

**Rise With ABA**

**Parent Intake Packet**

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## 

## Welcome

Thank you for your interest in Rise With ABA services. We hope that you will find all information helpful and are excited to be a part of your journey. Our primary focus is to provide your child and your family with quality services that are collaborative, innovative and all-encompassing. Integrity, safety, and accountability are of the utmost importance.

Please review all information attached concerning Rise With ABA policies and procedures, processes, and services. Fill out all of the attached patient history and background information before the scheduled assessment in order to expedite the process. All information will be used to create an appropriate treatment plan that will allow for success now and in the future.

If at any point you need assistance, please do not hesitate to contact us via phone call, text, or email. We look forward to working with you and your child.

Rise With ABA Staff

## Staff

Please feel free to contact any staff member below to begin services or ask questions pertaining to the process.

**Amy Lee, Owner and Director**

**(979) – 627 – 8138;** [**amy.lee@risewithaba.com**](mailto:amy.lee@risewithaba.com)

# What is ABA?

Applied Behavior Analysis (ABA) is an evidence-based approach to creating meaningful or socially significant behavior change. New skills and behaviors are taught while existing behaviors are modified. ABA focuses on behaviors that are observable and measurable, with respect to their function. This is determined through the collection of data that involves antecedents and consequences, which are events that occur directly before and after the behavior of interest. This approach utilizes principles of reinforcement, to increase skills that are functional and socially significant throughout the child’s daily life. ABA not only teaches these skills, but also promotes maintenance and generalization of the skills. ABA also serves to decrease behaviors that may interfere with learning, such as tantrums, aggression, or stereotypy. Treatment plans are developed to facilitate learning based on the individualized need of each child. Areas that we work on include (but are not limited to):

* **Language and Functional Communication**: Communicating needs/wants to others
* **Independent Play**: Playing alone without assistance
* **Social Skills**: Interacting with others
* **Imitation**: Imitating behaviors or vocalizations of others
* **Gross/Fine Motor Skills**: Control over balance and body movement
* **Listener Responding**: Attending and responding to spoken words
* **Visual/Perceptual Skills**: Interpreting things he/she sees visually
* **Self-help Skills**: Skills such as dressing, grooming, feeding, toilet training

# What Is Required To Start ABA Services?

1. Completed Intake Packet: any other evaluations or reports would be helpful
2. Intake Interview
3. If insurance is involved then pre-authorization is required prior to any evaluation, therapy or other services being provided
4. Assessments completed by Rise With ABA and parents
5. Meeting with Clinical Supervisor to discuss treatment goals and program plan
6. Arrangement of therapy schedule

# Types of Services Rise With ABA Provides

#### Center-based 1:1 Therapy

Rise With ABA provides a center-based program in which basic skills are taught to each child to enhance learning. Each child participates in 1:1 sessions with a BCBA, BCaBA, or Registered Behavior Technician based upon his or her individual programming created by the BCBA.

#### Home based 1:1 Therapy

To ensure all skills are generalized and parents and family members are able to successfully implement the plan at home, some in home based services will be recommended.

#### Functional Behavior Analysis (FBA)

This is designed for children who may have behaviors that are interfering with their ability to learn. An analysis of the behavior of concern will be completed via parent interview and direct observation. Once the analysis is conducted, a plan will be written to address the behaviors of concern.

###### Parent Training

All ABA services include a component of parent training. In order for center-based ABA therapy to have lasting effects, parents must assist the child with bringing the skills he or she learns at the center to other natural environments, especially in the home and community settings. Parent education and trainings will be available through Rise With ABA. Participation by parents, guardians, or caretakers is not only encouraged but expected for any program to be successful.

# Assessments Used For Client Intake

***ABLLS-R:***

The Assessment of Basic Language and Learning Skills *Revised* is a criterion-referenced assessment protocol that is used to assess the language, academic, self-help, and motor skills of children with ASD and other developmental disabilities. The purpose of the assessment is to develop an individualized curriculum and skills tracking system. It provides a task analysis of skills, breaking each skill down to the separate components necessary to perform the skill adequately.

***FBA***:

The Functional Behavioral Assessment Functional Behavior Assessment is the primary tool used to identify and attempt to understand a child's behavior. It is used develop strategies and interventions to address the problem behaviors. The process identifies the specific target behaviors and the purpose of the behavior.

