

ABA Child Intake Form

This form is to be completed by the **Parent/Guardian of the client** prior to the initial consultation visit.

Medical Information

Name of Physician:

Physician's Address:

Physician's Phone Number:

Does your child have any current health condition?

Yes No

List any medications your child is currently taking, including the dosage, frequency, and any side effects experienced.

Does your child currently have any diagnoses?

Yes No

Educational Information

Does your child attend school?

Yes No

Name of School:

Classroom Type:

Teacher/Grade:

Address:

School Phone Number:

Current/Previous Therapy Provider Information**Behavioral Therapy**

Provider Name:

Contact Name:

Phone Number:

Dates of Service:

Please state the therapy outcome with the behavioral therapy provider.

Speech Therapy

Provider Name:

Contact Name:

Phone Number:

Dates of Service:

Please state the therapy outcome with the speech therapy provider.

Occupational Therapy

Provider Name:

Contact Name:

Phone Number:

Dates of Service:

Please state the therapy outcome with the occupational therapy provider.

Other Therapy

Provider Name:

Contact Name:

Phone Number:

Dates of Services:

Please state the therapy outcome with the other therapy provider.

Child's Current Behaviors and Expected Outcomes

Please provide detail regarding the concerns of your child's development (if any).

Please describe any problem behaviors or interfering behaviors of concern.

Please state the expectations/goals that you have for your child while engaging in a behavioral program.

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

Referred by: