Welcome!

Thank you for choosing Therapy & Learning Center of GA, LLC. To help meet your child's needs. We sincerely appreciate this opportunity and look forward to working with you and your child.

The attached New Client Paperwork packet includes important information about the practice. Please take time to fill out as much information as possible regarding your child's developmental history, as this information can be vital to the direction of the therapy plan. We understand that these forms can be time consuming however, it is important that we have as much information as possible prior to your visit so that we may provide the best possible service for your child. If your child has any recent evaluations completed by other health professionals (psychologist, IEP, etc.), please bring copies of these with you or you may email them to us in advance.

Please see our Policies & Procedures Packet for information regarding payment, insurance, and cancellations and our ABA Specific Policies regarding other pertinent procedures to ABA therapy.

Sincerely,

Amy Squires, M.S.CCC-SLP
Speech and Language Pathologist
Director of Therapy and Learning Center of GA
GA License #: SLP 008235
ASHA Certification #: 12132094

Therapy & Learning Center of GA

ABA Intake Form

Identifying Information:

Date Completing Form: _____

Client Name:_____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

E-mail:_____

Phone 1: _____ Phone 2: _____

Parent/Guardian Names: _____

Mother's Occupation: _____Father's Occupation:_____

Does the child lives with both parents? ☐ Yes ☐ No

Primary Language Spoken in Home: _____

Others living the home (names, ages, and relationship to Client): _____

_____

Person Completing Form: _____ Relationship to Client: _____

Pediatrician: _____ Phone:_____

Previous evaluations (list): _____

Therapy to date (list): _____

Insurance Information

☐ Check this box if you plan to pay privately for services.

Insurance Company: _____ ID Number: _____

Subscriber Name: _____ Group Number: _____

Medical Information

Current Diagnoses: _____

Milton Speech Pathology Therapy & Learning Center of GA

Prenatal/Birth History

Full Term: ☐ Yes ☐ No; If No, how many weeks? _____

Illnesses or accidents during pregnancy: _____

_____

Use of alcohol, tobacco, or medications during pregnancy: _____

_____

Any other unusual conditions that may have affected pregnancy and/or birth? _____

_____

Birth weight: _____ Delivery: ☐ Vaginal ☐ Cesarean ☐ Breech

Medical History

Please check if your child has had any of the following (and if so, at what age):

- ☐ Adenoidectomy_____
- ☐ Allergies_____
- ☐ Asthma_____
- ☐ Breathing Difficulties_____
- ☐ Chronic Ear Infections_____
- ☐ Ear tubes_____
- ☐ Encephalitis_____
- ☐ Hearing Loss_____
- ☐ Head Injury_____
- ☐ High Fevers_____
- ☐ Measles_____
- ☐ Meningitis_____
- ☐ Mumps_____
- ☐ Scarlet Fever_____
- ☐ Seizures_____
- ☐ Sinusitis_____
- ☐ Sleeping Difficulties_____
- ☐ Thumb/Finger Sucking_____
- ☐ Tonsillectomy_____
- ☐ Vision Problems_____

Explain any checked items here: _____

_____

Please list all medications your child is taking: _____

_____

List all known allergies: _____

_____

Any additional information you would like us to know: _____

_____

Developmental History

In your opinion, how does your child's overall development compare to that of other children his/her age? _____

_____

Give the approximate age at which your child:

Sat unsupported: _____ Crawled: _____ Stood: _____

Walked Alone: _____ Was Toilet Trained: _____ Feed Self: _____

Dress Self: _____ Tie shoes: _____

Grasped crayon/pencil: _____

Does your child have any difficulty understanding you? (If so, please describe): _____

_____

Does your child have difficulty following directions? (If so, please describe): _____

_____

Is there family history of autism, ADHD, or speech and hearing problems? (If so, please explain): _____

_____

How would you characterize your child's interaction with:

