Intake Application

General Information

**Write name AND address as it appears on insurance card.*

Child's Name:_____DOB:_____Age:_____

How did you hear about Every Day Counts? _____

Physical Address: _____

Mailing Address (if different): _____

___Male Referred By:_____Diagnosing Dr: _____

___Female Primary Diagnosis:_____Secondary Diagnosis: _____

Date diagnosis was given: _____

Ethnicity: white, black, Hispanic, Asian, other_____SSN: _____

Guardian Information

Guardian Name:_____Relationship:_____

Phone number:_____Address if different from above: _____

Email address: _____

Do you live with patient: y / n

Place of employment:_____Address:_____

Phone Number:_____Contact:_____

Guardian Name:_____Relationship:_____

Phone number:_____Address if different from above: _____

Email address: _____

Do you live with patient: y / n

Place of employment:_____Address: _____

Phone Number:_____Contact: _____

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Siblings

Name:_____Age:_____

Name:_____Age:_____

Name:_____Age:_____

Name_____Age: _____

Services Being Requested

Check all ABA Services you are inquiring about for your child:

___ home based

___school based

___center based (Livonia)

___parent coaching

Schedule Availability:

Write n/a if unavailable

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Saturday: _____

Insurance Information

Primary:_____Insurance ID Number:_____

Name of policy holder:_____Bayou Health Provider: y / n

Policy holders DOB: _____

Secondary:_____Insurance ID Number:_____

Name of policy holder:_____Bayou Health Provider: y / n

Emergency Contact

Other than guardians listed above

Name:_____Relationship:_____

Address:_____Phone Number: _____

Authorized to pick up: y / n

Name:_____Relationship:_____

Address:_____Phone Number: _____

Authorized to pick up: y / n

Name:_____Relationship:_____

Address:_____Phone Number: _____

Authorized to pick up: y / n

Authorized Pick-Up (if center setting)

List if not listed above

Name:_____Relationship: _____

Phone Number: _____

Name:_____Relationship: _____

Phone Number: _____

Name:_____Relationship: _____

Phone Number: _____

Name:_____Relationship: _____

Phone Number: _____

Physicians

Primary Physician:_____Group: _____

Phone number:_____Permission to contact? y / n

Diagnosing Dr:_____Group: _____

Phone number:_____Permission to contact? y / n

Specialist:_____Group: _____

Phone number:_____Permission to contact? y / n

Specialist:_____Group: _____

Phone number:_____Permission to contact? y / n

Other Therapies/Services

Include how often, dates and if currently receiving

Speech: ___y ___ n

Name of Provider:_____Group: _____

Length of sessions:_____# days/week:_____Effective: ___y ___n

Begin date:_____- End date_____or Current ___y ___n

Occupational Therapy: ___y ___ n

Name of Provider:_____Group: _____

Length of sessions:_____# days/week:_____Effective: ___y ___n

Begin date:_____- End date_____or Current ___y ___n

Other: ___y ___ n
Name of Provider:_____Group: _____

Length of sessions:_____# days/week:_____Effective: ___y ___n

Begin date:_____- End date_____or Current ___y ___n

Education

Intake Application

School Name: _____ Grade attended: _____

Currently enrolled: y / n

School Name: _____ Grade attended: _____ Currently enrolled: y / n

School Name: _____ Grade attended: _____ Currently enrolled: y / n

Other Services provided at school: _____

If other services are provided, who are they provided by? _____

Current IEP? ___ yes ___ no If yes, attach to intake.

Past ABA Services

Past ABA Received? ___ yes ___no If yes, received by:_____

Dates of services: Began_____End_____

Reason for discontinuing? (If more than 1 past provider- list them below with dates & name of providers)

Reason for seeking out Every Day Counts for services: _____

_____

_____

_____

_____

Allergies

List all allergies: _____

Treatment for allergies listed: _____

Diagnosing Dr: _____

_____

Current Medications

Medication: _____Dose: _____Frequency: _____ Effective: y / n

Medication: _____Dose: _____Frequency: _____ Effective: y / n

Medication: _____Dose: _____Frequency: _____ Effective: y / n

Medication: _____Dose: _____Frequency: _____ Effective: y / n

Medication: _____Dose: _____Frequency: _____ Effective: y / n

Behaviors of Concern

List the top behaviors of concern you have regarding your child

1. Describe the behavior:

How often does it occur?

How long does it last?

Rate severity: Circle one- mild / moderate / severe

(mild = disruptive but little risk of injury; moderate= property damage or minor injury; severe= significant threat to health or safety)

2. Describe the behavior:

How often does it occur?

How long does it last?

Rate severity: Circle one- mild / moderate / severe

(mild = disruptive but little risk of injury; moderate= property damage or minor injury; severe= significant threat to health or safety)

3. Describe the behavior:

How often does it occur?

How long does it last?

Rate severity: Circle one- mild / moderate / severe

(mild = disruptive but little risk of injury; moderate= property damage or minor injury; severe= significant threat to health or safety)

What situations are these behaviors MOST likely to occur?
(Days/times/setting/activities/persons present)

What typically happens right BEFORE problem behavior occurs?

What typically happens right AFTER problem behavior occurs?

What current treatments are being implemented for the behaviors listed above? Are these treatments successful?

What treatments have been implemented in the past?

What motivates or interests your child? What makes them happy?

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

Skills Assessment

Check the most appropriate that describes your child.

Skill	Always	Sometimes	Never
Does your child speak freely and easily?			
Does your child use sentences to get their needs or wants met?			
Does your child communicate with gestures, sign language, or communication device?			
Does your child ask for at least 5 items on a daily basis?			
Skill	Always	Sometimes	Never
Does your child say words or sounds you say after you say them (echo you)?			
Does your child answer questions correctly when asked (if the answer is known)?			
Does your child follow directions and routines out of context?			

If you show your child how to do something, will they do it after you show them? (imitation)			
Does your child follow simple motor commands (ie. they are told to clap (without being shown) and they clap)?			
Does your child make eye contact?			
Does your child look when someone walks in a room?			
Does your child engage in age appropriate activities?			
Does your child have a particular topic they could engage in all day if you would let them?			
Is your child free of urine accidents?			
Is your child free of bowel movement accidents?			
Does your child wear underwear?			
Does your child dress by themselves?			
Does your child have a sense of danger?			

Parent/Guardian Signature:_____Date: _____

Reviewed By (Staff Signature):_____Date: _____