***VBMAPP***:

The VB-MAPP is a criterion-referenced assessment tool, curriculum guide, and skill tracking system that is designed for children with autism, and other individuals who demonstrate language delays. There are five components of the VB-MAPP: Milestones, Barriers and Transition Assessment, Task Analysis and Skills Tracking and Placement and IEP Goals. They provide a baseline level of performance, a direction for intervention, a system for tracking skill acquisition and a tool for outcome measures.

# 

# Financial Information

Rise With ABA is willing to participate with any major insurance provider in the State of Texas. Please contact us to find out if we are currently providers for your insurance company.

All fees are based on the service performed including copays.

# Rules and Regulations

##### Scheduling And Sessions

Sessions for ABA therapy are typically scheduled in 2-3 hour blocks. The research demonstrates that longer sessions result in greater retention of skills and mastery is sustained.

The parent or legal guardian is not required to be present during the therapy session but should arrive 10 minutes prior to the end of the session for consultation with the therapist.

Please provide 30 days notice on significant changes to ABA scheduling in order to facilitate consistency in service delivery. This may include a request for change in schedule, long vacation, or termination of services.

Sessions will involve direct services with the client, time to prep materials, data collection, and time to discuss the session with the parent.

##### Absences, Vacations And Holidays

1. I/We understand that in the event of inclement weather, all programs at Rise With ABA will follow the local public school’s procedures. I/ We further understand that the Clinical Director has the discretion to cancel appointments due to exigent circumstances if needed even if the schools have not closed.
2. Rise With ABA has scheduled vacation and holidays where all services will be canceled. I/We understand that we will be provided with a calendar of those scheduled days in advance.
3. I/We understand that requests for leaves of absence or extended vacation from the program must be submitted with at least 30 days’ notice and will be reviewed by the Clinical Director. Upon approval, arrangements will be made on a case by case basis.

##### Illness Policy

* 1. I/We understand that if my child’s temperature is at or above 100 degrees I/we will be contacted and that my/our child will be required to be picked up.
  2. I/We understand that my child must be fever free for a minimum of 24 hours before returning to therapy, without the aid of any fever reducing substance.
  3. I/We understand the I/we will be called to pick up my child from therapy or home therapy sessions ended, if he/she has two (2) or more unexpected instances of diarrhea. I/We understand that my/our child will not be permitted to resume therapy until 24 hours have passed with no diarrhea instances.
  4. I/We understand that I/we will be called to pick up my child from therapy or home therapy sessions ended, if he/she has one (1) or more instances of vomiting. I/We understand that my/our child will not be allowed to resume therapy until 24 hours have passed with no instances of vomiting.
  5. I/We understand that I/we may bring my/our child to therapy if he/she has a common cold (slight occasional cough, clear runny nose, occasional sneezing). I/we further understand that if my/our child has discharge of any other color than clear, my/our child will not be seen for therapy.
  6. I/We understand that if my/our child has any rash other than a mild diaper rash I/we must bring a not from the doctor stating the rash is not contagious.
  7. I/We understand that by law my/our child is not permitted to be seen for therapy if he/she has contracted a communicable disease. Examples of communicable diseases are (but not limited to): Conjunctivitis (Pink eye), Impetigo, Hepatitis A, Scabies, Ringworm, Infections Diarrhea, Chicken Pox, Scarlet Fever, Lice, and Strep Throat. I/we understand that if my/our child is thought to have a communicable disease I/we will be contacted and that my/our child will not be permitted to be seen for therapy. I/we further understand that my/our child will not be permitted to attend therapy until a doctor’s note has been provided stating that my/our child is no longer contagious.

Observation Of Client

1. I/We understand that my/our child could be videotaped while receiving therapy from Rise With ABA for the purpose of training staff members and/or receiving video updates on my/our child’s progress. I/We understand that any video will be kept confidential.
2. I/We understand that professionals, other clients, potential clients, staff, and therapists in training will occasionally be observing therapy. In these cases, I/we will be informed of the purpose of the observation.
3. I/We understand that I/ We may view my/our child while he/she is receiving therapy. In addition, I/we may be asked to observe procedures in order to promote generalization.

