



## Gulf Breeze ABA Service Inquiry Questionnaire

### Client Information

- **Client's Full Name:**
- **Date of Birth:**
- **Gender:**
- **Primary Caregiver's Name (if applicable):**
- **Relationship to Client:**
- **Primary Contact Number:**
- **Email Address:**
- **Residential Address (street, city, state):**

### Preferred Method of Contact

- Phone**
- Email**
- Text Message**

### Insurance Information

- **Insurance Provider:**
- **Policy Number:**
- **Group Number (if applicable):**
- **Insurance Contact Person and Phone Number:**

### Reason for Referral

**Who referred you to Gulf Breeze ABA?**

- Self**
- Family Member**
- Healthcare Professional**
- Other (please specify):**

**Please describe the primary concerns or reasons for seeking ABA therapy:**

**Telehealth Services**

**Are you open to participating in Telehealth ABA therapy sessions (via video conferencing or other online platforms)?**

- Yes**
- No**
- Maybe (please specify any concerns or conditions):**

**If you are open to Telehealth services, do you have the necessary technology (e.g., computer, internet connection, webcam) to participate effectively?**

- Yes**
- No**
- Not sure**

**Do you have any specific preferences or requirements for Telehealth sessions (e.g., times, platforms)?**

**Client History and Current Needs**

**Has the client previously received ABA therapy or any other behavior interventions?**

- Yes**
- No**

**If yes, please provide details:**

**Please describe any diagnoses or conditions relevant to the client's behavior (e.g., Autism Spectrum Disorder, ADHD, etc.):**

**What are the client's current strengths and skills?**

**What specific behaviors or challenges are you hoping to address with ABA therapy?**

**What are your goals or desired outcomes from therapy?**

**Are there any additional comments or concerns you would like to share?**