any problems at school in the past?_____

_____

Previous ABA Treatment Information:

Previous (or current) ABA Provider: _____ State: _____

BCBA Supervisor Name: _____**Please attach intake and final reports**

Dates of service: _____ to _____ Weekly schedule: _____

Service Intensity: ____ low (less than 10 hrs/week) ___ moderate (10-25 hours) ___ high (25-40 hours)

Reason for Leaving: _____

Previous ABA Provider and BCBA: _____ State: _____

Dates of service: _____ to _____ Weekly schedule: _____

Reason for Leaving: _____

Have you received service from more than these providers? Y / N

ABA Training Topics- please circle the topics that you received training on and feel competent with:

Behavior Management / Mands / Reinforcement / Rules / Teaching Daily Routines / Teaching Vocalizations

Play Skills / Verbal Behavior / Other: _____

Other Service Information:

Please list all other services that are currently provided outside of school, such as speech, occupational therapy, physical therapy, psychologist, social skills groups, hippotherapy, respite, biofeedback, music therapy, etc.

Service Type	Agency/ Provider	Schedule (days and times)

Potential Reinforcers:

Are there toys, snacks, activities that your child whines/cries/bargains for? _____

_____

If your child could do whatever they wanted, what would they do? _____

_____

What are their special interests (Minecraft, Pokemon, Legos, Chess, Sports, Music, Bugs, Anime, Coding, Kendama, My Little Ponies, Marine Life, Celebrities, Art, Video Games, etc.)

_____

_____

Things your child doesn't like:

Are there places, noises, people, activities, things, etc. that your child doesn't like: _____

_____

How do you know they don't like it? _____

Problem Behavior:

Please describe some of your child's behavior(s) that is a concern for you:

Behavior 1:_____

How often does this behavior occur? (# of times per day or week) _____

How long has this behavior been happening? _____

How can you make it stop in the moment? _____

Behavior 2:_____

How often does this behavior occur? (# of times per day or week) _____

How long has this behavior been happening? _____

How can you make it stop in the moment? _____

Behavior 3:_____

How often does this behavior occur? (# of times per day or week) _____

How long has this behavior been happening? _____

How can you make it stop in the moment? _____

Has your child EVER engaged in any of these behaviors past age 2? Please circle: biting others / head banging / smearing feces / spiting at people / pica (eating non-food) / throwing large objects / threatening with knives

If you circled anything please describe: _____

Any other self-injury- please describe very specifically _____

Have you been trained in safety restraints? Y / N

Does your child regularly have problem behavior when you: Tell them no? Y / N Make them wait? Y / N

Take things away? Y / N Make them share or take turns? Y / N End an activity? Y / N

If possible, please record several videos of your child in situations that typically evoke problem behavior. We will watch these together after 6 months of treatment.

Primary Goals:

What are the most immediate goals you have for your child?

1. _____

2. _____

3. _____

What changes would improve your family's home life?

1. _____

2. _____

3. _____

If possible, please also record several videos of your child playing with you. Videos do not need to be edited or made pretty in any way. Video is a good baseline measure and will be very valuable to evaluate progress in treatment.

Please mail or hand-deliver this form to: 99-950 Iwaena St. Suite 2, Aiea, HI 96701
Or scan and email to Christy@autismbehaviorconsulting.com

Remember to attach the following if applicable:

- ✓ Copies of front and back of insurance cards
- ✓ All reports that contain a diagnosis
- ✓ IEP or 504 Plan
- ✓ Previous ABA intake and exit reports

And save these for your records

- ✓ Video of problem behavior
- ✓ Video of play skills