### Medical Information

1. I/We understand that I/we have agreed to release my/our child’s medical and psychological records to Rise With ABA. Releasing these records will allow us to review my/our child’s diagnosis, developmental, medical, levels of intellectual, behavioral, and social functioning as well as their medical history.
2. I/ We understand that I/we give Rise with ABA permission to seek medical assistance for my/our child in case of an emergency. Medical attention will be sought without my/our verbal permission if I/we are either unreachable, time is of the essence, or other unforeseeable circumstances arise.
3. I/we understand that there are medical conditions, as well as certain medications (such as insulin), that the staff of Rise with ABA is not qualified to deal with and/or administer. If a medical condition arises that the staff is NOT able to handle, my child may not be able to be seen by the staff.

## Cancellation Policy and Fees

**If written notice for cancellation of a session is not received 24 hours prior to the scheduled session, documentation for a no call/no show will be applied. If more than 3 no call/no shows are documented, the fourth and any cancelation thereafter will result in a $50.00 fee. This ensures consistent and quality service are provided to our clients.**

Signature Agreement for Rules and Regulations of Rise With ABA:

Signature (Parent/ Guardian #1) Date

### Release Form

REQUEST/AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL AND MENTAL HEALTH RECORDS AND INFORMATION

SOURCE OF INFORMATION

Person or facility: Address:

Phone # \_\_\_\_\_\_\_\_\_\_

IDENTIFYING INFORMATION

Name: Address:

Phone #: \_\_\_\_DOB: Social Security #:

Parent/Guardian: Address:

Phone # \_\_\_\_\_\_\_\_\_

I hereby authorize the source named above to send the records marked below to Rise With ABA at the address listed above.

Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness:

Psychological evaluation(s) or testing records, and behavioral observations or checklists completed by and staff member or by the client.

Psychiatric evaluations, reports, or treatment notes

Treatment plans, recovery plans, aftercare plans

Admission and discharge summaries

Social histories, assessments with diagnosis, prognoses, recommendations, and all similar documents

Information about how the client’s condition affects or has affected his or her ability to complete tasks, activities of daily living, or ability to work.

Workshop reports and other vocational evaluations and reports.

Billing records

Academic or educational reports

Report of teachers/staff observations

Achievement and other test results

Other:

I further authorize the source named above to speak by telephone with staff of Rise With ABA about the reasons for my/the client’s referral, and the relevant history or diagnosis, and other similar information that can assist with my/the client’s receiving treatment or being evaluated.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Printed Name

### Service Agreement and Consent Form

This document contains important information about our professional services and business policies. It also contains summary information about the Health Information and Portability and Accountability Act (HIPPA), a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPPA requires that we provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPPA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with the information. Although these documents are long and sometimes complex, it is very important that you read them carefully and that you ask questions you have about the procedures at any time. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligation imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. If you have any questions or concerns, please feel free to discuss them with us.

##### Services Offered

We will provide services specifically designed to help you and/or your minor child, or otherwise provide you with referrals to other professionals. Our behavioral services consist primarily of individual behavioral and skill assessments and short and long-term ABA service provision to youth in the autism spectrum but are not limited to those areas.

##### Appointments

Except for rare emergencies, we will see your child at the time scheduled. We understand that circumstances (such as illness or family emergency) may arise which necessitate the occasional cancellation of appointments. In these cases, in order to avoid any misunderstanding, we ask that you give us as much notice as possible. This will allow us to offer your time to another person. You will be charged the standard hourly rate (see below) for appointments missed or canceled with less than 24 hours’ notice. Please note that most insurance companies will not reimburse you for missed appointments and you remain responsible for these charges. 75% attendance is required to maintain services. 3 or more no call/no shows will result in termination of services.

##### Confidentiality, Records, and Release Of Information

All services are confidential except to the extent that you provide us with written authorization to release specified information to specific individuals, or under other conditions and us mandated by Texas and Federal law and our professional codes of conduct/ethics. These exceptions are discussed below.

To Protect Client From Harm

If we have reason to suspect that a minor, elderly, or disabled person is being abused, we are required to report this and ay additional information upon request to the appropriate state agency. If we believe that a client is threatening serious harm to him/herself or others, we are required to take protective actions which could include notifying the police, an intended victim, a minor’s parents, or others who could provide protection, or seek appropriate hospitalization.

