Intake Form

Name (Last, First):_________________________________ Date of Birth: _________________

Address: ____Zip Code:_______________

Parent/Guardian Names: ____________________________ Primary language used at home? _________

Address (if diff): ____

Home Phone: _______________________________ Work/Cell Phone: ____________________

May we leave messages regarding appointments on these numbers? ________________

Email Address: ____

Family History of Medical or Behavioral Health Conditions? Yes or No

If yes, please explain: ____

Sibling(s) Name/ age/ diagnosis ____

District/School: ____

Grade/Placement/Times: ____

____

Primary Diagnosis: ______________________________ Date of Diagnosis: _________

Secondary Diagnosis: ____________________________ Date of Diagnosis: _________

Current Service Providers (other than school):

	Provider Name/Agency	Hours each week	Start Date	Current Provider? Y or N	End Date
Speech /Language Therapy					
Occupational Therapy					
Behavioral Health					
Other					

Emergency Contact Information (other than parents)
Name: __________________________ Relationship to Client: ______________________________
Phone: __________________________ Will the client recognize him/her? ____________________

Insurance Information
Insurance Name: ____

Insured Name: __________________________________ Relation to Client: ___________________

Insured Address (if different):____

Insured Social Security Number: _________________Medicaid Number: ____________________

Employer Name/Address/Phone: ____

Physician Name/Address/Phone: ____

Medication Information

Medication Name	Dosage	Frequency	Prescribing Physician

Health Information (Please provide details for anything unusual) (Please list any immediate family members with each condition)

Condition	Yes/No	Details/Dates
Asthma		
Chicken Pox		
Diabetes		
Frequent Colds or Ear Infections		
Seizures		
Dietary Restrictions		
Activity Limitations		
Allergies (food, drug, environmental)		
Vaccines		
Hearing Screening/Tested		
Vision Screening/Tested		
Conditions During or Post Pregnancy		
Other		

Development (Specify any skill that developed early, late, or regressed)

Skill	Initial Age	Regression Age	Details/Current
Stranger Anxiety			
Separation Anxiety			
Crawls			
Walks			
Single Words			
Simple Sentences			
Eats with Utensil			
Other			

Activities of Daily Living (ADLs)

Feeding

- Favorite Foods: ____
  ____
- Are there foods the child would eat in the past but will not eat now? ☐ Yes ☐ No
  If yes, please list:____
- Is the child required to sit with the family for meals? Describe routine for meals.
  ____
  ____
- Does the child graze (snack all day)? ____

Dressing

- In what ways does the child participate in dressing? (Chooses between shirts, pulls on pants, gets socks from drawer) Are skills delayed?_____________________________
  ____
- Does the child keep the clothes on all day or are there sensory issues with clothing?
  ____

Toileting

- Is the child potty trained? ☐ Completely ☐ Day-trained ☐ Needs Reminders ☐ No
- Does the child have a toileting routine? If so, explain____________________________
  ____

Bathing

- Does the child independently brush teeth or tolerate someone else doing it? ________
  ____
- Does the child like baths/showers? Explain routine for bathing. __________________
  ____

Sleeping

- Does the child nap? If so, what time?____
- Does the child consistently sleep through the night in his/her own bed? ____________
  ____
- What time does the child typically wake up in the morning and go to bed at night?
  ____

Is there anything else you would like us to know about your child's ADLs? ______________
____
____
____

Have you had ABA therapy before? If yes, how was your experience? ___________________
____
____

Cultural/Religious Beliefs (Required by Optum Insurance) ______________________________
____
____

Treatment Priorities

Following assessment, I will provide you with my recommendations for treatment priorities. However, I would like to know what your priorities are for your child and your family. These can be addressing behavior in certain environments (tantrums in grocery store) or establishing routines for ADLs (child does not sit during meals). My goal is to address your priorities as quickly as possible. Please note that I often need to teach or address pre-requisite behaviors in order to target a priority behavior. We will work together to determine a time-line for your child. Please discuss your treatment priorities below.

