ABA S.T.E.P.S, LLC
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CHILD INTAKE INFORMATION

Name_____ Date of Birth _____Age _____ Gender (M/F) _____

Address_____ _____ NJ, _____

Home Phone # _____ Cell# (MOM)_____ Cell# (DAD)_____

Parent Email Address _____

Reason For Referral: _____

MEDICAL HISTORY

Primary Diagnosis, Code, Age Diagnosed _____

Diagnosing Physician_____

Other Diagnosis/ Disability_____

Name of Primary Care Physician: _____

Physician's Address:_____Physician's Phone:_____

INSURANCE INFORMATION:

PRIMARY INSURANCE _____Insured's Name, DOB_____

SECONDARY INSURANCE _____Insured's Name, DOB_____

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Circle One) YES NO

Please sign here for either answer:_____

Date of last medical evaluation:_____ Date of next appointment:_____

Current medications being taken:

1)_____ Dosage/Freq _____ Start Date_____Purpose_____

2)_____ Dosage/Freq _____ Start Date_____Purpose_____

3)_____ Dosage/Freq _____ Start Date_____Purpose_____

4)_____ Dosage/Freq _____ Start Date_____Purpose_____

Prescribed by: _____

ANY ALLERGIES? Please list _____

Has your child ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital Mo/Yr Reason

_____ _____ _____

_____ _____ _____

_____ _____ _____

Describe any important medical history, chronic ailments, or other health problems your child experiences:_____

_____

_____

_____

Describe any other health problems or important medical history about your child's immediate family members and close relatives, including chronic ailments:_____

_____

_____

Does your child have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list: _____

_____

_____

_____

SCHOOL HISTORY

Does your child experience any developmental, academic or behavior problems while in school or daycare, with peers or teachers? (Circle One) YES NO If yes, please explain:_____

_____

What was the last year of school your child completed? _____

What school is he/she attending? _____Hours per week_____

Is your child home-schooled? (Circle One) YES NO

What type of classroom / placement is your child currently in? _____

List any therapies your child receives, the hours per week and the provider:_____

FAMILY INFORMATION

Please check all information which applies to your child's biological parents:

MOTHER	FATHER
____ living	____ living
____ deceased	____ deceased
____ married	____ married
____ divorced	____ divorced
____ remarried ____# of times	____ remarried ____# of times

With whom does your child live: _____

What custody and/or visitation orders are in place? :_____

*** Please copy orders to be placed in client's file.**

Does your child consider anyone else to be a "parent" in his/her life? YES NO If so, whom?_ _____

Describe your relationship with your child:

Currently: _____

_____

In the past: _____

_____

Describe your child's relationship with his/her other parent:

Currently: _____

_____

In the past: _____

_____

List first names and ages of your child's brothers & sisters:

Name	Age	Relationship (biological, step, half, etc.)	Lives with:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe any problems which occurred in your child's family relating to:

Alcohol/drug abuse: _____

_____

Sexual/physical/emotional abuse:_____

_____

Others living in the home with your child:

Name	Age	Relationship	Grade/Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MENTAL STATUS

Please check any of the following that describe how you believe your child has been feeling lately:

____sad ____anxious ____depressed ____frightened ____guilty ____angry ____ashamed ____aggressive ___resentful
____worthless ___tearful ____irritable ____confused _____extreme ups/downs _____jealous _____hopeless ___helpless

Describe any behaviors your child has demonstrated that cause concern:_____

_____

Any physical Aggression? _____ Severity: (circle) Mild Moderate Severe

Frequency of above behaviors and triggers (what seems to cause the behaviors to occur):_____

_____

How do you usually respond to these behaviors _____

Has your child had any change in sleeping habits? (Circle One) YES NO Describe: _____

_____

Has your child had any change in eating habits? (Circle One) YES NO

Describe:_____

_____

Has your child ever considered suicide in connection with his/her **current** problem? (Circle One) YES NO

If so, please give a brief description with dates:_____

Has your child ever **considered suicide** in the **past**? (Circle One) YES NO

Has your child **attempted suicide recently** or in the **past**? (Circle One) YES NO

If so, please give a brief description with dates:_____

_____

Has your child tried to hurt others or animals recently or in the past? (Circle One) YES NO

If yes, please explain:_____

_____

LEVEL OF FUNCTIONING

Describe your child's communication skills _____

Please describe what activities your child participates in:_____

_____

Likes/ Dislikes _____

Who is in your child's support network? _____

_____

Please describe your child's level of physical activity: _____

_____

How much time does your child play on the computer, watch TV, or play video games: _____

_____

Is there any other information regarding your child that you would like to share with your child's Therapist that is not covered on this form? You may also use this space to complete earlier responses.

_____

_____

_____

_____

Please list your therapy goals for your child:

_____

_____

_____

_____

THANK YOU!

I would be interested in the following for my child: (circle all that apply)

ABA Home Therapy Parent/ Family Training Social Skills therapy/ groups
In- School Shadowing Summer Camp Shadow

Family Availability:

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

Monday:
Tuesday:
Wednesday:
Thursday:
Friday:
Saturday:
Sunday:

Liability Waiver

I hereby waive and release ABA STEPS and its associates, officers, directors, employees, vendors,and contractors from any and all claims for loss, injury, or damage. I further agree to indemnify and hold harmless ABA STEPS LLC 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 related activities. This agreement shall remain in effect for the duration of participation by my child /family in ABA STEPS related therapy/ activities. I also hereby grant ABA STEPS and its associates the 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

INCLUDE the FOLLOWING:

Full report from diagnosing Physician with Diagnosis and Code

Prescription for ABA Therapy

Copy of Insurance Cards (Front and Back)

Please scan this document to us and retain a copy for your records. Thank You