##### Professional Consultations

Behavior Analysts routinely consult about cases with other professionals. In so doing, we make every effort to avoid revealing the identity of our clients, and any consulting professionals are also required to refrain from disclosing any information we reveal to them.

##### Records

We will review all testing results during our feedback session, and offer you opportunities to ask questions and discuss the results with us. You will receive a written report that summarizes the findings. This report will include a summary and interpretation of all individual testing, as well as impressions from individual observations and consultations conducted as a part of a comprehensive individual evaluation. Upon your request, we are happy to provide you with a written summary of our impressions from other meetings, consultations, or observations as well.

##### Payment For Services

If necessary, we may seek assistance from an outside party in order to collect payment for services rendered to you. In such cases, any disclosures are limited to the minimum that is necessary to achieve the purpose. Copays are the responsibility of the beneficiary.

##### Health Care Insurance

If we do not file your insurance claims at this time, we will provide you with statements that you may submit to your insurance carrier or complete any forms as required by your insurance carrier in order to obtain reimbursement for out-of- network providers. In order to assist you with obtaining reimbursement for our services, your insurance carrier may require that we provide a clinical diagnosis, or additional clinical information such as treatment plans or summaries, copies of your child’s entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you and your child that is necessary for the purpose requested. By signing this Agreement, you agree that we can provide requested information to your carrier if/when you choose to file a claim for any services that we have provided to you or your child.

##### Professional Records

You should be aware that, pursuant to HIPPA, we keep clients’ Protected Health Information in two sets of professional records. One set contains the Clinical Record and the other the professional’s personal notes.

##### Client Rights

HIPPA provides you with several rights with regards to your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your records; requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about your policies and procedures recorded in your records; and the right to a paper copy of the Agreement; the attached Notice Form, and our privacy policies and procedures.

##### Contacting Us

Given their many professional commitments, our professionals are often not immediately available by telephone. If you need to leave a message, we will make every effort to return your call promptly (within 24-48 hours with the exception of holidays and weekends). If you are difficult to reach, please leave some times when you will be available.

##### Consent

Your signature(s) below indicates that you have read the information in this document and agree to be bound by its terms, and that you have received the HIPPA notice from described above or have been offered a copy and declined. Consent by all parents/legal guardians (those with legal custody) is required.

|  |  |  |  |
| --- | --- | --- | --- |
| Client/Child’s Name |  | Date |  |
| Parent/Guardian #1 Name | Parent/Guardian #2 Name |  |  |
| Parent/Guardian #1 Signature | Parent/Guardian #2 Signature |  |  |

### Client Confidentiality Contact Form

Client confidentiality is a top priority for Rise With ABA. Therefore, it is important that you provide us with the following information to ensure there is no violation of your privacy.

In the event that I, , am unable to be reached, Rise With ABA may leave information with the following:

Other Adult in Household (Name):

On Home Voice Mail (#):

On Cell Phone (#):

I may be reached at my work number:

May leave a message at work on my voice mail:

Other: (Please describe):

Text:

OPT OUT (Initials) . In the event that I am unable to be reached, Rise With ABA MAY NOT leave information with anyone but myself. I understand that if the status of any of the above information changes, it will be my responsibility to inform the staff of Rise With ABA.

Parent’s Signature: Date:

### Informed Consent For Services

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, as a parent or guardian, give my consent for Rise With ABA to provide behavior analytic services to my child, \_\_\_\_\_\_\_\_\_, in accordance with the ethical guidelines proposed by the Behavior Analytic Certification Board (BACB). I also understand that I may withdraw my consent and terminate treatment at any time and for any reason.

I understand that any information provided in this intake as well as any information obtained at any point during the interview process or course of treatment, is kept strictly confidential in accordance with HIPAA regulation guidelines and the law.

I understand that Board Certified Behavior Analysts are bound to strict ethical guidelines of practice and that any issues of concern that may arise throughout the treatment process that are out of the behavior analyst’s area of experience may result in referrals to a more appropriate agency or individual.

Signature: Date: Printed Name: Name of Client:

## Release, Indemnification and Hold Harmless Agreement for Transportation

As a necessary and indispensable part of my being allowed to participate in, community outings, field trips, and other necessary transportation sponsored by Rise With ABA, I do hereby agree and represent, on my behalf and on behalf of my heirs, personal and legal representatives, successors, assigns, employees, dependents, and associates as follows:

I , willingly assume any and all risks and danger inherent with or incidental to myself and my minor child, participation in all sessions and travel to and from community locations, or classes, and any and all activities in connection with any such activities sponsored by Rise With ABA.

