CT ABA SERVICES LLC

Intake Application Form

Insurance Prov: _____

Policy# _____

Personal Information:

1. Full Name (client):_____

2. Date of Birth: _____

3. Gender: _____

4. Address: _____

5. City: _____

6. State/Province: _____

7. Zip/Postal Code: _____

Parent or Guardian

Phone Number: _____

Email Address: _____

10. Preferred Contact Method: (Check one)
- [ ] Phone
- [ ] Email

Emergency Contact Information:

Name: _____

Relationship: _____

Phone Number: _____

Medical Information:

Primary Care Physician: _____ Phone:_____

Diagnosis Information:

Date of Autism Diagnosis: _____

Diagnosing Physician: _____

Any co-occurring medical conditions or allergies?
Yes
No
If yes, please provide details: _____

Educational Information:

Current School/Program: _____

Individualized Education Plan (IEP):

Is there an IEP in place?
Yes
No
If yes, please provide a copy if available.

Behavioral History:

Has the individual received behavioral therapy or intervention in the past?
___ Yes
___ No
If yes, please provide details:

Communication:

Communication Preferences: (Check all that apply)
__ Verbal
__ Non-verbal
__ Augmentative and Alternative Communication (AAC) Device

Sensory Sensitivities:

Please describe any specific sensory sensitivities or triggers:

Additional Information:

Is there any additional information you would like to share about the individual's needs or preferences?

Consent:

I, the undersigned, certify that the information provided in this intake application is accurate to the best of my knowledge. I understand that this information will be used for the purpose of planning and providing appropriate support and services for the individual with autism.

Signature: _____

Date: _____

Thank you for completing this intake application. Your cooperation in providing accurate and detailed information is essential in helping us understand and support the individual's unique needs. We will review the information provided and contact you for further steps in the intake process.