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 (not currently available) ___parent coaching

Schedule Availability:

Write n/a if unavailable

Monday: _____________________________________

Tuesday: _____________________________________

Wednesday: __________________________________

Thursday: ____________________________________

Friday: ______________________________________

Saturday: _____________________________________

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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: ____________________

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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

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Education

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?			

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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: _____________