I understand and accept that accidents occur, although Rise With ABA will make every attempt to maintain the utmost safety for all parties involved. In any event and regardless of the nature of any injury, damage, or loss that I may suffer or that may accrue to the benefit of or damage to any of the persons named above, no claim or demand will be made on or against you, Rise With ABA, or on or against any of the agents, representatives, associates, employees, or contractors of Rise With ABA.

###### I give permission for my child to be transported to and from the below activities by staff or contractors of Rise With ABA:

###### \_\_\_\_\_School

Community Outings \_\_\_\_\_Medical Needs (Clinics/ER/Hospital)

Field Trips Other

**This agreement is knowingly, willingly and freely given, and I fully understand and agree that it is a release and waiver of certain rights I may have and shall act as a complete bar against any claims that might otherwise be brought.**

I have been given a copy of this agreement, which I have read and I understand and acknowledge its terms. Its contents have also been explained to me. I understand the consequences of my signature to this agreement.

Signature of Parent: Date:

Print Name:

Child Intake Questionnaire

The following questionnaire is to be completed by the child’s parent or legal guardian. This form has been designed to provide essential information before your initial appointment in order to make the most productive and efficient use of our time. Please feel free to add any additional information which you think may be helpful in understanding your child. Rise With ABA will hold information provided by you as strictly confidential and will only be released in accordance with HIPPA guidelines and as mandated by law.

PLEASE PRINT

##### Child Information

**Child’s name:**DOB: Age: Male: Female:

Address: City: State: Zip: Phone: Type:

School District: Name of School: Grade: Date enrolled: Date of IEP: Placement: Mainstream Inclusion Resource Other: Days and times of attendance: Teacher (s):

Contact Information: Did the teacher report any problems? (please explain):

##### Family Information



*Mother’s/guardian’s name:*  Occupation: Address (if different from client): City: State: Zip:

Phone: Type: Email address:

Father*’s/guardian’s name:*  Occupation: Address (if different from client): City: State: Zip:

Phone: Type: \_ Email address:

Marital status of parents: Married Separated Divorced Single Parent (s) with custody of child:

Step-parents: Was child adopted? Yes No

Referred by:

Insurance Provider: Provider Number: Contact Number: If Military: Sponsor

Sponsor Rank: Sponsor SSN:

##### 

##### Types of Programs Please mark all that are of interest):

Center-based ABA Therapy:

Home-based ABA Therapy:

##### 

##### 

##### Developmental History

Please indicate the age at which your child did the following:

|  |  |
| --- | --- |
| **Milestone** | **Age** |
| **Rolled over consistently** |  |
| **Sat up unsupported** |  |
| **Stood** |  |
| **Crawled** |  |
| **Walked unassisted** |  |
| **Said 1st word intelligible to strangers** |  |
| **Said two-three word phrases** |  |
| **Used sentences regularly** |  |
| **Toilet trained during the day** |  |
| **Dry through the night (6+ months)** |  |
| **Dressed self** |  |
| **Fed self** |  |
| **Colored** |  |

##### 

##### Social Skills

Please indicate if your child is experiencing any of the following:

|  |  |  |
| --- | --- | --- |
| **ISSUE** | ** or X** | **COMMENTS** |
| **Plays independently** |  |  |
| **Plays with toys appropriately** |  |  |
| **Attempts to involve others in play** |  |  |
| **Engages in interactive play with peers** |  |  |
| **Engages in pretend play** |  |  |
| **Spontaneous vocalization/language** |  |  |
| **Imitates sounds/words/phrases** |  |  |
| **Communicates wants/needs** |  |  |
| **Follows simple directions** |  |  |
| **Labels items/events/actions** |  |  |
| **Answers WH questions** |  |  |
| **Engages in verbal exchanges with others** |  |  |
| **Imitates simple gestures (fine motor)** |  |  |
| **Imitates simple gestures with objects** |  |  |
| **Imitates gross motor skills** |  |  |
| **Problems making/keeping friends** |  |  |
| **Problems getting to/staying asleep** |  |  |
| **Problems controlling temper** |  |  |
| **Problems with authority** |  |  |
| **Anxiety** |  |  |
| **Unmotivated** |  |  |
| **Concentration difficulties** |  |  |

