Elite Spectrum ABA

"Providing exceptional care and assistance in helping families conquer autism"

New Client Intake Packet ©2020

Table of Contents

I. General Information

Services Interested In:

- ☐ In-Home ABA Therapy
- ☐ Clinic based ABA Therapy
- ☐ Speech Therapy
- ☐ Social Skills
- ☐ School/Education Consultation

How did you hear about us?

- ☐ Social media
  - List platform: _____
- ☐ Web search
- ☐ Referral
  - If so, by who: _____
- ☐ Other
  - Please explain: _____

Client Information:

Name: _____

DOB: _____

Age: _____

Address: _____

SSN#: _____

List all diagnoses: _____

_____

_____

_____

Parent/Guardian Information:

Mother's Name: _____

Mother's Phone #: Cell # _____ Alternate # _____

Mother's Email: _____

Father's Name: _____

Father's Phone #: Cell # _____ Alternate # _____

Father's Email: _____

II. Health and Emergency Information

1. Is your child on a special diet? If so, please explain.

2. Please list any medications your child is currently taking.

3. Does your child have any allergies? If so, please list.

4. Is your child medically fragile? Please describe.

5. Is your child independent in toileting? Please describe.

6. Is your child physically handicapped, requiring the need for any special accommodations? Please describe.

In the event of an emergency, please list emergency contacts that we are authorized to contact.

Name	Relationship	Phone Number
Name	Relationship	Phone Number

Any other Health Information that is important for ESABA to know?

III. Academic Information

School District

Campus and Grade:

Classroom Type:
(General Ed., Life Skills, Resource, etc.)

Academically Strong Areas

Academically Weak Areas

- ☐ Verbal
- ☐ Sign Language
- ☐ Picture Exchange
- ☐ Combination

Mode of Communication

Description

IV. Behavioral Information

Problem Behaviors:

- ☐ Aggression
- ☐ Throw objects
- ☐ Tantrums
- ☐ Spits
- ☐ Self-Injurious
- ☐ Property Destruction
- ☐ Runs from assigned areas
- ☐ Pica (eats nonfood items)

Other:

How do you usually handle these problem behaviors?

What are the top two behaviors you'd like to see decrease?

Reinforcers:

- ☐ Salty Foods
- ☐ Praise/Attention
- ☐ Sweet Foods
- ☐ Frequent Breaks
- ☐ Toys
- ☐ Peer Interactions

Describe the things your child has high preference for and might work for:

V. Speech & Language Information

Has your child received a speech-language evaluation/screening?	☐	Yes	☐	No
If yes, when and where was it completed? What were the results?				
If no, the Speech Language Pathologist will need to conduct a full comprehensive evaluation prior to beginning services.				
What language is spoken in the home?				
Is there a second language spoken in the home?				
Has your child received any other evaluation and/or therapy (physical, occupational, vision) or counseling?	☐	Yes	☐	No
If yes, please describe:				
Does your child have an IEP in place?	☐	Yes	☐	No
If so, what services are received?				
What school subjects or pre-school activities does your child enjoy?				
What is your child's current reading level?				

VI. General Summary

Tell us anything else about your child that you would like his/her BCBA and/or SLP to know to better help them work together.

Email completed intake packet plus Insurance Form to info@elitespectrumaba.com. Please allow 24-48 hours for a response.

Insurance Reimbursement Form

Client's Information:

Name: _____ DOB: _____

Gender: _____ Phone #: _____

Address: _____

_____

Diagnosis: _____

_____

_____

Insured's Information:

Insurance Company: _____

Identification #: _____ Group/ Plan #: _____

Employer: _____

Name: _____ DOB: _____

Gender: _____ Email: _____

***Please provide us with a copy of the front and back of your insurance identification card. ***