Siblings: _____

Parents: _____

Peers: _____

Other adults: _____

Has your child attended daycare? _____

Number of regular playmates: _____

Does your child's attention span seem appropriate for his/her age? _____

Is your child active, hyperactive, or lethargic? If yes, please explain: _____

_____

How does your child handle frustration? _____

_____

What motivates your child the most? _____

What discipline works best? _____

Milton Speech Pathology Therapy & Learning Center of GA

Educational Information

Name of School: _____

Classroom Type: _____

Teacher(s): _____

Behavioral Provider (if any): _____

Speech Provider (if any): _____

OT Provider (if any): _____

Other Therapy Provider (if any): _____

How does your child's teacher describe his/her performance? _____

_____

Has the teacher expressed concerns? If so, what? _____

_____

Is your child having difficulty with any subjects? _____

What are your child's favorite subjects? _____

If your child has been enrolled in Special Education services, has an Individualized Education Plan (IEP) been developed? (If so, please attach a copy)

_____

Does your child have a 504 plan? _____ (If so, please attach a copy)

Milton Speech Pathology Therapy & Learning Center of GA

Client's Interests

Please indicate anything that the clinicians should know when working with your child.

1. Preferences (favorite activities, food, interests, topics, sensory):

_____

_____

_____

2. Dislikes (aversions):

_____

_____

_____

3. Other – including any information regarding your child's interests you want us to know!

_____

_____

_____

Concerns

Reason for seeking ABA Services [Please explain]: _____

_____

_____

Please list client strengths: _____

_____

Developmental Concerns

Please indicate by marking the box and explaining each domain.

☐ Cognitive/Learning: _____

_____

☐ Motor: _____

_____

☐ Behavior: _____

_____

☐ Language: _____

_____

☐ Social: _____

_____

☐ Peer Interaction: _____

_____

☐ Play/Leisure: _____

_____

☐ Academics (Reading/Writing/Math): _____

_____

☐ Executive Functioning (Organization/Flexibility/Attention): _____

_____

☐ Other: _____

_____

Parent/Family Preferences

Please list the top three areas/goals you would like to see improvement for the client in the next 6 months:

1. _____

_____

2. _____

_____

3. _____

_____

Cultural Considerations

Please describe below important cultural practices, rituals, traditions or beliefs that you believe are important for us to aware of prior to initiating a therapeutic relationship.

_____

_____

_____

_____

Therapy & Learning Center of GA

Consent Form

This form must be completed before services can be initiated. If the client is under the age of 18 years, all legal guardians must sign the form.

Consent for Treatment: I hereby attest that I have voluntarily applied for and entered into treatment, or give my consent for the minor or person under my legal guardianship, at Therapy & Learning Center of GA. I understand that I may terminate these services at any time.

Consent to Communicate with Insurance Company: I give consent to Therapy & Learning Center of GA and its employees/agents to communicate with my insurance company and to release any health information needed in order to authorize visits and collect payment.

Receipt of Policies and Procedures: I hereby attest that I have received a copy of Therapy & Learning Center of GA's Policies and Procedures, including payment policies, and have read, understand, and consent to be bound by its content.

Receipt of Client's Rights: I hereby attest that I have received a copy of the Client Rights notice, have read, and understand its content.

Receipt of Privacy Policy and Consent for Disclosure of Health Information: I have been provided a copy of Therapy & Learning Center of GA's Notice of Privacy Policies detailing how my medical record may be used and disclosed under Federal and State law. I understand that as a part of Therapy & Learning Center of GA's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity (i.e., insurance, emergency, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax and e-mail only to appropriate parties. I fully understand and accept the terms of this Consent and acknowledge the receipt of the Privacy Notice. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I understand that by refusing to sign this consent or revoking this consent, Therapy & Learning Center of GA may refuse to treat me. I further understand that Therapy & Learning Center of GA reserves the right to change its privacy policies and will provide me with a copy of any revised notice.

I acknowledge that if I elect service time beyond what my insurance company will cover that I am voluntarily paying for that service time.

Photocopy Authorization: I permit a photocopy of this consent form as if it were an original executed consent.

Name of Client (Printed): _____

By signing below, you are attesting to the accuracy of the above statements including all consents and authorizations implied therein. A copy of this agreement is available upon request.

Legal Guardian Signature Date

_____ _____