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: _____

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 Service: _____

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: _____