1. ____
   ____
2. ____
   ____
3. ____
   ____
4. ____
   ____

Thank you for taking the time to provide me with this information about your child. Use this page to discuss anything else you would like me know. I look forward to working with your family. Please contact me by phone or email at any time.

Records Release

I, ___________________________, the parent/guardian of _________________________, DOB ______________

authorize the release of any and all requested medical/psychological/educational/behavioral/criminal records relevant to my child upon presentation of this signed release form or a copy of same.

Purpose of disclosure: ____

RELEASE FROM: (LEAVE BLANK)

Name___________________________________

Address_________________________________

City____________________________

State_______ Zip _________

Phone _____________________________

Fax _______________________________

RELEASE TO:

PlayDate Behavioral Interventions

6050 Erin Park Drive

Colorado Springs, CO 80918

(719) 465-3989 Office

(719) 375-8499 Fax

____

Signature of Parent(s)/Guardian

____

Date

As a parent, you have the right to refuse release of information. Please complete the bottom of this document **ONLY IF YOU REFUSE** to release information.

I, ___________________________, the parent/guardian of _________________________, DOB ___________________

refuse the release of any and all requested medical/psychological/educational/behavioral/criminal records relevant to my child.

____

Signature of Parent(s)/Guardian

____

Date

***Unless revoked, this authorization expires one year from date of signature.

Behavior Inventory

Please indicate which, if any, of the following behaviors your child is currently displaying or has displayed within the past 12 months.

	Currently	In the past 12 months
Aggressive Behaviors (toward others)		
Hitting		
Kicking		
Biting		
Hair Pulling		
Spitting		
Throwing Objects		
Other (please specify)		
Self-Injurious Behaviors		
Hand Biting		
Head Banging		
Scratching		
Pica		
Hitting		
Other (please specify)		

Behavior Intervention Plans (BIP)

Does your child currently have a BIP? ☐ Yes ☐ No

If yes, please describe the behaviors addressed and attach a copy of the current BIP.

____
____
____

Has your child had a BIP in the last 12 months? ☐ Yes ☐ No

If yes, please describe the behaviors addressed and who developed the BIP.

____
____
____

Please describe any inappropriate behaviors your child typically displays in the following situations:

Classroom: ____

____

Community: ____

____

Please describe reinforcers and triggers for your child:

Reinforcers: ____

____

Triggers: ____

____

**This is only one component of the assessment used to measure your child's areas of strengths and weakness which the BCBA will use to develop or update treatment/behavior plans. In addition to this Behavior Inventory, all parents/guardians are required to complete an Initial Social Skills Inventory. Our consultants will perform Direct Observations of your child in multiple environments on separate days with different staff. Other assessments which may be administered depending on each client's individual needs include but are not limited to; the FAST, Essentials for Life, ABLLS-R, AFLS, VB-MAPP, ABC Data collection, the Vineland, or Functional Analysis.*

Consent and Agreement for ABA Assessments and Evaluation

Client Name: ___________________________ DOB: __________ Date:_____________

I, __________________________________, agree to allow the behavior analyst to perform Applied Behavioral Analysis assessments and Report writing.

I understand that these assessments may include direct, face to face contact, caregiver interviews, reviewing of records, consultations with other therapists, scoring, interpreting results, and any other activities to support these services.

I understand that these assessments are to be done for the purpose(s) of:

1. Determination of skills and deficits
2. Recommendations for educational, social, emotional, language, and behavioral planning
3. Measurement of skill acquisition program efficacy

Assessments will be chosen that are suitable for the purposes described above. These assessments will be given and scored according to the instructions in the assessment manuals, so that valid scores will be obtained. These scores will be interpreted according to scientific findings and guidelines from scientific and professional literature.

I agree to support PlayDate Behavioral Interventions as much as I can by supplying full answers, making an honest effort, and working as best I can to make sure that the findings are accurate.

____ ___________________________

Signature of Parent/Guardian Date