# Tomorrow's Superheroes PLLC
# Applied Behavior Analysis (ABA) Intake Form

## Child Information

| | |
|---|---|
| Last Name: | Today's Date: |
| First Name: | Date of Birth: |
| Middle Name: | Age: years months |
| Home Phone: | Gender: |
| Address: | City: |
| State: Zip: County: | Race/Ethnicity: |

## Child's Primary Health Care Doctor

| | |
|---|---|
| Doctor's Name: | Phone: |

## Autism Diagnosis Information

| | |
|---|---|
| My child was diagnosed by:<br>Phone number of person who diagnosed: | Date of diagnosis: |

## Health Care Coverage Information

Primary Coverage for ABA:

- ☐ Medicaid
- ☐ Private Insurance
- ☐ Self-Pay

Please complete the following and attach a copy of primary insurance card

| | | |
|---|---|---|
| Plan Name | Policy # | Group# |
| Subscriber (Name of Insured) | | Subscriber's DOB |
| Place of employment | | |

Secondary Coverage for ABA:

- ☐ Medicaid
- ☐ Private Insurance

Please complete the following and attach a copy of secondary insurance card

| | | |
|---|---|---|
| Plan Name | Policy # | Group# |
| Subscriber (Name of Insured) | | Subscriber's DOB |
| Place of employment | | |

## Who has current custody/guardianship of child?

☐both parents ☐mother ☐father ☐relative: ☐other:

If there is a parenting plan, please provide a copy.

## Your availability for ABA appointments (Check all that are possible)

☐ Weekdays, during school hours:

Morning ☐M ☐T ☐W ☐Th ☐F Afternoon ☐M ☐T ☐W ☐Th ☐F

☐ Weekdays, after school hours: ☐M ☐T ☐W ☐Th ☐F

## Parent 1 or Legal Guardian Information

| | |
|---|---|
| Full Name: | Relationship to Child: |
| Address: (if different from child) | DOB: |
| | Cell Phone: |
| City: | Home Phone: |
| State: | Business Phone: |
| E-mail: | Occupation: |

## Parent 2 or Legal Guardian Information

| | |
|---|---|
| Full Name: | Relationship to Child: |
| Address: (if different from child) | DOB: |
| | Cell Phone: |
| City: | Home Phone: |
| State: | Business Phone: |
| E-mail: | Occupation: |

## Emergency Contact

| | |
|---|---|
| Full Name: | Phone (h): |
| Relationship to Child: | Phone (w): |

## Other People Living in the Home

| | | | |
|---|---|---|---|
| Name: | Relationship: | Age: | Gender: |
| Name: | Relationship: | Age: | Gender: |
| Name: | Relationship: | Age: | Gender: |
| Name: | Relationship: | Age: | Gender: |

## Other People Significant to your Child NOT Living in the Home

| | | | |
|---|---|---|---|
| Name: | Relationship: | Age: | Gender: |
| Name: | Relationship: | Age: | Gender: |

| Name: | Relationship: | Age: | Gender: |
|---|---|---|---|

**Were you referred for ABA by someone?**

☐Yes ☐No If yes, who:

**Goals for your child:**

**Please describe any behavior concerns your child has (e.g., self-injurious, aggressive towards others, etc.) and methods used to decrease behaviors.**

**Please describe your child's current communication skills (e.g., sign language, PECS, verbal).**

**What else would you like us to know about your child?**

**If your family has cultural, religious, ethnic or social beliefs about physical or mental health or illness that you feel would help us in understanding your child and family, please describe below.**

## Current & Previous Services

**Current School/Placement (Type of Special Educational Services)**

| Name of School: | Years attended: |
|---|---|
| Address: | Placement: |
| Phone: | Hours in school per week: |

## Previous Schools/Placements (Type of Special Educational Services)

| | |
|---|---|
| Name of School: | Years attended: |
| City/State: | Placement: |
| Name of School: | Years attended: |
| City/State: | Placement: |

## Behavioral Consultation Provider

If your child receives or has received behavioral services, please complete below:

Dates of service: to Frequency of service: per

Agency: Provider Name:

Provider Phone:

Please describe services:

Please describe the results in achieving goals:

## Additional Diagnostic Information

If your child has other diagnoses, please list below:

## Medication Information

Is your child on medication? ☐Yes ☐No

If yes, please list below:

| Medication: | Dosage: | When given: | Used for: | Prescribed by: |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Please list additional medications on a separate page and attach

## Other medical conditions or allergies

Below, please list medical conditions or allergies that need to be considered when delivering ABA treatment:

| Condition or allergy: | Doctor treating it: | Doctor's specialty: |
|---|---|---|
| | | |
| | | |
| | | |

## Supportive Services

Please list other services your child currently receives both in school and out of school. Please enclose a copy of the child's most recent IEP or IFSP and goals from each area checked.

| Service/Therapy: | Location: | Minutes/Week: |
|---|---|---|
| ☐ Early Intervention Services<br>Provider: | ☐ School ☐ Home | |
| ☐ Speech and/or language therapy<br>Provider: | ☐ School ☐ Home | |
| ☐ Occupational Therapy<br>Provider: | ☐ School ☐ Home | |
| ☐ Physical Therapy<br>Provider: | ☐ School ☐ Home | |
| ☐ Vision services<br>Provider: | ☐ School ☐ Home | |
| ☐ Hearing services<br>Provider: | ☐ School ☐ Home | |
| ☐ Psychotherapy/Counseling<br>Provider: | ☐ School ☐ Home | |
| ☐ Other<br>Provider: | ☐ School ☐ Home | |

**Please enclose the following documents if available. These will be required prior to the start of services.**
**Please email or fax completed intake form and additional documents to**
**drkaybcba@tomorrowssuperheroes.com Fax: (844) 906-2424**
**Any questions please call (601) 385-1536**

- ☐ Copy of your insurance card
- ☐ Copy of current IEP or IFSP
- ☐ Diagnostic report
- ☐ Prescription letter for ABA
- ☐ Copy of parenting plan