ABA STEPS, LLC
Behavioral Specialists
908.858.0858

Child Intake Form

Client Name:_____ DOB: _____ (M / F)

Address: City/ State : Zip:

Parent / Guardian Name(s):_____

Phone:

Email:

Reason for Referral:

Medical History

Dx / Code_____ Age at Dx _____ Diagnosing Physician_____ Ph: _____

Other Dx/ Disability _____

Current Primary Physician_____

Address/ Ph_____

Consent to consult with above named Physicians? : (Y / N)

Insurance Information

Primary Insurance and ID #:
Policy Holder Name/ DOB:
Secondary Insurance (if any):

Medications: (list all)

1. _____Purpose_____ dosage:
2. _____Purpose_____ dosage:
3. _____Purpose_____ dosage:

Allergies? _____

Has your child ever been hospitalized for medical or psychiatric reasons?

Reason :

Date(s):

Facility:

Health challenges of immediate family members: _____

_____

Does anyone in your family experience mental health issues such as depression/ anxiety or other emotional difficulties?
_____

FAMILY INFORMATION

Siblings:_____ Age(s):_____

Pets: _____ Disposition: (friendly/ aggressive)

Eating /Sleeping Habits of Child: _____

Likes/ Dislikes_____

Behavior

Has your child ever :

Tried to hurt others or animals?
Self injured?
Displayed concerning behavior?
Display disregard for safety?

Displayed Aggression ?
-Frequency and Severity (please describe what this looks like):

-Triggers?

-How do you respond to this behavior?

Talked about or attempted suicide?

Does your child display sterotypic (stimming) behavior?

Functioning

Describe your child's communication skills : _____

_____

Does your child attend outside Speech or Occupational Therapy? _____

School : _____
What grade/ program/ class setting does your child attend? _____

Does your child have an IEP? _____

What are your child's favorite activities?

Least favorite?

Favorite foods_____Favorite snacks_____

Level of physical activity :(LOW / MODERATE/ HIGH/)

How much time PER DAY does your child spend on a phone/ watching TV/ playing video games ? _____

FAMILY AVAILABILITY

It is strongly suggested that your child be available for the majority of time they are not in school to optimize the benefits of home- based ABA therapy.

Sun:

Mon:

Tues:

Wed:

Thurs:

Fri:

Sat:

Please list your therapy goals for your child :

Liability Waiver

I hereby waive and release ABA STEPS LLC and its associates, directors, employees, and vendors from any and all claims for loss, injury, or damage. I further agree to indemnify and hold harmless ABA STEPS from any and all losses, claims, or damage. This is an express waiver and release from any and all claims arising from my child's participation in any ABA STEPS related activity. This agreement shall remain in effect for the duration of participation by my child/ family in ABA STEPS related therapy / activities.I also grant ABA STEPS and its associates permission to provide emergency medical care in the event of a medical emergency.

Financial Waiver

I have been informed that I am financially responsible for all services which may not be covered by my insurance plan. I agree to accept all financial responsibility for all costs associated with services provided by ABA STEPS LLC.

Parent/ Guardian:_____ Date:_____
(Type Initials as signature)