##### 

##### Self – Care

How well does your child complete each of the following?

|  |  |  |  |
| --- | --- | --- | --- |
| **TASK** | **INDEPENDENT** | **SOME HELP** | **FULLY ASSISTED** |
| **Dressing** |  |  |  |
| **Eating** |  |  |  |
| **Drinking** |  |  |  |
| **Toileting** |  |  |  |
| **Brushing Teeth** |  |  |  |
| **Washing Hands** |  |  |  |

##### Daily Routines

Describe your child’s basic daily routine (include times to wake up, naps, bedtime, meals, school, etc.

|  |  |
| --- | --- |
| **TIME OF DAY** | **DESCRIPTION OF ROUTINE** |
| **Morning** |  |
| **Afternoon** |  |
| **Early Evening** |  |
| **Night** |  |

List any serious operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other special conditions your child has had:

##### 

##### Allergies

Please circle any of the following conditions that your child has had:

|  |  |  |  |
| --- | --- | --- | --- |
| **Allergic reactions** | **Earaches** | **Hives** | **Broken bones** |
| **Ear infections** | **Itchy eyes** | **Constipation** | **Eczema** |
| **Seizures** | **Dehydration** | **Heart problems** | **UTI** |
| **Diabetes** | **Hemorrhoids** | **Other** | **Other** |

##### Medications

List any medications your child is currently taking or has taken for extended periods:

|  |  |  |  |
| --- | --- | --- | --- |
| **MEDICATION** | **PURPOSE** | **DOSAGE** | **DATES** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Is your child on a special diet? Yes No If yes, please explain:

Which hand does your child write/hold pencil with? Right Left No dominance shown

Does your child have any vision problems? Yes No

Please list the date of the last vision test and who performed (pediatrician, optometrist, school)

Does your child have any hearing problems? Yes No

Please list the date of the last hearing test and who performed (pediatrician, audiologist, school)

Name of child’s physician (s):

Practice name: Address:

Phone number: - -

##### Related Services

Service/Therapy: Provider: Dates of service: to Address:

Phone: May we contact: Hours per week:



Service/Therapy: Provider: Dates of service: to Address:

Phone: May we contact: Hours per week:



Service/Therapy: Provider: Dates of service: to Address:

Phone: May we contact: Hours per week:

Behaviors of Concern

|  |  |  |
| --- | --- | --- |
| **ISSUE** | ** or X** | **COMMENTS** |
| **Self-stimulatory behaviors: vocal, flapping, lining up objects** |  |  |
| **Self-injurious behaviors: banging head, eye**  **poking, biting self** |  |  |
| **Unsafe behaviors to self: running away, climbing on furniture** |  |  |
| **Unsafe behaviors to others: hitting, throwing, objects** |  |  |
| **Ritualistic/obsessive behaviors: wearing same**  **clothes, only talks about one topic** |  |  |
| **Concerns with accepting no/ transition** |  |  |

Please provide more details concerning challenging behaviors using the chart below.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Behavior** | **How often does it happen?**  **DAILY WEEKLY MONTHLYSEVERAL TIMES A YEAR** | **How long does it usually last? SECONDS**  **1-5 MIN**  **5-15 MIN**  **< 30 MIN** | **What kind of damage does it cause?** | **What could you do that would guarantee I would see the behavior?** | **What could you do that would very likely make the behavior stop?** |
| **1.** |  |  |  |  |  |
| **2.** |  |  |  |  |  |
| **3.** |  |  |  |  |  |
| **4.** |  |  |  |  |  |
| **5.** |  |  |  |  |  |

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Please list any fears or non-preferred items/activities your child may have:

Please list any reinforcers your child may have:

##### Extra-Curricular Activities

Please indicate any extra-curricular activities, including sports, clubs, hobbies, lessons, etc.:

|  |  |  |
| --- | --- | --- |
| **Football** | **Karate** | **Dance (Type)** |
| **Baseball** | Piano | Music (Type) |
| **Cheerleading** | Scouts | Gymnastics |
| **Basketball** | Soccer | Other: |

Any other information that may by useful